State of New Hampshire
Department of Health and Human Services

2017 New Hampshire External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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Table of Contents

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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**). Both health plans are 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 over 300 performance measures.
- Requiring health plan accreditation by the National Committee for Quality Assurance (NCQA).
- Reporting validated measures to the public via medicaidquality.nh.gov.
- Requiring each health plan to implement a quality assurance and performance improvement program.
- Participating in a program evaluation conducted by the external quality review organization (EQRO).

The 2017 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), performance measure validation (PMV), and encounter data validation (EDV). Further analysis was conducted of each MCO's health outcome and beneficiary experience of care data compared to national performance measures. In 2017, HSAG also conducted focus group activities at the MCM Program level and provided recommendations concerning the MCO administration of a provider satisfaction survey and a behavioral health (BH) member satisfaction survey.

Health Plan Evaluation

HSAG observed very strong performance by both MCOs (i.e., scores of 97.3 percent for **NHHF** and 98.6 percent for **Well Sense**) in the review of compliance with federal and State standards. This year's PIP validation included a review of the outcomes of the studies (i.e., current rates); only one **NHHF** PIP and no **Well Sense** PIPs demonstrated statistically significant improvement over baseline rates.

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

Opportunity for improvement exists to improve the outcomes for three **NHHF** PIPs and three **Well Sense** PIPs. For both MCOs, PMV results were successfully approved for reporting, in contrast to the previous two years when both MCOs had one measure that could not be reported. In state fiscal year (SFY) 2017, the MCOs met the contract requirements for two EDV measures by passing both the electronic X12 data interchange (EDI) compliance edits and the accuracy edits for servicing providers in the National Council for Prescription Drug Program (NCPDP) files. Opportunities for improvement in EDV remain for **NHHF** and **Well Sense** in three areas: data accuracy related to member identification (ID) numbers, data accuracy related to servicing provider information for 837 Professional/Institutional (P/I) files, and timely encounter data submissions.

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. The current survey covered CY 2016 and generated results for 18 adult and child measures. The results for 11 **NHHF** adult and child measures were statistically significantly higher than the national average, as were the results for eight **Well Sense** adult and child measures. The remaining measures for both MCOs (i.e., seven **NHHF** adult and child measures, and 10 **Well Sense** adult and child measures) were neither statistically significantly higher nor lower than the national average. This year's rates improved over the rates reported last year.

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. **NHHF** met or exceeded the national Medicaid 90th percentile for eight measures, and **Well Sense** met or exceeded the national Medicaid 90th percentile for 10 measures. This year, only one measure's rate remained below the national Medicaid 25th percentile for both MCOs: *Chlamydia Screening in Women—Total.* This was an improvement over the prior year when eight measures for **NHHF** and four measures for **Well Sense** fell below the national Medicaid 25th percentile.

[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 (MCM) Program Evaluation

Two focus group activities were convened during SFY 2017, one in the fall and one in the spring. The targeted population for the fall focus groups included individuals who were enrolled in the MCM Program from July 2015 to August 2016. Results indicated an improvement in the enrollees' regard for their MCO and health coverage compared with previous interviews and focus groups. Of the participants who said they or their child had a chronic health condition, half said their care was more consistent and comprehensive while the other half said their care was equally as consistent and comprehensive as it was before enrolling. Suggestions included expanding coverage for dental care, vision care, prescriptions, and mental health; and increasing the number of primary care providers (PCPs) and specialists in the networks to decrease travel times and reduce appointment wait times.

The spring focus groups included individuals who were enrolled with the MCM Program through the Choices for Independence (CFI) Waiver. Overall, participants reported positive experiences with their MCO, and they were satisfied with the availability of doctors and specialists in the networks. The area of dissatisfaction most discussed included access to medical equipment and supplies as well as home health care support. Some participants were satisfied with transportation, and others noted challenges with the process for scheduling transportation appointments. Suggestions included expanding coverage for home health care, medical equipment and supplies, dental care, prescriptions, and mental health care.

Overall Conclusions From the SFY 2017 External Quality Review Organization (EQRO) Activities

In SFY 2017, the EQRO's activities revealed positive results as well as areas for improvement for the MCM Program. Rates improved from the prior year in the compliance reviews and PMV. Regarding HEDIS, only one rate remained below the national Medicaid 25th percentile for each MCO. This year's CAHPS results were statistically significantly higher than the national average, or were neither statistically significantly higher nor lower than the national average. The MCOs need to ensure that all activities continue to improve the rates and results over the next year, and areas that could be specifically targeted for improvement include the PIPs and EDV. Many of the same activities will be conducted in SFY 2018, which will allow further evaluation of targeted opportunities for improvement identified in this report.

2. Overview of the 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 most beneficiaries receiving their acute care services through one of three MCOs: **New Hampshire Healthy Families**, **Well Sense Health Plan**, or **Meridian Health Plan** (**Meridian**). In August 2014, **Meridian** exited New Hampshire, and over 30,000 beneficiaries were successfully transitioned to the remaining two plans. Each health plan is responsible for coordinating and managing beneficiary care through dedicated staff and a network of qualified providers. At the end of CY 2016, 135,548 New Hampshire Medicaid beneficiaries were enrolled in the MCM Program.[2-1] Most beneficiaries were females and children and adolescents 0–18 years of age—all receiving Medicaid based on low income eligibility standards.

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 over 300 performance measures.
- Requiring health plan accreditation by NCQA.
- Reporting validated measures to the public via medicaidquality.nh.gov.
- Requiring each health plan to implement a quality assurance and performance improvement program.
- Participating in a program evaluation conducted by the EQRO.

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 services through the program.[2-2] Currently the MCOs provide acute care services for the long-term care population, and they will provide long-term services and supports (LTSS) when Step 2, Phase 2 is implemented. Step 2, Phase 2, and Phase 3 of the MCM Program include beneficiaries receiving LTSS waiver services through nursing facilities or the CFI 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.

[2-1] The data source for all enrollment data is the December 1, 2016, extract from the New Hampshire MMIS.

[2-2] Approval from CMS Section 1915b Waiver.

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 2017 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 "an annual 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 MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity."[3-2] This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information of any beneficiary. The current report contains findings from the activities conducted during SFY 2017.

Additionally, the report presents and 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, timeliness of care, and access to health care services provided by each health plan and provides an assessment of the follow-up to the SFY 2016 recommendations for improvement. Appendices to this report include a list of abbreviations and acronyms; the methodology for conducting contractual compliance, PIPs, and PMV; and demographics of the New Hampshire MCM Program.

External Quality Review Activities, Conclusions, and Recommendations

Managed Care Organization (MCO) Contractual Compliance

Each year HSAG conducts an on-site compliance review at **NHHF** and **Well Sense** to ensure compliance with federal and State requirements. Subsequent to the comprehensive contract review in SFY 2014, the SFY 2015 review initiated a three-year cycle of reviewing one-third of the elements

[3-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 30, 2017.

[3-2] U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Jan 4, 2018.

contained in the comprehensive compliance tool. The SFY 2017 review was the third year of the three-year cycle of evaluating one-third of the compliance requirements.

Findings

Table 3-1 illustrates the overall score for the 2017 Compliance Review for **NHHF** and **Well Sense**.

Table 3-1—Summary of the SFY 2017 Compliance Review Scores for NHHF and Well Sense

Overall Rate for the 2017 Compliance Review	NHHF	Well Sense
Overall Score	97.3%	98.6%

The 2017 compliance review included 14 standards. **NHHF** achieved 97.3 percent on the 110 elements reviewed, and **Well Sense** achieved 98.6 percent on the 111 elements reviewed. The 2017 compliance review also included a separate assessment of four checklists: Network Management, Call Center, Member Identification Cards, and Notice Requirements. Additionally, HSAG conducted file reviews for initial credentialing files and recredentialing files. Table 3-2 shows the overall score for the four checklists and the two file reviews.

Table 3-2—Summary of the SFY 2017 Compliance Review Checklist and File Review Scores for NHHF and Well Sense

Checklist Reviews and File Reviews	NHHF	Well Sense
Checklist Reviews Total Score	100%	97.9%
File Reviews Total Score	99.6%	90.6%

NHHF scored 100 percent and **Well Sense** scored 97.9 percent on the checklist reviews. **NHHF** scored 99.6 percent and **Well Sense** scored 90.6 percent on the initial credentialing and recredentialing file reviews.

Conclusions and Recommendations for MCO Contractual Compliance

NHHF

NHHF achieved a comprehensive score of 97.3 percent on the SFY 2017 compliance reviews. The review included an examination of 14 standards with 105 **NHHF** elements *Met* (95.5 percent), four elements *Partially Met* (3.6 percent), and one element *Not Met* (0.9 percent). One element in one initial credentialing file was found to be noncompliant with State requirements, and **NHHF** achieved a 100 percent compliance score on the four checklist reviews.

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

- Plan documents must include:

  - The member type and the number of referrals of members for social services and community care.
  - The requirement to establish edits in the pharmacy systems for children ages 5 and under being prescribed antipsychotics, and children ages 3 and under being prescribed psychotropic medications.
  - Benchmarks and reduction goals for 30-day and 180-day readmissions to the New Hampshire Hospital.
  - The requirement that members who choose to enroll during a renegotiation or re-procurement enrollment period will be accepted by **NHHF**.
- The annual provider satisfaction survey must include a statistically valid sample from each major provider type, as required by DHHS.
- Initial credentialing files must be processed within the time frame established by DHHS.

Well Sense

Well Sense achieved a comprehensive score of 98.6 percent on the SFY 2017 compliance reviews. The review included an examination of 14 standards with 108 **Well Sense** elements *Met* (97.3 percent) and three elements *Partially Met* (2.7 percent). **Well Sense** obtained a score of 100 percent on the credentialing file review and 82.7 percent on the recredentialing file review (i.e., recredentialing files were missing proof of reviewing performance data). One element on the Member Identification Card Checklist was noncompliant.

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

- Plan documents must include the requirement to establish edits in the pharmacy systems for children ages 5 and under being prescribed antipsychotics, and children ages 3 and under being prescribed psychotropic medications.
- The recredentialing files must include documentation of the review of provider performance data including, but not limited to, member complaints and appeals, quality of care, and appropriate utilization of services.
- The annual provider satisfaction survey must include a statistically valid sample from each major provider type, as required by DHHS.
- The member identification card must include information advising members how to file an appeal or grievance.

For additional information concerning the compliance activities, see Section 4 on page 4-1 in the Detailed Findings.

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.

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

The purpose of a PIP, as defined by 42 CFR §438.330(d),[3-3] is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. To ensure that such projects 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

The SFY 2017 HSAG review involved the Design, Implementation, and Outcomes stages of the four PIP topics selected by **NHHF** and three of the four PIP topics selected by **Well Sense** as shown in Table 3-3. The **Well Sense** *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP was a replacement PIP topic, initiated in 2015; therefore, this PIP had only progressed through the Design and Implementation stages for the SFY 2017 validation. One of the four PIP topics conducted by each MCO focused on BH, as required by DHHS.

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

NHHF PIP Topics	Well Sense PIP Topics
Comprehensive Diabetes Screening—Vision Screening	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
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 3-4 shows the aggregate number of applicable evaluation elements that were scored *Met* for each PIP stage and the combined overall percentage of evaluation elements *Met* for the four 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 the Outcomes stage, the PIPs are assessed for improvement in study indicator outcomes (i.e., rates as compared to the baseline).

[3-3] U. S. Government Printing Office. (n.d.). *Quality Assessment and Performance Improvement Program.* Available at: https://www.govregs.com/regulations/title42_chapterIV_part438_subpartE_section438.330. Accessed on: Dec 12, 2017.

Table 3-4—2017 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% (69/69)	100% (57/57)
Implementation	Activities VII–VIII	90% (47/52)	96% (43/45)
Outcomes	Activities IX–X	62% (8/13)	60% (6/10)
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**93%**	**95%**

Both MCOs met 100 percent of the requirements for all activities in the Design stage of each PIP. The health plans designed and implemented scientifically sound PIPs supported by key research principles and quality improvement (QI) methods. The MCOs demonstrated solid performance in the Implementation stage, receiving a *Met* score for 90 percent or more of evaluation elements in this stage, across all PIPs. For SFY 2017, the MCOs reported the Remeasurement 1 study indicator results for each PIP (except one **Well Sense** PIP) and described QI activities that occurred during the Remeasurement 1 measurement period. With the reporting of Remeasurement 1 results, the MCOs progressed through Activity IX of the Outcomes stage for each of the PIPs except the **Well Sense** *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP, which progressed only through Activity VIII of the Implementation stage. **NHHF** and **Well Sense** have opportunities for improvement in the Outcomes stage, receiving a *Met* score for 62 percent and 60 percent, respectively, across all PIPs that progressed to this stage.

Conclusions and Recommendations

NHHF and Well Sense

NHHF and **Well Sense** designed scientifically sound projects supported by 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 QI activities in the Implementation stage. There were opportunities for improvement related to evaluating intervention effectiveness. The MCOs have more substantial opportunities for improvement in the Outcomes stage. One **NHHF** PIP, and none of the **Well Sense** PIPs, demonstrated statistically significant improvement over baseline across all study indicators at the first remeasurement. The MCOs should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement of study indicator outcomes in the future.

HSAG offered the following recommendations for both MCOs to strengthen and improve future PIP performance:

- Develop and implement evaluation processes for each intervention implemented. The evaluation process for an intervention should be designed to measure impact on the study indicator outcomes and should distinguish the intervention's impact from other concurrent interventions. The evaluation process should allow the MCO to gauge effectiveness of an intervention throughout the measurement period so that the intervention can be refined and improved to support optimal improvement of study indicator outcomes.
- Use intervention-specific evaluation results to guide decisions about improvement strategies as the PIP progresses. Intervention evaluation results should be used in conjunction with causal/barrier analyses to continually refine improvement strategies, supporting the achievement of significant improvement in PIP outcomes.

For additional information concerning the PIP activities, see Section 4 on page 4-7 in the Detailed Findings.

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

Performance Measure Validation (PMV)

As required by 42 CFR §438.358(b)(ii),[3-4] HSAG completed the validation of MCO performance measures for SFY 2017, and this section provides a summary of the findings, conclusions, and recommendations from the PMV activities.

Findings

Table 3-5 provides an overview of the findings generated by the HSAG review team for the one state-specific measure (i.e., *Ambulatory Care: Physician/Advance Practice Registered Nurse (APRN)/Clinic Visits per Member per Month by Subpopulation* [*AMBCARE.10]*) reported for 63 subpopulations validated during the SFY 2017 PMV audit.

Table 3-5—SFY 2017 PMV Findings

Performance Measures	SFY 2017	
	NHHF	Well Sense
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable	Acceptable
All primary and secondary coding schemes captured	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable
Appropriate provider data systems and processing	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable

Conclusions and Recommendations

NHHF

NHHF staff members were dedicated to quality reporting. In SFY 2017, **NHHF** reported measure data to DHHS in a timely manner throughout the year. **NHHF** appropriately captured the reporting periods

[3-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 30, 2017.

for the measure utilizing systematic practices when possible to reduce manual processing of data to ensure data integrity.

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

- **NHHF** should facilitate the review of source code as part of the validation process to ensure that auditors can identify concerns early in the audit process to allow **NHHF** to make corrections as needed before final rate validation.
- **NHHF** should thoroughly review and understand the reporting specifications and intent of the measures required for reporting by DHHS prior to reporting any measures and seek clarification from DHHS, if needed. HSAG found that **NHHF** had incorrectly calculated the denominator for the measure under review. After DHHS provided an extension, **NHHF** corrected the source code to include all subpopulations. Since DHHS has other measures that use similar measure specifications for denominator identification, **NHHF**'s calculation error potentially impacted other measures. **NHHF** should apply any corrections that were made for *AMBCARE.10* to other measures as appropriate.

Well Sense

Well Sense staff members were well versed in quality reporting. HSAG noted that **Well Sense** staff continued to be dedicated to accurate reporting and demonstrated this through regular internal meetings and quality review sessions. **Well Sense** reviewed the measure specifications, asked questions, and obtained clarification from DHHS when staff members were 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 monitored its vendors closely to ensure all data submissions were timely and complete. HSAG noted that **Well Sense** continued to accurately capture the reporting periods for the measure.

There were no new recommendations for **Well Sense**. The auditor suggested that **Well Sense** staff members continue to request clarification from DHHS for measure specifications as well as for questions related to reporting.

For additional information concerning the validation of the MCO performance measures, see Section 4 on page 4-15 in the Detailed Findings.

For additional information concerning HSAG's methodology for validating MCO performance measures, see Appendix B on page B-9 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 2017, 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.[3-5] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

For each of the four global ratings, the percentage of respondents who chose a positive satisfaction 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."

Each measure rate was compared to the NCQA national average, and a statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted in Table 3-6 and Table 3-7 with arrows. An upward green arrow (↑) is denoted if the lower limit of the confidence interval was higher than the national average. However, if the upper limit of the confidence interval was lower than the national average, then a downward red arrow (↓) is denoted. If the national average was within the confidence interval, then there was no significant difference, which is denoted with a dash (—).

[3-5] For 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).

Table 3-6 contains the results from the 2017 Adult Medicaid CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to the NCQA national averages.[3-6]

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

CAHPS Measure	2017 Adult Medicaid Positive Rates	2016 National Average Comparison	2017 Adult Medicaid Positive Rates	2016 National Average Comparison
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**74.8%**	—	**80.3%**	↑
Rating of All Health Care	**75.5%**	—	**74.3%**	—
Rating of Personal Doctor	**83.8%**	↑	**81.9%**	—
Rating of Specialist Seen Most Often	**85.1%**	↑	**87.9%**	↑
Composite Measures	**NHHF**		**Well Sense**	
Getting Needed Care	**84.7%**	↑	**84.2%**	↑
Getting Care Quickly	**88.2%**	↑	**84.3%**	↑
How Well Doctors Communicate	**93.8%**	↑	**91.4%**	—
Customer Service	**87.4%**	—	**89.2%**	—
Shared Decision Making	**86.9%**	↑	**83.4%**	↑

Note: ↑ indicates the measure rate is statistically significantly higher than the national average
— indicates the measure rate is neither statistically significantly higher nor lower than the national average

3-6 The 2017 Adult Medicaid CAHPS Results presented in Table 3-6 for **NHHF** and **Well Sense** are based on the responses of adult Medicaid beneficiaries that returned a completed CAHPS survey. **NHHF** surveyed a total of 2,160 adult Medicaid members, of which 580 completed surveys were returned. **Well Sense** surveyed a total of 1,350 adult Medicaid members, of which 366 completed surveys were returned. In 2016, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 24.8 percent, which was lower than the adult Medicaid **NHHF** and **Well Sense** response rates.

Table 3-7 contains the results from the 2017 General Child CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to NCQA national averages.[3-7]

Table 3-7—NHHF and Well Sense Child Medicaid CAHPS Results

CAHPS Measure	2017 Child Medicaid Positive Rates	2016 National Average Comparison	2017 Child Medicaid Positive Rates	2016 National Average Comparison
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**85.9%**	—	**84.7%**	—
Rating of All Health Care	**89.8%**	↑	**87.5%**	—
Rating of Personal Doctor	**90.8%**	—	**90.5%**	—
Rating of Specialist Seen Most Often	**82.1%**	—	**89.0%+**	—
Composite Measures	**NHHF**		**Well Sense**	
Getting Needed Care	**88.1%**	↑	**87.9%**	↑
Getting Care Quickly	**92.7%**	↑	**94.9%**	↑
How Well Doctors Communicate	**96.1%**	↑	**96.0%**	↑
Customer Service	**86.3%**	—	**85.7%+**	—
Shared Decision Making	**82.9%**	↑	**75.3%+**	—

Note: ↑ indicates the measure rate is statistically significantly higher than the national average
— indicates the measure rate is neither statistically significantly higher nor lower than the 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

NHHF's adult Medicaid population rates were statistically significantly higher than NCQA's 2016 Medicaid national average, with the exception of *Rating of Health Plan, Rating of All Health Care,* and *Customer Service*, which were neither statistically significantly higher nor lower than the national average. **NHHF**'s child Medicaid population rates were statistically significantly higher than NCQA's 2016 Medicaid national average with the exception of *Rating of Health Plan, Rating of Personal*

[3-7] The 2017 Child Medicaid CAHPS Results presented in Table 3-7 for **NHHF** and **Well Sense** are based on the responses of parents/caretakers of child Medicaid beneficiaries, selected as part of the general child sample only, that returned a completed CAHPS survey (i.e., based on the results of the general child population only). A total of 2,640 **NHHF** general child Medicaid members were selected for surveying, of which 561 completed surveys were returned. A total of 1,799 **Well Sense** general child Medicaid members were selected for surveying, of which 410 completed surveys were returned. In 2016, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey was 23.0 percent, which was higher than the child Medicaid **NHHF** response rate and lower than the child Medicaid **Well Sense** response rate.

Doctor, Rating of Specialist Seen Most Often, and *Customer Service,* which were neither statistically significantly higher nor lower than the national average.

HSAG recommends the following for **NHHF**:

- The plan should focus QI efforts on enhancing members' experiences with *Rating of Health Plan* and *Customer Service* for the adult and child populations, *Rating of All Health Care* for the adult population, and *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* for the child population.

Well Sense

Well Sense's adult Medicaid population rates were statistically significantly higher than NCQA's 2016 Medicaid national averages with the exception of *Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate,* and *Customer Service,* which were neither statistically significantly higher nor lower than the national average. **Well Sense**'s general child Medicaid population rates were statistically significantly higher than NCQA's 2016 Medicaid national averages with the exception of *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Customer Service,* and *Shared Decision Making,* which were neither statistically significantly higher nor lower than the national average. HSAG recommends the following for **Well Sense**:

- The plan should focus QI efforts on enhancing members' experiences with *Rating of All Health Care, Rating of Personal Doctor,* and *Customer Service* for the adult and child populations; *How Well Doctors Communicate* for the adult population; and *Rating of Health Plan, Rating of Specialist Seen Most Often,* and *Shared Decision Making* for the child population.

For additional information concerning the CAHPS Survey, see Section 4 on page 4-16 in the Detailed Findings.

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.[3-8] **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 (FARs), information system compliance tools, and the interactive data submission system (IDSS) files approved by an NCQA-licensed organization (LO).

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 47 performance measures to NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2016 (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:

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

[3-8] National Committee for Quality Assurance. (n.d.). *HEDIS & Performance Measurement*. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Nov 30, 2017.

Table 3-8—Summary of Scores for 2016 HEDIS Measures With National Comparative Rates for NHHF

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile but Below the 90th Percentile	Met 50th Percentile but Below the 75th Percentile	Met 25th Percentile but Below 50th Percentile	Under 25th Percentile	Total
Prevention	3	12	4	0	1	**20**
Acute and Chronic Care	2	4	7	1	0	**14**
BH	3	5	2	3	0	**13**
All Domains	**8**	**21**	**13**	**4**	**1**	**47**
Percentage	**17.02%**	**44.68%**	**27.66%**	**8.51%**	**2.13%**	**100%**

NHHF's rates ranked at or above the national Medicaid 50th percentile for 42 measures (89.36 percent), with eight of these measures meeting or exceeding the national Medicaid 90th percentile (17.02 percent). The rate for one measure (2.13 percent) fell below the national Medicaid 25th percentile.

Table 3-9—Summary of Scores for 2016 HEDIS Measures With National Comparative Rates for Well Sense

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile but Below the 90th Percentile	Met 50th Percentile but Below the 75th Percentile	Met 25th Percentile but Below 50th Percentile	Under 25th Percentile	Total
Prevention	4	12	3	0	1	**20**
Acute and Chronic Care	3	8	2	1	0	**14**
BH	3	2	6	2	0	**13**
All Domains	**10**	**22**	**11**	**3**	**1**	**47**
Percentage	**21.28%**	**46.81%**	**23.40%**	**6.38%**	**2.13%**	**100%**

Well Sense's rates ranked at or above the national Medicaid 50th percentile for 43 measures (91.49 percent), with 10 of these measures meeting or exceeding the national Medicaid 90th percentile (21.28 percent). The rate for one measure (2.13 percent) fell below the national Medicaid 25th percentile.

Conclusions and Recommendations

NHHF

The following rates met or exceeded the national Medicaid 90th percentile, indicating positive performance for **NHHF**:

- Three Prevention measure rates: *Adults' Access to Preventive/Ambulatory Health Services*, *Childhood Immunization Status—Combination 10*, and *Non-Recommended Cervical Cancer Screening in Adolescent Females*

- Two Acute and Chronic Care measure rates: *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid* and *Controlling High Blood Pressure*
- Three BH measure rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up*, *Diabetes Monitoring for People with Diabetes and Schizophrenia*, and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

The following rate fell below the national Medicaid 25th percentile, indicating opportunities for improvement for **NHHF**:

- One Prevention measure rate: *Chlamydia Screening in Women—Total*

Well Sense

The following rates met or exceeded the national Medicaid 90th percentile, indicating positive performance for **Well Sense**:

- Four Prevention measure rates: *Adults' Access to Preventive/Ambulatory Health Services*, *Adolescent Well-Care Visits*, *Non-Recommended Cervical Cancer Screening in Adolescent Females*, and *Prenatal and Postpartum Care—Postpartum Care*
- Three Acute and Chronic Care measure rates: *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*, and *Controlling High Blood Pressure*
- Three BH measure rates: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

The following rate fell below the national Medicaid 25th percentile, indicating opportunities for improvement for **Well Sense**:

- One Prevention measure rate: *Chlamydia Screening in Women—Total*

For additional information concerning the HEDIS measures, see Section 4 on page 4-27 in the Detailed Findings.

Encounter Data Validation (EDV)

HSAG continued to use an Encounter Data Quality Reporting System (EDQRS) for SFY 2017 to evaluate 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 (P/I) and NCPDP pharmacy files to HSAG daily/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

For encounters received from MCOs between July 1, 2016, and June 30, 2017, this section presents the aggregate rates for five 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).
- Encounter data shall be submitted weekly (Standard 25.2.24.3.1).
- Encounter data shall be submitted within 30 calendar days of claim payment (Standard 25.2.24.3.1).

Table 3-10 displays aggregate compliance rates for each MCO in relation to the standards. Values in green font indicate rates meeting the corresponding standards, and values in red font indicate rates below the corresponding standards by more than 10 percentage points.

Table 3-10—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*		99.4%	97.6%	99.5%	96.9%	99.9%	99.9%
Validity of Servicing Provider Information*							
Percent Present	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		97.7%	97.8%	96.3%	94.3%	98.2%	98.1%
Timeliness*							
Weekly Submission	100%	98.1%	90.4%	98.1%	88.5%	98.1%	96.2%
Submission Within 30 Days of Claim Payment	100%	70.7%	39.4%	62.5%	42.8%	90.8%	3.3%

* Refer to Table 4-16 to Table 4-19 for more details 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 encounters 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. While both **NHHF** and **Well Sense** met the percent accurate standard for their NCPDP encounters, neither of them met the percent accurate standard for 837 P/I encounters.
- Weekly Submission: **NHHF** and **Well Sense** submitted all three types of encounters to DHHS for more than 88 percent of the weeks in SFY 2017, which was below the standard of 100 percent.
- Submission Within 30 Days of Claim Payment: The percentages of encounters submitted to DHHS within 30 calendar days of claim payment dates for both **NHHF** and **Well Sense** were considerably below the standard of 100 percent.

Conclusions and Recommendations

NHHF

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

- X12 EDI compliance edits
- Accuracy for servicing providers in NCPDP encounters

HSAG recommends that **NHHF** focus on the following:

- Data accuracy related to member identification numbers for all three encounter types
- Data accuracy related to servicing provider information for 837 P/I encounters
- Timely encounter data submissions including both weekly submissions to DHHS and submissions to DHHS within 30 days of the claim payment date

Well Sense

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

- X12 EDI compliance edits
- Accuracy for servicing providers in NCPDP encounters

HSAG recommends that **Well Sense** focus on the following:

- Data accuracy related to member identification numbers for all three encounter types
- Data accuracy related to servicing provider information for 837 P/I encounters
- Timely encounter data submissions including both weekly submissions to DHHS and submissions to DHHS within 30 days of the claim payment date

For additional information concerning EDV, see Section 4 on page 4-83 in the Detailed Findings.

Other External Quality Review (EQR) Activities

Focus Groups

Horn Research, a subcontractor to HSAG, conducted focus groups in fall 2016 and spring 2017.

Horn Research conducted the fall focus groups by telephone and interviewed 28 participants representing all regions in the State. The targeted population for the interviews was comprised of individuals from **NHHF** and **Well Sense** who were enrolled in the MCM Program from July 2015 to August 2016.

- Four key points of inquiry were explored with the focus groups:
  - Access to care.
  - Experience with care management.
  - Elements of an ideal MCO.
  - Suggested improvements.
- Results indicated an improvement in enrollees' regard for their MCO and health coverage compared with previous rounds of interviews and focus groups. Overall, participants reported that their experience with their MCO was positive.
- Half of the participants who said they or their child had a chronic health condition reported that their care was more consistent and comprehensive, while the other half reported that their care was equally as consistent and comprehensive as it was before enrolling in their MCO.
- Participants reported that an ideal MCO would provide additional benefits to members (e.g., dental care, medications, vision care).
- Suggestions for improvement included expanding coverage for dental care, vision care, prescriptions, and mental health. Participants suggested increasing the number of PCPs and specialists to decrease travel times and reduce appointment wait times, and adding benefits to support healthier lifestyles (e.g., gym memberships, nutritional counseling).

Horn Research also conducted the spring focus groups by telephone, with 30 MCO members participating in the interviews. The target population included individuals who were enrolled with the MCM Program through the CFI Waiver (i.e., seniors or adults who qualify medically for the level of care provided in nursing facilities).

- Four key points of inquiry were explored during this period's data collection efforts:
  - Members' experience with their MCO
  - Access to care
  - Quality of care management
  - Suggested improvements
- Participants reported positive experiences with their MCO.

- Most participants were satisfied with the availability of doctors and specialist care through their network as well as the process for accessing medications. Participants were dissatisfied with their access to needed medical equipment and supplies as well as home care support.
- Transportation was an important benefit for this population, and while some participants were satisfied with their transportation support, others noted challenges with the centralized process used to schedule transportation, issues with the assistance received from the drivers, and being late for appointments.
- Over two-thirds of the participants indicated that case management support was provided by a community organization. Only four participants noted that they received case management support from their MCO.
- Suggested improvements included:
  - Expanding coverage for home care, medical equipment and supplies, dental care, prescriptions, and mental health care.
  - Streamlining the scheduling of transportation, ensuring that the transportation vendor is on-time for scheduled appointments, and receiving adequate physical support from the drivers.
  - Adding benefits to support healthier lifestyles (e.g., gym memberships, nutritional counseling).

For additional information concerning the focus group activities, see Section 4 on page 4-88 in the Detailed Findings.

Provider Satisfaction Survey

DHHS contracted with HSAG to recommend a provider satisfaction tool that could be used by the MCOs to determine the providers' level of satisfaction with the MCOs. Previously, each MCO used the Symphony Performance Health Analytics (SPHA) Provider Satisfaction Survey with varying supplemental questions, and the results of the two MCO surveys could not be compared due to the variations in the tools. To meet DHHS' need for a single, consolidated provider satisfaction survey instrument, HSAG developed a Custom Provider Satisfaction Survey that could be used to rate either one or both MCOs, depending on the provider's affiliation with **NHHF** and **Well Sense**. The survey consists of 23 questions, including 11 write-in questions specific to the domains shown in Table 3-11.

Table 3-11—Domains Included in the Custom Provider Satisfaction Survey Tool Created by HSAG

Domains in the Custom Provider Satisfaction Survey Developed by HSAG	Explanation of the Domains
General Position	Level of satisfaction with timeliness of claims payments and overall satisfaction
Providing Quality Care	Level of satisfaction with the MCOs' prior authorization process and formulary in terms of the impact on providers' ability to deliver quality care
Non-formulary drugs	Level of satisfaction with access to non-formulary drugs
Service Coordination	Level of satisfaction with the assistance given by service coordinators at the MCO
Specialists	Level of satisfaction with the MCOs' number of medical and BH specialists

HSAG recommended administering a mixed-mode methodology (i.e., mail/Internet and telephone follow-up) with the option to complete a paper-based survey, web-based survey, or telephone survey, and encouraged the MCOs to contract with the same third-party vendor to administer the survey. Using the same third-party survey vendor would allow for the possibility of sending one survey with response areas listed for each MCO to **NHHF** and **Well Sense** network providers reducing the number of surveys received by the providers, and improving the response rates from prior years.

For additional information concerning the provider satisfaction survey, see Section 4 on page 4-91 in the Detailed Findings.

Behavioral Health (BH) Member Survey

The State of New Hampshire received a Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant (MHBG) and is required to conduct an annual consumer satisfaction survey. **NHHF** and **Well Sense** also are required to administer a survey to members receiving BH services to fulfill requirements for NCQA Health Plan Accreditation. The purpose of the survey is to determine consumer satisfaction with the services and to ensure that quality, appropriate BH care and services are being delivered to beneficiaries. DHHS requested that HSAG research the surveys used by the three organizations and recommend one consolidated, comprehensive BH survey that could be administered by all three entities to satisfy the requirements of NCQA and SAMHSA.

NHHF, **Well Sense**, and the Bureau of Behavioral Health (BBH) provide BH services to Medicaid beneficiaries in the State. The MCOs furnish BH services to Medicaid members through network providers, other BH professionals, and community mental health centers (CMHCs). The BBH provides BH services to Medicaid and non-Medicaid recipients (e.g., commercially insured, private pay, non-funded) through the 10 CMHCs in the State.

HSAG reviewed the surveys used by the MCOs and interviewed staff at the Bureau of Mental Health Services, Division for BH, to determine the contents of the current BH surveys used in New Hampshire. Table 3-12 displays the surveys currently administered by the three entities providing BH services in New Hampshire.

Table 3-12—Surveys Administered by the BBH and the MCOs

DHHS Required BH Survey Areas	BBH (Modified Mental Health Statistics Improvement Program [MHSIP] Survey)	NHHF (Modified MHSIP Survey)	Well Sense (Custom BH Survey)
SAMHSA Community MHBG Requirements	X	X	
NCQA Health Plan Survey Accreditations*,[3-9]	X	X	X
Addresses Services Received From CMHCs	X	X	X
Addresses Services Received From Private Treatment or Counselor			X
Addresses Managed Care Services	X	X	X

* To meet the NCQA Health Plan Accreditation requirements, an organization must administer a BH survey. NCQA's specifications do not mandate the use of a particular survey instrument.

[3-9] National Committee for Quality Assurance (NCQA). *Standards and Guidelines for the Accreditation of Managed Behavioral Healthcare Organizations: Effective for Surveys Beginning on or after July 1, 2016.*

In addition to the survey instruments used by the two MCOs and BBH, HSAG evaluated two nationally recognized BH surveys: The Experience of Care and Health Outcomes (ECHO) Adult Survey and the CAHPS Home and Community-Based Services (HCBS) Adult Survey.[3-10]

Recommendations

HSAG recommended that DHHS implement an enhanced version of the MHSIP Consumer Survey, and the Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F) surveys when administering the survey to families or youth, with additional supplemental items. HSAG recommended 16 supplemental items based on modified questions from the nationally recognized ECHO survey to accompany the MHSIP survey. This enhanced MHSIP Consumer Survey will create a more robust survey instrument that meets DHHS' need to determine the level of satisfaction with the BH services provided for Medicaid and non-Medicaid members who receive services through the MCOs or the BBH. The recommended enhanced MHSIP Consumer Survey is applicable to all members, regardless of mental illness severity or payor type (i.e., Medicaid or non-Medicaid).

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

[3-10] Experience of Care and Health Outcomes (ECHO®) is a trademark of the Agency for Healthcare Research and Quality (AHRQ). The ECHO Survey is one of the survey products available through AHRQ's CAHPS User Network that assesses BH services provided by managed care plans and managed BH organizations.

Summary of Strengths and Opportunities for Improvement Concerning Quality, Timeliness of Care, and Access to Care Furnished by MCOs

From the results of this year's plan-specific activities, HSAG summarizes each MCO's strengths and opportunities for improvement and provides an assessment and evaluation of the quality, timeliness of care, and access to care and services that each MCO provides. The evaluations are based on the following definitions of quality, timeliness, and access:

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[3-11]

- ***Timeliness***—NCQA defines "timeliness" relative to utilization decisions as follows:

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3-12] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

- ***Access***—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services). [3-13]

[3-11] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 29, 2017.

[3-12] NCQA. *2016 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2016: UM5.

[3-13] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 29, 2017.

New Hampshire Healthy Families

Compliance

NHHF demonstrated strength in complying with federal and State standards by obtained an overall score of 97.3 percent in the SFY 2017 compliance review. Of the 14 standard areas reviewed, **NHHF** achieved *100 percent compliance* on 10 standards, demonstrating complete adherence to all requirements in these standards. **NHHF** also scored 90.0 percent or higher on two standards, demonstrating a high degree of adherence to the elements contained in those standards. The scores for two standards (i.e., Plans Required by the Contract and Member Enrollment and Disenrollment) were 87.5 percent, representing the greatest opportunity for improvement.

The 105 elements that received a *Met* score represented strengths in compliance with federal and State requirements for quality, timeliness of care, and access to care for the New Hampshire Medicaid beneficiaries. **NHHF** scored 100 percent on the requirements included on the four checklists, and 99.6 percent of the items required for the file reviews were compliant.

Opportunities for improvement exist for **NHHF** in the items that partially met or did not meet the requirements included in this year's review of compliance with federal and State requirements. **NHHF** needs to revise plan documents and systems to include required edits for the pharmacy and ensure that the annual provider satisfaction survey includes a statistically valid sample from each major provider type. Initial credentialing files need to be processed within the time limits established by DHHS, and **NHHF** needs to include information about accepting members who choose to enroll during a renegotiation or re-procurement enrollment period in plan documents. **NHHF** also must establish benchmarks and reduction goals for 30- and 180-day readmissions to the New Hampshire Hospital and create a report concerning the number of member referrals for social services and community care. The elements that need to be revised represent measures that could affect quality of care and access to care.

PIPs

During 2017, HSAG reviewed the Design, Implementation, and Outcomes stages for **NHHF**'s four PIPs. All four **NHHF** PIPs are related to quality of care, and one PIP also is related to access to and timeliness of care. One of the PIPs, related to quality of care, demonstrated strength by achieving statistically significant improvement over the baseline across all study indicators at the first remeasurement. The other three PIPs did not demonstrate statistically significant improvement in the Outcomes stage. **NHHF** should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement of study indicator outcomes for the three PIPs that did not demonstrate statistically significant improvement over the baseline for the study indicators at the first remeasurement.

PMV

HSAG noted that while **NHHF** had appropriate claims and encounters processes for the access to care measure, and captured provider information and all relevant data from core systems appropriately, **NHHF** did not use the additional data required to identify the subpopulations to capture the denominator appropriately. The numerator counts were also dependent on the denominator; therefore, the numerators also were incorrect and were not broken out by the appropriate subpopulations. This error was critical and systemic, leading to a biased numerator. After DHHS provided an extension, **NHHF** corrected the source code to include all subpopulations. HSAG conducted source code review and primary source verification, and approved the code. The WebEx review conducted with **NHHF** regarding the updated data demonstrated that **NHHF** was in compliance with the specifications following the updates to include the subpopulations. HSAG instructed **NHHF** to resubmit data for all quarters to DHHS. The *AMBCARE.10* measure, concerning access to care, was successfully approved for reporting for **NHHF**.

NHHF should consult with DHHS when producing measures to eliminate any issues related to understanding the measure requirements. **NHHF** should thoroughly review and understand the reporting specifications and intent prior to reporting any measures and seek clarification from the DHHS, if needed. **NHHF** would benefit from holding regular meetings with internal programmers to ensure the programming captures all measure specifications. **NHHF** should have source code walkthroughs with business owners to ensure all data elements for each measure are captured. Additionally, **NHHF** should have a formal signoff from both the business owners and programmers to ensure both parties agree with the final measure reporting. Since HSAG found that **NHHF** was incorrectly calculating the denominator for the measure under review and since DHHS has other measures that use similar measure specifications for denominator identification, **NHHF** should apply any corrections that were made for *AMBCARE.10* to other measures as appropriate.

CAHPS

Six positive rates for **NHHF**'s adult Medicaid population and five positive rates for the child Medicaid population in 2017 were statistically significantly higher than the 2016 NCQA adult and child Medicaid national averages. These measures represent responses related to access to care, timeliness of care, and quality of care. The remaining three 2017 **NHHF** adult measure rates and four 2017 child measure rates, representing the quality of care domain, were neither statistically significantly higher nor lower than the 2016 NCQA adult and child Medicaid national averages.

To improve CAHPS rates, **NHHF** could consider involving MCO staff members at every level to assist in improving *Rating of Health Plan* and *Customer Service* rates. Methods for achieving improvement could include ensuring that QI goals align with the mission and goals of the MCO, establishing MCO-level performance measures, clearly defining and communicating measures that require improvement, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives could be monitored and reported internally to assess the effectiveness of these efforts. Specific QI initiatives aimed at engaging employees could include departmental meetings, quarterly employee forums, annual staff meetings to discuss outcomes for the measures, topic-specific improvement teams, leadership development courses, and employee awards. Another way to include

staff members would be the creation of cross-departmental improvement teams to focus on specific topics targeted for improvement.

The rates for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider newsletters and providing periodic reminders about the importance of improving communication skills with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians should check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor/manage their conditions.

HEDIS

Based on the rates the MCO reported for the HEDIS measures, **NHHF** showed strong performance with meeting or exceeding the national Medicaid 90th percentile for three Prevention measure rates, two Acute and Chronic Care measure rates, and three BH measure rates. Those eight measures represent quality of care, timeliness of care, and access to care. HSAG recommends that **NHHF** analyze strategies that can be linked to improvements in the Prevention measure rate, representing quality of care, that fell below the national Medicaid 25th percentile. Because both MCOs remain below the Medicaid 25th percentile for the same measure, **NHHF** could consider collaborating with **Well Sense** to develop QI activities and share responsibilities for contacting the physicians who treat members impacted by this preventive measure.

Encounter Data Validation

NHHF met the standard for X12 EDI compliance edits and data accuracy for servicing provider information in NCPDP encounters. **NHHF** should continue improving data accuracy for the member identification number and servicing provider information for the outstanding encounter types; and timely data submissions to DHHS so that **NHHF** can meet the corresponding standards. Developing system edits to flag incorrect information prior to submission of the data may be helpful in eliminating errors with data accuracy. **NHHF** also may work with DHHS on example cases with inaccurate member identification numbers and/or servicing provider information to determine the root cause. Lastly, appointing a specific team member to be responsible for more stringent oversight of the due dates for submission of data may correct the timeliness issues. Determining access to care and health outcomes, representing quality of care, could be difficult if **NHHF** does not submit accurate and timely encounter data to DHHS.

Well Sense Health Plan

Compliance

Well Sense demonstrated strength in complying with federal and State standards by obtaining an overall score of 98.6 percent in the SFY 2017 compliance review. Of the 14 standard areas reviewed, **Well Sense** achieved *100 percent compliance* on 11 standards, demonstrating total adherence to all requirements in these standards. **Well Sense** also scored 95.0 percent or higher on three standards, demonstrating a high degree of adherence to the elements contained in those standards. The 108 elements that received a *Met* score represented strengths in the requirements for quality, timeliness of care, and access to care for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **Well Sense** in the items that partially met or did not meet the requirements included in this year's review of compliance with federal and State requirements. **Well Sense** needs to revise plan documents and systems to include required edits for the pharmacy and ensure that identification cards include information advising members how to file an appeal or grievance. An area requiring improvement involved the recredentialing files, which must provide evidence that **Well Sense** reviewed plan information (e.g., quality, utilization review, grievances) during the recredentialing process. **Well Sense** also needs to ensure that the annual provider satisfaction survey includes a statistically valid sample from each major provider type. The elements that need to be revised represent measures that could affect quality of care.

PIPs

During 2017, HSAG reviewed the Design and Implementation stages for **Well Sense**'s four PIPs, and the Outcomes stage for three PIPs. One PIP, related to quality of care, was a replacement topic and only progressed through the Design and Implementation stages for the SFY 2017 validation. The three **Well Sense** PIPs in the Outcomes stage are related to quality of care, and one PIP in the Outcomes stage also is related to access to care and timeliness of care. None of the three PIPs achieved statistically significant improvement over the baseline across all study indicators in the Outcomes stage. **Well Sense** should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement of study indicator outcomes for the three PIPs that did not demonstrate statistically significant improvement over the baseline for the study indicators at the first remeasurement.

PMV

HSAG noted that **Well Sense** had appropriate claims and encounters processes, and captured provider information and all relevant data from core systems appropriately. The *AMBCARE.10* measure concerning access to care was successfully approved for reporting. **Well Sense**'s quality team had adequate overview processes in place for the system to ensure all claims and enrollment processes were captured accurately. In addition, **Well Sense**'s source code developers followed the *AMBCARE.10* specifications appropriately.

Well Sense should continue to work with DHHS and HSAG to understand the details of each measure. **Well Sense** continues to rely on 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.

CAHPS

Five positive rates for **Well Sense**'s adult Medicaid population and three positive rates for the child Medicaid population in 2017 were statistically significantly higher than the 2016 NCQA adult and child Medicaid national average. These measures represent responses related to access to care, timeliness of care, and quality of care. The remaining four 2017 **Well Sense** adult measure rates and six 2017 child measure rates, representing the quality of care domain, were neither statistically significantly higher nor lower than the 2016 NCQA adult and child Medicaid national averages.

To improve CAHPS rates, **Well Sense** could consider involving MCO staff members at every level to assist in improving *Rating of Health Plan* and *Customer Service* rates. Methods for achieving improvement could include ensuring that QI goals align with the mission and goals of the MCO, establishing MCO-level performance measures, clearly defining and communicating measures that require improvement, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives could be monitored and reported internally to assess the effectiveness of these efforts. Specific QI initiatives aimed at engaging employees could include departmental meetings, quarterly employee forums, annual staff meetings to discuss outcomes for the measures, topic-specific improvement teams, leadership development courses, and employee awards. Another way to include staff members would be the creation of cross-departmental improvement teams to focus on specific topics targeted for improvement.

The rates for *Rating of All Health Care, Rating of Personal Doctor, Shared Decision Making, How Well Doctors Communicate, Customer Service,* and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider newsletters and providing periodic reminders about the importance of improving communication skills with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians should check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor/manage their conditions.

HEDIS

Based on the rates the MCO reported for the HEDIS measures, **Well Sense** showed strong performance with meeting or exceeding the national Medicaid 90th percentile for four Prevention measure rates, three Acute and Chronic Care measure rates, and three BH measure rates. Those 10 measures represent quality of care, timeliness of care, and access to care. HSAG recommends that **Well Sense** analyze

strategies that can be linked to improvements in the Prevention measure rate, representing quality of care, that fell below the national Medicaid 25th percentile. Because both MCOs remain below the Medicaid 25th percentile for the same measure, **Well Sense** could consider collaborating with **NHHF** to develop QI activities and share responsibilities for contacting the physicians who treat members impacted by this preventive measure.

Encounter Data Validation

Well Sense met the standard for X12 EDI compliance edits and data accuracy for servicing provider information in NCPDP encounters. **Well Sense** should continue improving data accuracy for the member identification number and servicing provider information for the outstanding encounter types; and timely data submissions to DHHS so that **Well Sense** can meet the corresponding standards. Developing system edits to flag incorrect information prior to submission of the data may be helpful in eliminating data accuracy errors. **Well Sense** also may work with DHHS on example cases containing inaccurate member identification numbers and/or servicing provider information to determine the root cause. Lastly, appointing a specific team member to be responsible for more stringent oversight of the due dates for submission of data may correct the timeliness issues. Determining access to care and health outcomes, representing quality of care, could be difficult to if **Well Sense** does not submit accurate and timely encounter data to DHHS.

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

MCO Contractual Compliance

The SFY 2014 compliance activities consisted of reviewing 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 comprehensive 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 comprehensive compliance tool. The current review in SFY 2017 included 14 standards with 110 applicable elements for **NHHF** and 111 applicable elements for **Well Sense**. HSAG also included the corrective action plan (CAP) elements from the SFY 2016 compliance review in the SFY 2017 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 2017 Compliance Review

Table 4-1 includes the findings from the SFY 2017 compliance reviews for **NHHF** and **Well Sense**.

Table 4-1—Comparison of MCO Scores for the SFY 2017 Compliance Review

Standard	Standard Name	2017 NHHF	2017 Well Sense
I	Delegation and Subcontracting	100%	100%
II	Plans Required by the Contract	87.5%	100%
III	Emergency and Post-stabilization Care	100%	100%
IV	Care Management/Care Coordination	90.0%	96.7%
V	Wellness and Prevention	100%	100%
VI	BH	100%	100%
VII	Member Enrollment and Disenrollment	87.5%	100%
VIII	Member Services	100%	100%

[4-1] New Hampshire Department of Health and Human Services. (2014). *Medicaid Managed Care Organization Contract and Amendments.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: Dec 13, 2016.

Standard	Standard Name	2017 NHHF	2017 Well Sense
IX	Cultural Considerations	100%	100%
X	Grievances and Appeals	100%	100%
XI	Access	100%	100%
XII	Network Management	100%	95.0%
XIII	Utilization Management	100%	100%
XIV	Quality Management	95.0%	95.5%
Overall Score		**97.3%**	**98.6%**

Of the 14 standards included in the SFY 2017 compliance review, **NHHF** achieved 100 percent compliance for 10 standards, 90–99 percent compliance for two standards, and 87.5 percent compliance for two standards. **Well Sense** achieved 100 percent compliance for 11 standards and 95–99 percent compliance for three standards.

The SFY 2017 compliance review included a review of initial credentialing and recredentialing files. The file reviews for both MCOs included a total of 278 elements. HSAG reviewed 38 files for **NHHF** and 40 files for **Well Sense**. The findings from the file reviews are shown in Table 4-2.

Table 4-2—Comparison of MCO Scores for the SFY 2017 File Reviews

File Review	NHHF	Well Sense
Initial Credentialing	99.3%	100%
Recredentialing	100%	82.7%
File Reviews Total Score	**99.6%**	**90.6%**

The MCOs both scored 100 percent on one of the file reviews: recredentialing for **NHHF** and initial credentialing for **Well Sense**. **NHHF** achieved 99.3 percent on the initial credentialing file review due to one file not meeting the processing time established by DHHS. Twenty-six of the 30 recredentialing files for **Well Sense** did not contain evidence of a provider performance review including, but not limited to, member complaints and appeals, quality of care, and appropriate utilization of services. **Well Sense** scored 82.7 percent on the recredentialing file review.

The SFY 2017 compliance review also included a review of four checklists: Network Management, Call Center, Member Identification Cards, and Notice Requirements. The checklist reviews for both MCOs included 48 elements, and the findings are displayed in Table 4-3.

Table 4-3—Comparison of MCO Scores for the SFY 2017 Checklist Reviews

Checklist	NHHF	Well Sense
Network Management	100%	100%
Call Center	100%	100%
Member Identification Cards	100%	90.9%
Notice Requirements	100%	100%
Checklist Reviews Total Score	**100%**	**97.9%**

NHHF achieved full compliance for all four checklists. The one checklist that did not achieve full compliance for **Well Sense** was the Member Identification Cards checklist. **Well Sense** must ensure that the member identification cards include information advising members how to file an appeal or grievance.

NHHF Conclusions and Recommendations for the Compliance Review

During **NHHF**'s SFY 2017 compliance review, 4.5 percent of the elements (n=5) were found to be noncompliant with federal and State regulations. The file reviews for credentialing and recredentialing were 99.6 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 policies, procedures, and staff interviews that the MCO corrected the deficiencies identified during the prior year's audit.

NHHF received 100 percent compliance on 10 standards, the four checklists, and the recredentialing file review. Two standards received a score of 90.0 percent or higher: Care Management/Care Coordination and Quality Management. One initial credentialing file was not completed within the time frame established by DHHS. The two standards representing the greatest opportunities for improvement received a score of 87.5 percent: Plans Required by the Contract and Member Enrollment and Disenrollment. HSAG offers the following recommendations for **NHHF**:

- Plan documents must include:
  - The member type, and the number of referrals of members for social services and community care.
  - The requirement to establish edits in the pharmacy systems for children ages 5 and under being prescribed antipsychotics, and children ages 3 and under being prescribed psychotropic medications.
  - Benchmarks and reduction goals for 30- and 180-day readmissions to the New Hampshire Hospital.
  - The requirement that members who choose to enroll during a renegotiation or re-procurement enrollment period will be accepted by **NHHF**.
- The annual provider satisfaction survey must include a statistically valid sample from each major provider type, as required by DHHS.
- Initial credentialing files must be processed in the time frame established by DHHS.

NHHF successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the current SFY 2017 compliance review.

Well Sense Conclusions and Recommendations for the 2017 Compliance Review

During **Well Sense**'s SFY 2017 compliance review, 2.7 percent of the elements (n=3) were found to be noncompliant with federal and State regulations. The file reviews for credentialing and recredentialing were 90.6 percent compliant with the required elements, and the checklist reviews generated a score of 97.9 percent compliance with required elements. HSAG also validated through a review of policies, procedures, and staff interviews that the MCO corrected the deficiencies identified during the prior year's audit.

Well Sense received 100 percent compliance on 11 standards, three checklists, and the initial credentialing file review. Three standards received a score of 90.0 percent or higher compliance: Care Management/Care Coordination, Network Management, and Quality Management. The Member Identification Card Checklist noted one area of improvement, with a score of 90.9 percent, and the recredentialing file review represented the greatest opportunity for improvement, with an 82.7 percent score. HSAG offers the following recommendations for **Well Sense**:

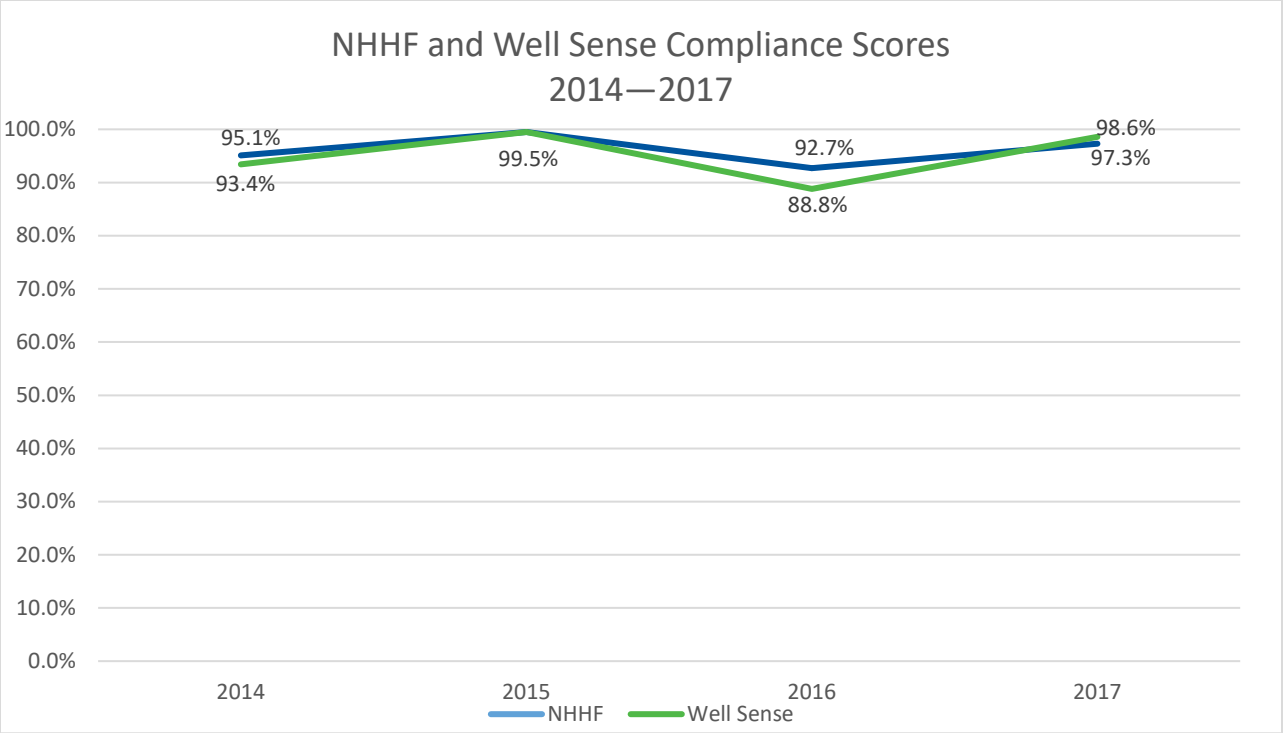
- Plan documents must include the requirement to establish edits in the pharmacy systems for children ages 5 and under being prescribed antipsychotics, and children ages 3 and under being prescribed psychotropic medications.
- Recredentialing files must document the review of provider performance data including, but not limited to, member complaints and appeals, quality of care, and appropriate utilization of services.
- The annual provider satisfaction survey must include a statistically valid sample from each major provider type, as required by DHHS.
- The member identification card must include information advising members how to file an appeal or grievance.

Well Sense successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the current SFY 2017 compliance review.

Trending

Figure 4-1 displays the compliance scores achieved by **NHHF** and **Well Sense** during the four years that HSAG conducted compliance reviews.

Figure 4-1—Compliance Scores for NHHF and Well Sense from 2014–2017

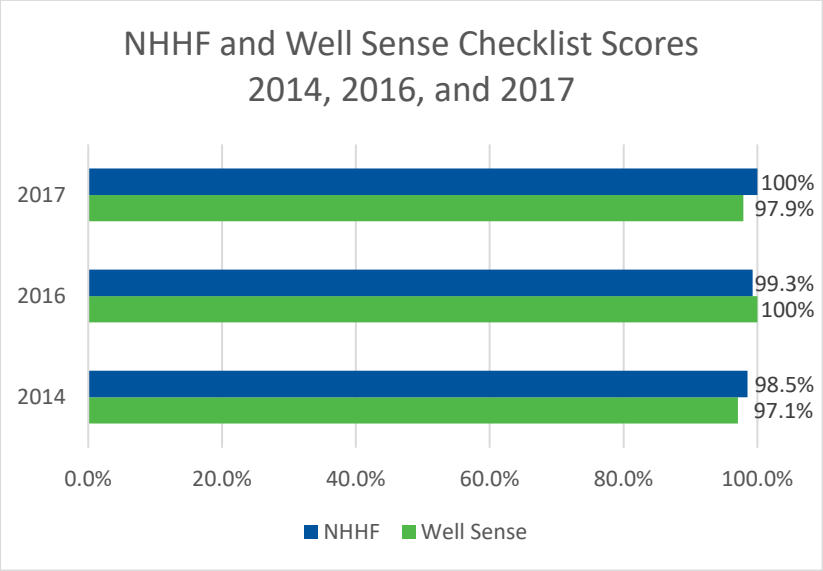


The scores for **NHHF** ranged from 92.7 percent in 2016 to 99.5 percent in 2015. The scores for **Well Sense** ranged from 88.8 percent in 2016 to 99.5 percent in 2015. As previously mentioned, the SFY 2014 compliance activities consisted of reviewing all 14 standards containing 294 applicable elements. Since that time, HSAG has reviewed one-third of the elements in 2015, 2016, and 2017. Appendix B includes information concerning the number of elements included in the reviews from 2014–2017.

Since 2015, the compliance tool has contained different elements for each year of the review. The MCOs scored the lowest scores in 2016 and the highest scores in 2015. The review in 2016 included an extra standard because DHHS requested that HSAG include the substance use disorder (SUD) requirements in that review. The MCOs scored under 50 percent for the SUD standard; however, **NHHF** and **Well Sense** submitted CAPs to correct the deficiencies noted in the review.

Figure 4-2 displays the checklists scores achieved by **NHHF** and **Well Sense** during the 2014, 2016, and 2017 compliance reviews. HSAG did not include a checklist review in the 2015 compliance review.

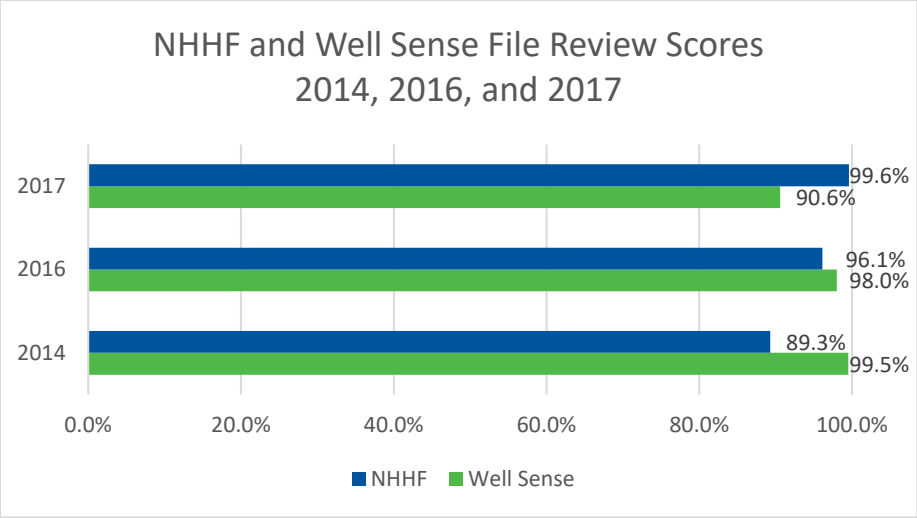
Figure 4-2—Checklist Scores for NHHF and Well Sense in 2014, 2016, and 2017



Ten checklists were included in the 2014 review, five checklists were included in the 2016 review, and four checklists were included in the 2017 review. One checklist was retired due to changing requirements in the contract between the MCOs and DHHS. Appendix B includes information concerning the names of the checklists included in the 2014, 2016, and 2017 reviews.

Figure 4-3 includes the file review scores achieved by **NHHF** and **Well Sense** during the 2014, 2016, and 2017 compliance reviews. HSAG did not include any file reviews in the 2015 compliance review.

Figure 4-3—File Review Scores Achieved by NHHF and Well Sense in 2014, 2016, and 2017



Five file reviews are included in the compliance audits in New Hampshire: grievances, appeals, denials of service, credentialing, and recredentialing. The 2016 review included three file reviews, and the 2017 review include two file reviews. Appendix B includes information concerning the file reviews included in the 2014, 2016, and 2017 audits.

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. 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 the first half of SFY 2017, 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 BH.

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	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
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 2017 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% (69/69)	100% (57/57)
Implementation	Activities VII–VIII	90% (47/52)	96% (43/45)
Outcomes	Activities IX–X	62% (8/13)	60% (6/10)
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**93%**	**95%**

For all PIPs, the Design stage establishes the methodological framework. 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 validation for SFY 2017 indicated that both MCOs met 100 percent of the requirements for all activities in the Design stage of each PIP. The health plans designed scientifically sound PIPs supported by key research principles. The technical designs of the PIPs were sufficient to measure and monitor PIP outcomes.

The Implementation stage includes data analysis and interpretation as well as development and implementation of improvement strategies. For the SFY 2017 validation, the MCOs reported results of the first remeasurement for each PIP (except the **Well Sense** *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP) and described improvement strategies that occurred during the first remeasurement period. The MCOs demonstrated solid performance in the Implementation stage, receiving a *Met* score for 90 percent and 96 percent of the evaluation elements, respectively, across all PIPs.

In the Outcomes stage, the PIPs are assessed for improvement in the study indicator outcomes. Both MCOs progressed through Activity IX of the Outcomes stage for each of the PIPs, reporting results of the first remeasurement and being evaluated for improvement, with one exception. Because **Well Sense** replaced one PIP topic in SFY 2017, the MCO only reported baseline results for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP and, therefore, did not progress to the Outcomes stage for this PIP. Both MCOs could improve the Outcomes stage, with 62 percent and 60 percent of the evaluation elements receiving a *Met* score, respectively. To improve performance in the Outcomes stage, the MCOs should revisit the causal/barrier analysis for each PIP to determine any previously unidentified barriers to improvement and review intervention evaluation results to identify gaps in existing interventions. The MCOs can improve performance and facilitate desired improvement in PIP outcomes by ensuring all high-impact barriers are addressed by innovative and effective interventions.

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—NHHF's Performance Improvement Project Outcomes for *Comprehensive Diabetes Care—Vision Screening*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
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%	65.6%↑*
↑* Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).		

For the *Comprehensive Diabetes Care—Vision Screening* PIP, **NHHF** reported a baseline study indicator rate of 59.8 percent. At Remeasurement 1, the MCO reported a rate of 65.6 percent. The Remeasurement 1 rate was a statistically significant ($p = 0.0442$) improvement of 5.8 percentage points over the baseline rate. The Remeasurement 1 rate also exceeded the MCO's goal of 65.5 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—NHHF's Performance Improvement Project Outcomes for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
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.	77.6%	78.7%→
→ Designates an improvement over the baseline measurement period that was not statistically significant (*p* value >= 0.05).		

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP, **NHHF** recalculated the baseline study indicator rate using updated HEDIS specifications so that the baseline and Remeasurement 1 rates would be comparable. HSAG recommended the baseline rate recalculation because NCQA changed the denominator definition in the HEDIS specifications after the baseline measurement period; the specification changes impacted the comparability of rates. Using the updated specifications, the MCO reported a baseline study indicator

rate of 77.6 percent and a Remeasurement 1 rate of 78.7 percent. The increase of 1.1 percentage points from baseline to Remeasurement 1 was not statistically significant ($p = 0.7784$). The Remeasurement 1 rate did not meet the MCO's goal of 89.0 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—NHHF's Performance Improvement Project Outcomes for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
1. The percentage of eligible members aged 3 to 17 years with evidence of Body Mass Index (BMI) documentation.	68.6%	57.9% ↓*
2. The percentage of eligible members aged 3 to 17 years with evidence of counseling for nutrition.	74.8%	65.6% ↓*
3. The percentage of eligible members aged 3 to 17 years with evidence of counseling for physical activity.	69.5%	59.6% ↓*
↓* Designates statistically significant decline over the baseline measurement period (p value < 0.05).		

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP, **NHHF** reported the following baseline rates for Study Indicators 1 (evidence of BMI documentation), 2 (evidence of counseling for nutrition), and 3 (evidence of counseling for physical activity) respectively: 68.6 percent, 74.8 percent, and 69.5 percent. At Remeasurement 1, the MCO reported a rate of 57.9 percent for Study Indicator 1 (evidence of BMI documentation). The Remeasurement 1 rate for Study Indicator 1 did not meet the MCO's goal of 75.0 percent and was a statistically significant ($p = 0.0016$) decline from the baseline rate. For Study Indicator 2 (evidence of counseling for nutrition), the MCO reported a Remeasurement 1 rate of 65.6 percent, which did not meet the goal of 80.5 percent and was a statistically significant ($p = 0.0041$) decline from baseline. For Study Indicator 3 (evidence for counseling of physical activity), the MCO reported a Remeasurement 1 rate of 59.6 percent, which did not meet the goal of 75.7 percent and was a statistically significant ($p = 0.0030$) decline from the baseline rate.

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

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

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
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%	78.9% →
→ Designates a decline over the baseline measurement period that was not statistically significant (*p* value >= 0.05).		

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **NHHF** reported a baseline study indicator rate of 79.3 percent. At Remeasurement 1, the MCO reported a rate of 78.9 percent. The decline of 0.4 percentage point from baseline to Remeasurement 1 was not statistically significant ($p = 0.9323$). The Remeasurement 1 rate of 78.9 percent did not meet the MCO's goal of 84.5 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—Well Sense's Performance Improvement Project Outcomes for *Chlamydia Screening*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
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%	42.7% →
→ Designates a decline over the baseline measurement period that was not statistically significant (*p* value >= 0.05).		

For the *Chlamydia Screening* PIP, **Well Sense** reported a baseline study indicator rate of 43.5 percent. At Remeasurement 1, the MCO reported a rate of 42.7 percent. The decline of 0.8 percentage point in the study indicator rate from baseline to Remeasurement 1 was not statistically significant ($p = 0.6164$). The Remeasurement 1 rate did not meet the MCO's goal of 47.5 percent.

Table 4-11 displays the baseline study indicator results for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP.

Table 4-11—Well Sense's Performance Improvement Project Outcomes for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Study Indicator	Baseline Period (1/1/2015–12/31/2015)	Remeasurement 1 (1/1/2016–12/31/2016)
1. The percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening or monitoring test performed in the measurement year.	85.4%	NA*
* The PIP had progressed to reporting only baseline results for calendar year 2015; therefore, improvement was not assessed.		

For the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* PIP, **Well Sense** reported a study indicator rate of 85.4 percent for the baseline measurement. The MCO initiated the PIP in 2015; therefore, it did not report Remeasurement 1 results for SFY 2017 validation. The MCO set a goal of 89.4 percent for Remeasurement 1, based on the baseline study indicator results.

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

Table 4-12—Well Sense's Performance Improvement Project Outcomes for *Reducing Hospital Readmissions*

Study Indicator*	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
1. The percentage of eligible members readmitted to New Hampshire Hospital within 30 days of discharge.	13.3%	8.0% ↓* **(lower rate is an improvement)**
2. The percentage of eligible members readmitted to New Hampshire Hospital within 60 days of discharge.	18.1%	11.9% ↓* **(lower rate is an improvement)**
3. The percentage of eligible members readmitted to New Hampshire Hospital within 90 days of discharge.	18.8%	14.8% →
* The PIP's study indicators are inverse indicators, where a lower rate is better. ↓* Designates statistically significant improvement over the baseline measurement period (p value < 0.05) in an inverse indicator, where a lower rate is better. → Designates (for an inverse indicator, where a lower rate is better) an improvement over the baseline measurement period that was not statistically significant (p value >= 0.05).		

For the *Reducing Hospital Readmissions* PIP, **Well Sense** reported the following baseline rates for Study Indicators 1 (30-day readmission rate), 2 (60-day readmission rate), and 3 (90-day readmission rate) respectively: 13.3 percent, 18.1 percent, and 18.8 percent. At Remeasurement 1, the MCO reported a rate of 8.0 percent for Study Indicator 1 (30-day readmission rate). The Remeasurement 1 rate for Study Indicator 1 surpassed the MCO's goal of 8.1 percent and was a statistically significant (p = 0.0244) improvement from the baseline rate. For Study Indicator 2 (60-day readmission rate), the MCO reported

a Remeasurement 1 rate of 11.9 percent, which surpassed the goal of 12.3 percent and was a statistically significant (p = 0.0216) improvement from baseline. For Study Indicator 3 (90-day readmission rate), the MCO reported a Remeasurement 1 rate of 14.8 percent, which did not meet the goal of 12.9 percent. While the Remeasurement 1 rate for Study Indicator 3 was an improvement of 4 percentage points from the baseline rate, the improvement was not statistically significant (p = 0.1581).

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

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

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)
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%	79.8% →
→ Designates an improvement over the baseline measurement period that was not statistically significant (p value >= 0.05).		

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **Well Sense** reported a baseline study indicator rate of 77.5 percent. At Remeasurement 1, the MCO reported a rate of 79.8 percent. The increase of 2.3 percentage points from baseline to Remeasurement 1 was not statistically significant (p = 0.4683). The Remeasurement 1 rate did not meet the MCO's goal of 83.1 percent.

Conclusions and Recommendations

NHHF

NHHF designed scientifically sound projects supported by key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. **NHHF** had opportunities for improvement in the Implementation stage related to selection and timing of interventions and insufficient evaluation of intervention effectiveness. In the Outcomes stage, the MCO achieved statistically significant improvement over baseline for one PIP and non-statistically significant improvement for another PIP. For the two remaining PIPs, the study indicators demonstrated declines in study indicator outcomes from baseline to Remeasurement 1. Improving the selection, timing, and evaluation of improvement strategies will support the progression toward achieving statistically significant improvement for each PIP.

HSAG offered the following recommendations to strengthen the **NHHF** PIPs and support improvement in PIP outcomes:

- **NHHF** should ensure that each implemented intervention is an active, measurable improvement strategy. Passive interventions such as mass member mailings are unlikely to impact study indicator outcomes and are difficult to measure for effectiveness.
- **NHHF** should implement interventions early enough during the measurement period to allow time for impacting the study indicator outcomes. Improvement strategies initiated earlier in the

measurement period allow more time for intervention evaluation and refinement, more time for reaching members and providers, and more time for the targeted service to occur—ultimately impacting the annual study indicator result.

- **NHHF** should develop and implement evaluation processes for each intervention implemented. The evaluation process for an intervention should be designed to measure impact on the study indicator outcomes and should distinguish the intervention's impact from other concurrent interventions. The evaluation process should allow the MCO to gauge effectiveness of an intervention throughout the measurement period so that the intervention can be refined and improved to support optimal improvement of study indicator outcomes.
- **NHHF** should use intervention-specific evaluation results to guide decisions about improvement strategies as the PIP progresses. Intervention evaluation results should be used in conjunction with causal/barrier analyses to continually refine improvement strategies, supporting the achievement of significant improvement in PIP outcomes.

Well Sense

Well Sense designed scientifically sound projects supported by key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. **Well Sense** had opportunities for improvement in the Implementation stage related to insufficient evaluation of intervention effectiveness. In the Outcomes stage, the MCO demonstrated non-statistically significant improvement in two of the PIPs and statistically significant improvement in two of three study indicators in one PIP; however, no PIPs demonstrated statistically significant improvement across all study indicators from baseline to Remeasurement 1. Developing more robust intervention evaluation processes should support the MCO's efforts toward achieving statistically significant improvement for each PIP**.**

HSAG offered the following recommendations to strengthen the **Well Sense** PIPs and support improvement in PIP outcomes:

- **Well Sense** should develop and implement evaluation processes for each intervention implemented for each PIP. The evaluation process for an intervention should be designed to measure impact on the study indicator outcomes and should distinguish the intervention's impact from other concurrent interventions. The evaluation process should allow the MCO to gauge effectiveness of an intervention throughout the measurement period so that the intervention can be refined and improved to support optimal improvement of study indicator outcomes.
- **Well Sense** should use intervention-specific evaluation results to guide decisions about improvement strategies as the PIP progresses. Intervention evaluation results should be used in conjunction with causal/barrier analyses to continually refine improvement strategies, supporting the achievement of significant improvement in PIP outcomes.

PMV

The following section of the report describes the results of HSAG's SFY 2017 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 of care, and access to care provided by the New Hampshire Medicaid MCOs. During SFY 2017, each MCO submitted rates for one state-specific measure, *AMBCARE.10*, for 63 subpopulations that were validated during PMV. Recommendations are offered to each MCO to facilitate continued QI in the Medicaid program. The measure reviewed in SFY 2017 and a complete description of the audit methodology used to conduct the review of performance measures are included in Appendix B.

Results for SFY 2017

Table 4-14 provides an overview of the findings of the HSAG performance validation review for SFY 2017.

Table 4-14—SFY 2017 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 Systems and Process Findings	Acceptable	Acceptable
Prior Authorization Data System and Process Findings	Acceptable	Acceptable
Performance Measure Production and Reporting Findings	Acceptable	Acceptable

Conclusions and Recommendations for Improvement

NHHF

NHHF used a variety of methods for producing the measure under review and had staff who were dedicated to quality reporting. **NHHF** did not use the data required to identify subpopulations to capture the denominator appropriately. The numerator counts were also dependent on the denominator; therefore, the numerators were also incorrect and were not broken out by the appropriate subpopulations. This error was critical and systemic, leading to a biased numerator. After DHHS provided an extension, **NHHF** corrected the source code to include all subpopulations. HSAG conducted source code review and primary source verification, and approved the code. A WebEx review conducted with **NHHF** to review updated data demonstrated that **NHHF** was compliant with the specifications following the updates to include the subpopulations. HSAG instructed **NHHF** to resubmit data for all quarters to DHHS.

NHHF should consult with DHHS when producing measures to eliminate any issues related to understanding the measure requirements. **NHHF** should thoroughly review and understand the reporting specifications and intent prior to reporting any measures and seek clarification from DHHS, if needed. **NHHF** would benefit from holding regular meetings with internal programmers to ensure the programming captures all measure specifications. **NHHF** should have source code walkthroughs with business owners to ensure all data elements for each measure are captured. Additionally, **NHHF** should have a formal signoff from both the business owners and programmers to ensure both parties agree with the final measure reporting. Since HSAG found that **NHHF** was incorrectly calculating the denominator for the measure under review and since DHHS has other measures that use similar measure

specifications for denominator identification, **NHHF** should apply any corrections that were made for *AMBCARE.10* to other measures as appropriate.

Well Sense

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

Well Sense should continue to work with DHHS and HSAG to understand the details of each measure. **Well Sense** continues to rely on 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.

CAHPS

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. Morpace and SPHA, NCQA-certified HEDIS/CAHPS survey vendors, administered the 2017 CAHPS surveys for **NHHF** and **Well Sense**, respectively.

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.[4-2] Adult members and parents or caretakers of child members completed the surveys in 2017, 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.[4-3] The global ratings reflected patients' overall satisfaction with their personal doctor,

[4-2] For the adult and child Medicaid populations, **NHHF** and **Well Sense** used an enhanced mixed-mode (i.e., mail followed by telephone follow-up) survey methodology pre-approved by NCQA.

[4-3] For this report, the 2017 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

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 fewer 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 2016 NCQA CAHPS Adult and General Child Medicaid national averages, where applicable.[4-4] Each measure rate was compared to the NCQA national average, and a statistically significant difference was identified by using the confidence interval for each measure rate. The measure rates, confidence intervals, and the NCQA national average are displayed in the figures below. Statistically significant differences between each measure rate's lower and upper confidence intervals and the NCQA national average are discussed below the figures.

Results

NHHF

A total of 2,160 **NHHF** adult Medicaid members were surveyed in 2017, of which 580 completed surveys were returned. After ineligible members were excluded, the response rate was 27.51 percent. In 2016, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 24.8 percent, which was lower than the **NHHF** adult Medicaid response rate. Figure 4-4 and Figure 4-5 show the 2017 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2016 national average for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s adult Medicaid population.

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.

4-4 National data were obtained from the 2016 Quality Compass. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

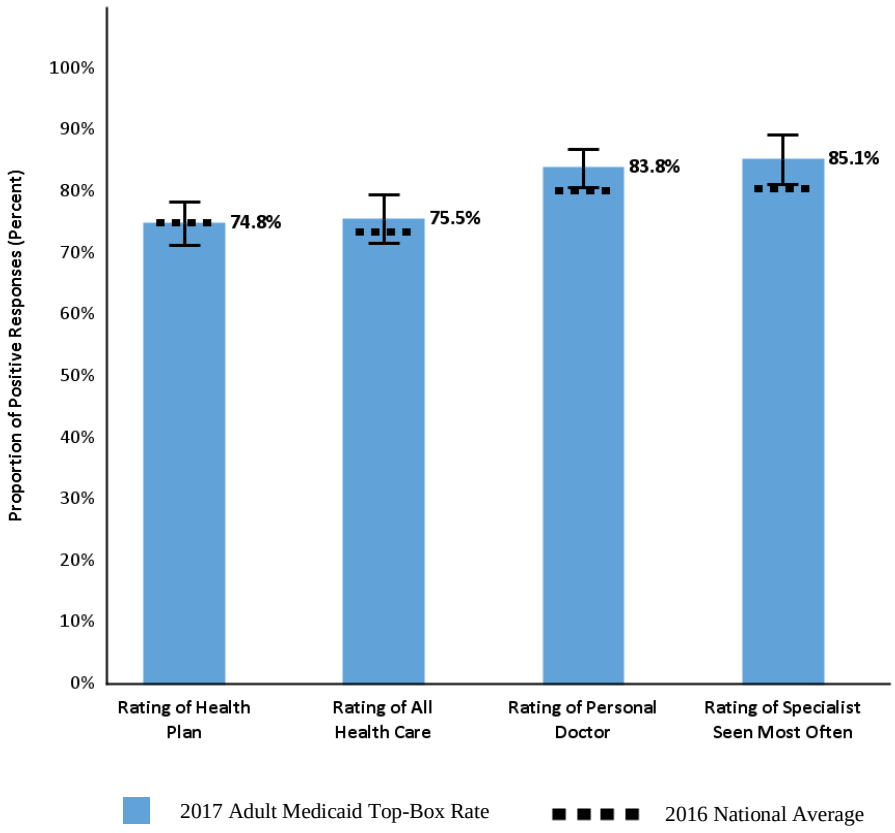
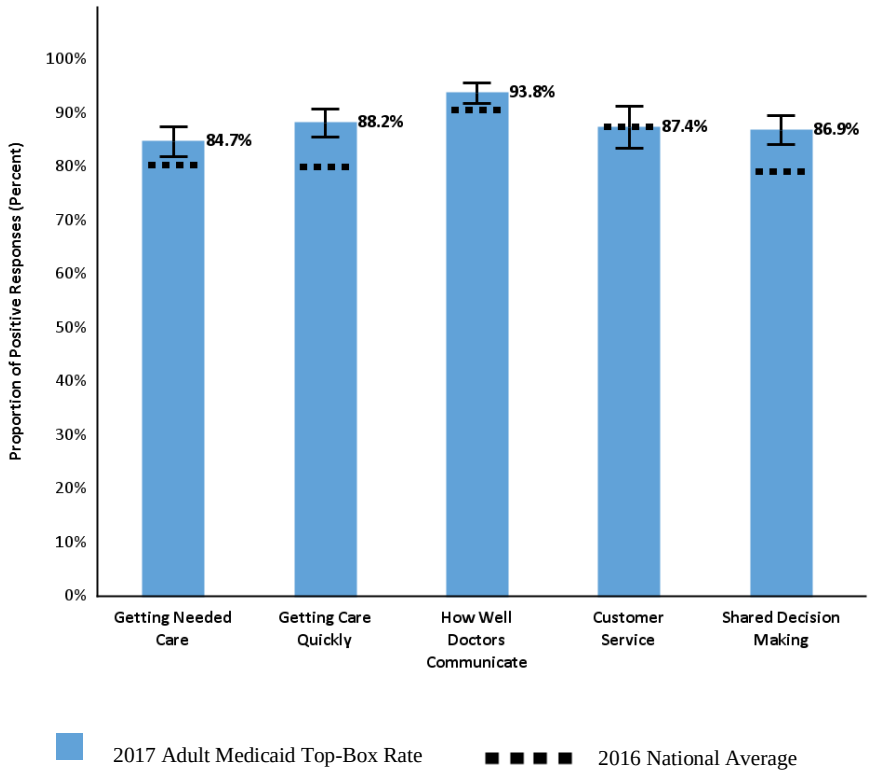


Figure 4-5—NHHF Adult Medicaid CAHPS Results: Composite Measures



For **NHHF**'s adult Medicaid population, all rates were statistically significantly higher than NCQA's 2016 Medicaid national average, except for *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*, which were neither statistically significantly higher nor lower than the national average.

A total of 2,640 **NHHF** general child Medicaid members were surveyed in 2017, of which 561 completed surveys were returned on behalf of the child members. After ineligible members were excluded, the response rate for the general child population was 21.39 percent.[4-5] In 2016, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement set was 23.0 percent, which was higher than the **NHHF** general child Medicaid response rate. Figure 4-6 and Figure 4-7 show the 2017 general child positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2016 national average for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s general child Medicaid population.[4-6]

[4-5] 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).

[4-6] The 2017 child Medicaid CAHPS results presented in Figure 4-6 and Figure 4-7 for **NHHF** are based on results of the general child population only.

Figure 4-6—NHHF Child Medicaid CAHPS Results: Global Ratings

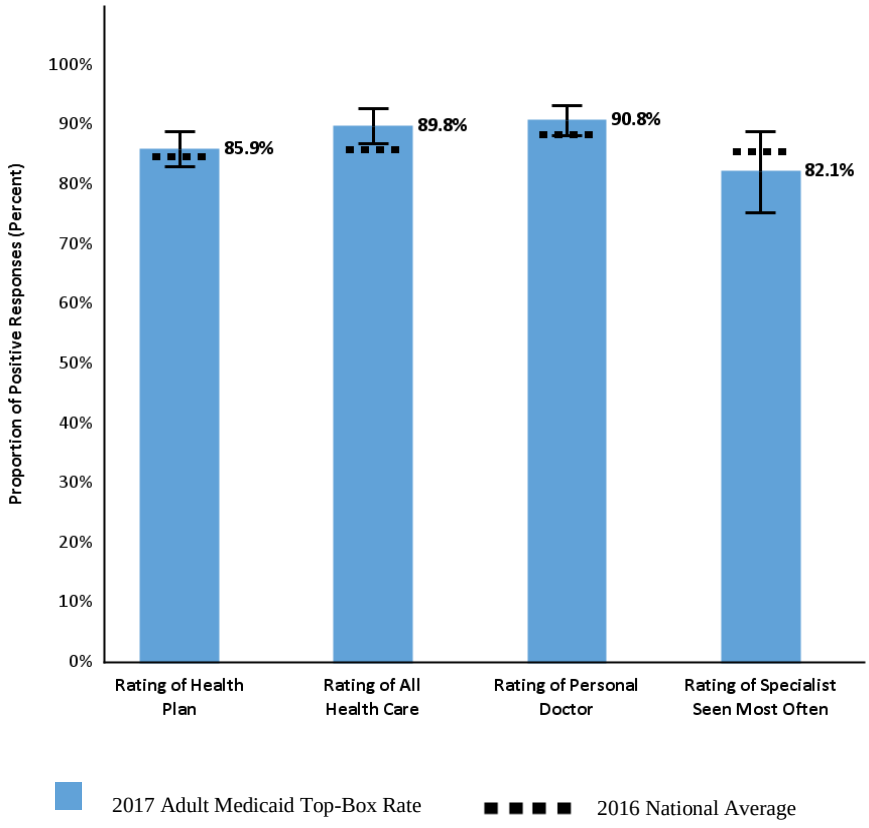
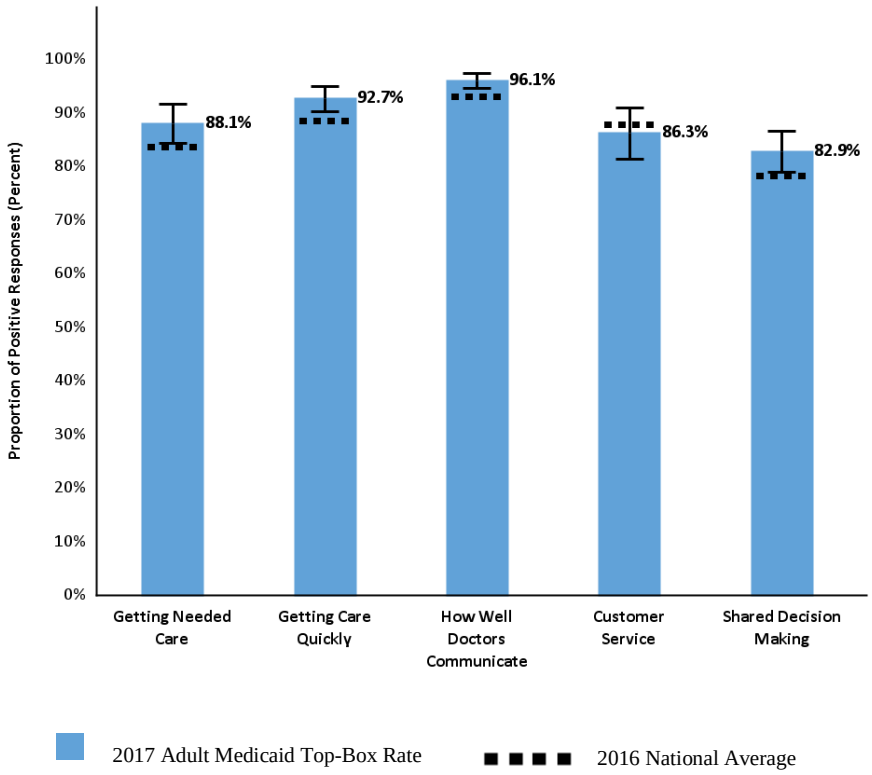


Figure 4-7—NHHF Child Medicaid CAHPS Results: Composite Measures



For **NHHF**'s general child Medicaid population, all rates were statistically significantly higher than NCQA's 2016 Medicaid national average, except for *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*, which were neither statistically significantly higher nor lower than the national average.

Well Sense

A total of 1,350 **Well Sense** adult Medicaid members were surveyed in 2017, and 366 completed surveys were returned. After ineligible members were excluded, the response rate was 28.24 percent. In 2016, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 24.8 percent, which was lower than the adult Medicaid **Well Sense** response rate. Figure 4-8 and Figure 4-9 show the 2017 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2016 national average for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s adult Medicaid population.

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

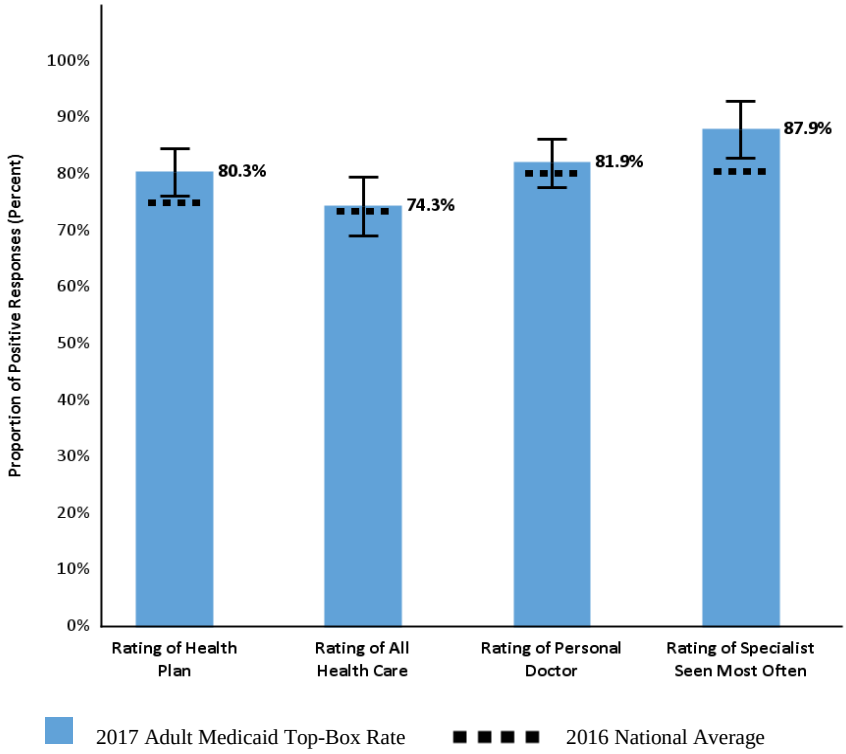
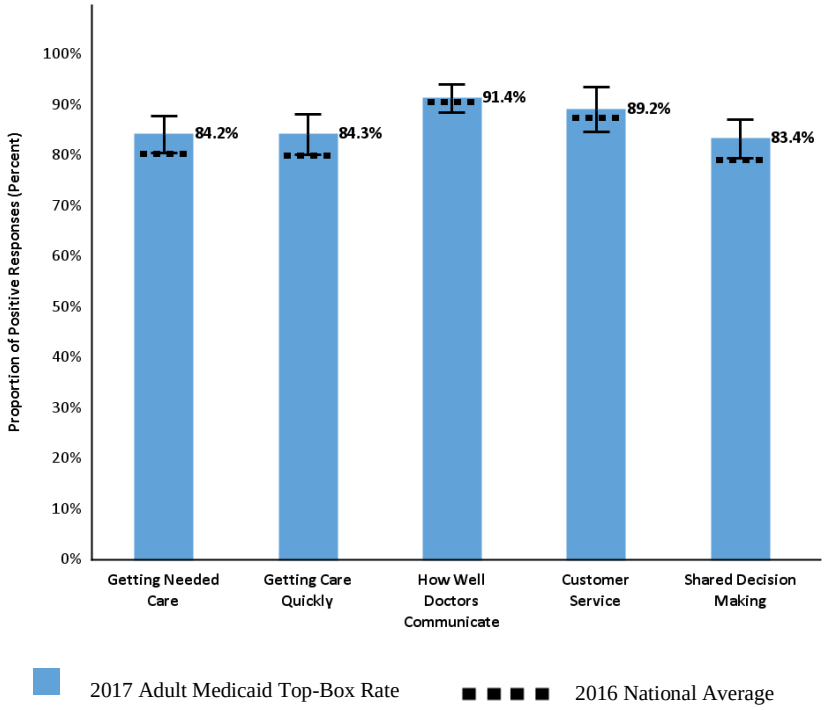


Figure 4-9—Well Sense Adult Medicaid CAHPS Results: Composite Measures



For **Well Sense**'s adult Medicaid population, all rates were statistically significantly higher than NCQA's 2016 Medicaid national averages, except for *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Customer Service*, which were neither statistically significantly higher nor lower than the national average.

In 2017, a total of 1,799 **Well Sense** general child Medicaid members were surveyed, of which 410 completed surveys were returned on behalf of the child members. After ineligible members were excluded, the response rate for the general child population was 23.12 percent.[4-7] In 2016, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement set was 23.0 percent, which was lower than the **Well Sense** child Medicaid response rate. Figure 4-10 and Figure 4-11 show the 2017 general child positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2016 national average for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s general child Medicaid population.[4-8]

[4-7] 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).

[4-8] The 2017 child Medicaid CAHPS results presented in Figure 4-10 and Figure 4-11 for **Well Sense** are based on results of the general child population only.

Figure 4-10—Well Sense Child Medicaid CAHPS Results: Global Ratings

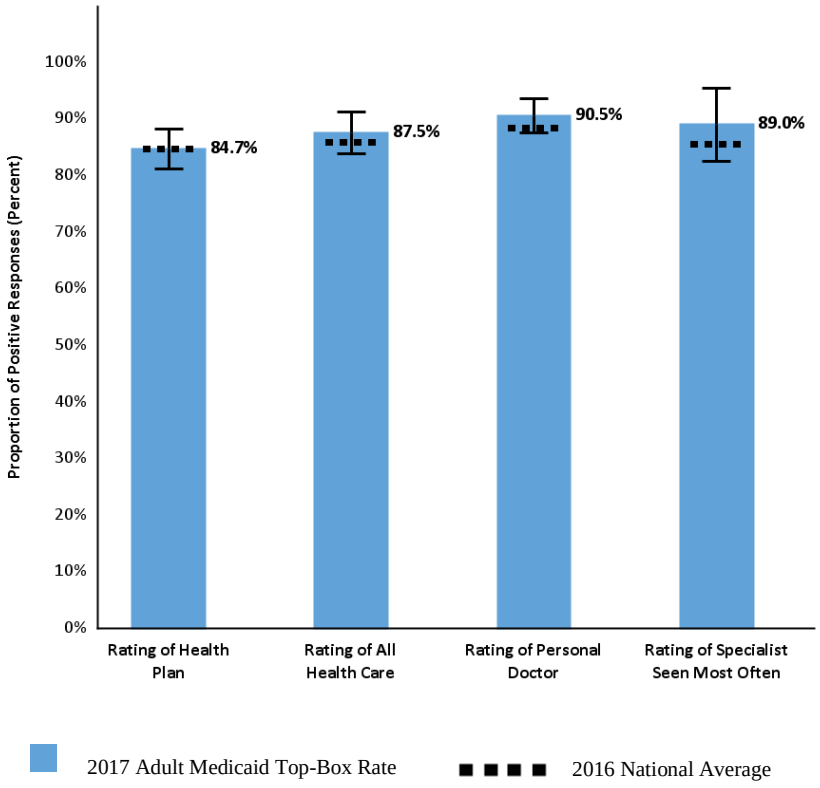
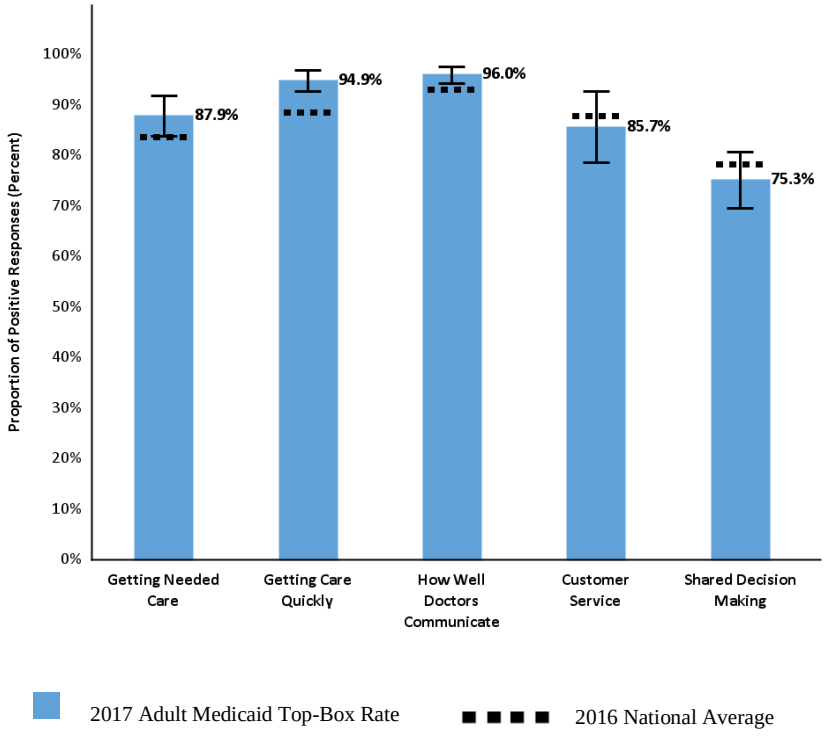


Figure 4-11—Well Sense Child Medicaid CAHPS Results: Composite Measures



For **Well Sense**'s general child Medicaid population, all rates were statistically significantly higher than NCQA's 2016 Medicaid national averages, except for *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Customer Service,* and *Shared Decision Making*, which were neither statistically significantly higher nor lower than the national average.

Conclusions and Recommendations for Improvement

NHHF

HSAG performed a comparison of the adult and child Medicaid populations' 2017 CAHPS survey results to the 2016 NCQA CAHPS adult and general child Medicaid national averages to determine potential areas for improvement. Since none of the 2017 positive rates for the adult or child Medicaid populations were statistically significantly lower than the 2016 NCQA Medicaid national averages, HSAG recommends that **NHHF** focus QI efforts on the following measures that were neither statistically significantly higher nor lower than the national average: *Rating of Health Plan* and *Customer Service* for the adult and child populations; *Rating of All Health Care* for the adult population; and *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* for the child population.

NHHF could consider involving MCO staff members at every level to assist in improving the *Rating of Health Plan* and *Customer Service* rates. The progress of QI initiatives could be monitored by cross-departmental teams and reported internally to assess the effectiveness of improvement efforts. Engaging employees in departmental meetings, quarterly employee forums, annual staff meetings to discuss outcomes for the measures, topic-specific improvement teams, leadership development courses, and employee awards could instill ownership in the improvement process.

The rates for *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **NHHF** could include reminders about the importance of improving communication skills with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives.

Well Sense

HSAG performed a comparison of the adult and child Medicaid populations' 2017 CAHPS survey results to the 2016 NCQA CAHPS adult and general child Medicaid national averages to determine potential areas for improvement. Since none of the 2017 positive rates for the adult or child Medicaid populations were statistically significantly lower than the 2016 NCQA Medicaid national averages, HSAG recommends that **Well Sense** focus QI efforts on the following measures that were neither statistically significantly higher nor lower than the national average: *Rating of All Health Care, Rating of Personal Doctor,* and *Customer Service* for the adult and child populations; *How Well Doctors Communicate* for the adult population; and *Rating of Health Plan, Rating of Specialist Seen Most Often,* and *Shared Decision Making* for the child population.

To improve CAHPS rates, **Well Sense** could consider involving MCO staff members at every level to assist in improving the *Rating of Health Plan* and *Customer Service* rates. The progress of QI initiatives could be monitored by cross-departmental teams and reported internally to assess the effectiveness of improvement efforts. Engaging employees in departmental meetings, quarterly employee forums, annual

staff meetings to discuss outcomes for the measures, topic-specific improvement teams, leadership development courses, and employee awards could instill ownership in the improvement process.

The rates for *Rating of All Health Care, Rating of Personal Doctor, Shared Decision Making, How Well Doctors Communicate, Customer Service,* and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **Well Sense** could include reminders about the importance of improving communication skills with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives.

HEDIS

This section reports results of the 2017 NCQA HEDIS Compliance Audits™ for the health plans.[4-9] NCQA's Information System (IS) standards are the guidelines used by certified NCQA HEDIS compliance auditors to assess a health plan's ability to report HEDIS rates accurately and reliably.[4-10] Compliance with the guidelines also helps an auditor to understand a health plan's HEDIS reporting capabilities. For HEDIS 2017, health plans were assessed on six IS standards. To assess an MCO's adherence to the IS standards, HSAG reviewed several documents for the New Hampshire MCOs. These included the MCOs' FARs, IS compliance tools, and the IDSS files approved by the HEDIS compliance auditor.

Both MCOs contracted with an NCQA LO to have their measure rates reviewed by a HEDIS compliance auditor. 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 provided 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.

[4-9] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[4-10] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.* Washington D.C.

- 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

For HEDIS 2017, NCQA retired the *Call Answer Timeliness* measure and therefore removed IS Standard 6.0—Member Call Center. The IS standard associated with member call center data also was not applicable to the measures reported by the MCOs.

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 all applicable IS assessment standards. The plan implemented significant improvements to its medical record review validation (MRRV) processes. The auditor encouraged the plan to ensure that sufficient detail was included in the Roadmap development to minimize review issues. **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 two 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. **Well Sense** failed the validation process for hybrid group E, as the chart provided by the plan did not meet the requirements for a valid hit. The auditor suggested that, for next year's HEDIS review, the plan submit two hits for each measure validated for the convenience sample. **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.

Well Sense elected to use three supplemental data sources, two standard and one nonstandard, for its performance measure reporting. The plan did not provide detailed documentation of the mapping from the software vendor's data format to the plan's data format. Therefore, the lead auditor could not identify mapping concerns or opportunities for improvement. The lead auditor recommended that **Well Sense** document its data mapping in a clear, concise manner.

HEDIS Measures Results

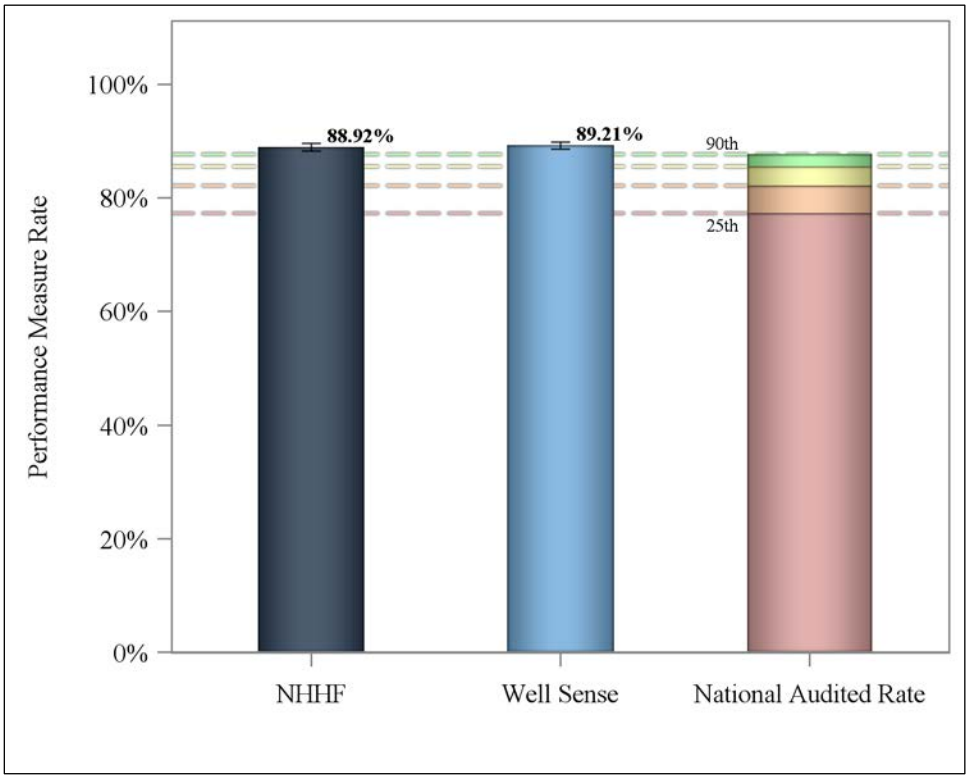
HSAG organized, aggregated, and analyzed the validated performance measure data to draw conclusions about **NHHF**'s and **Well Sense**'s performance in providing quality, accessible, and timely care to its members. The following performance measure results reflect all three domains of care—quality, access, and timeliness. Each figure contains CY 2016 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 2016. 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 2016. **NHHF**'s and **Well Sense**'s *AAP—Total* measure results are shown in Figure 4-12.

Figure 4-12—CY 2016 *AAP—Total* Measure Results

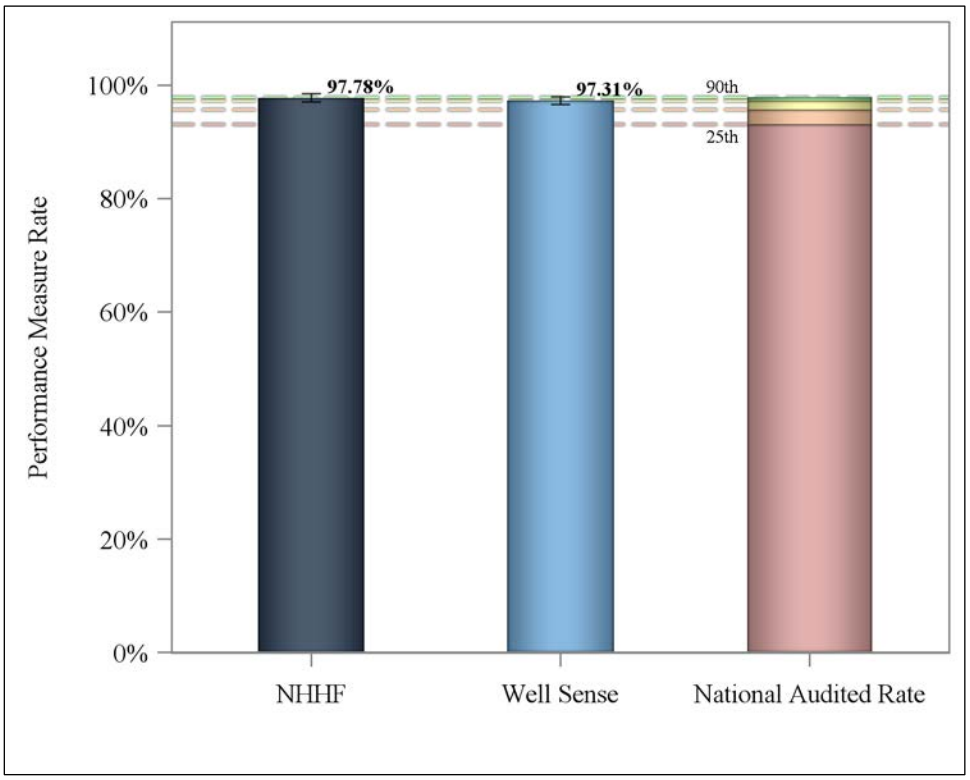


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CAP—12–24 Months* measure results are shown in Figure 4-13.

Figure 4-13—CY 2016 *CAP—12–24 Months* Measure Results

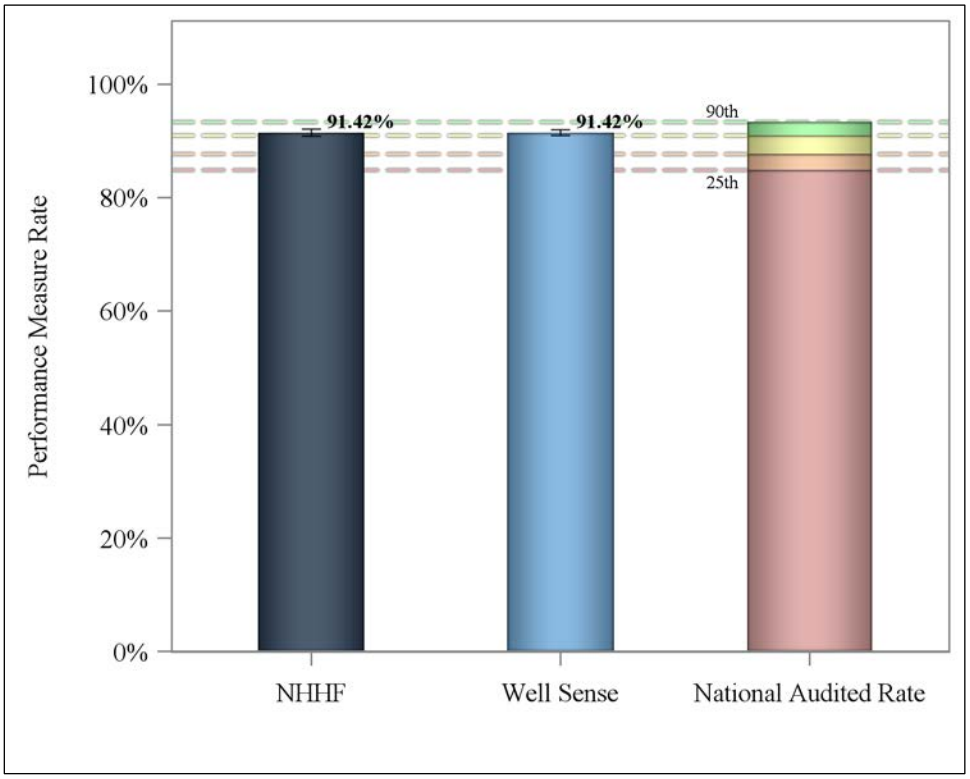


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CAP—25 Months–6 Years* measure results are shown in Figure 4-14.

Figure 4-14—CY 2016 *CAP—25 Months–6 Years* Measure Results

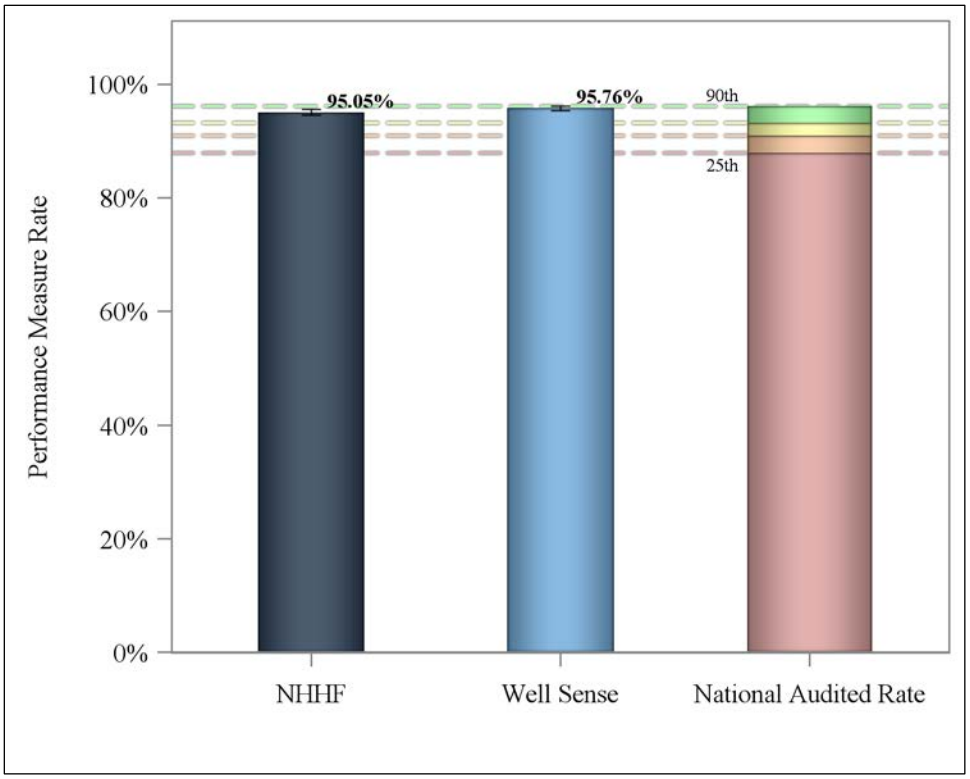


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CAP—7–11 Years* measure results are shown in Figure 4-15.

Figure 4-15—CY 2016 *CAP—7–11 Years* Measure Results

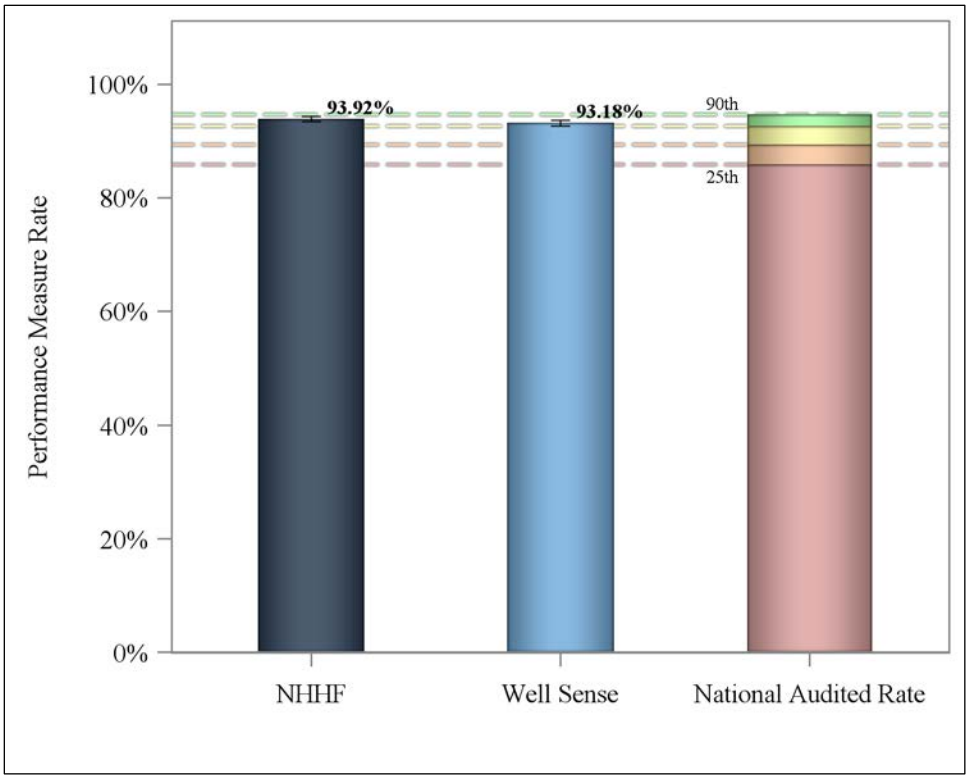


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CAP—12–19 Years* measure results are shown in Figure 4-16.

Figure 4-16—CY 2016 *CAP—12–19 Years* Measure Results

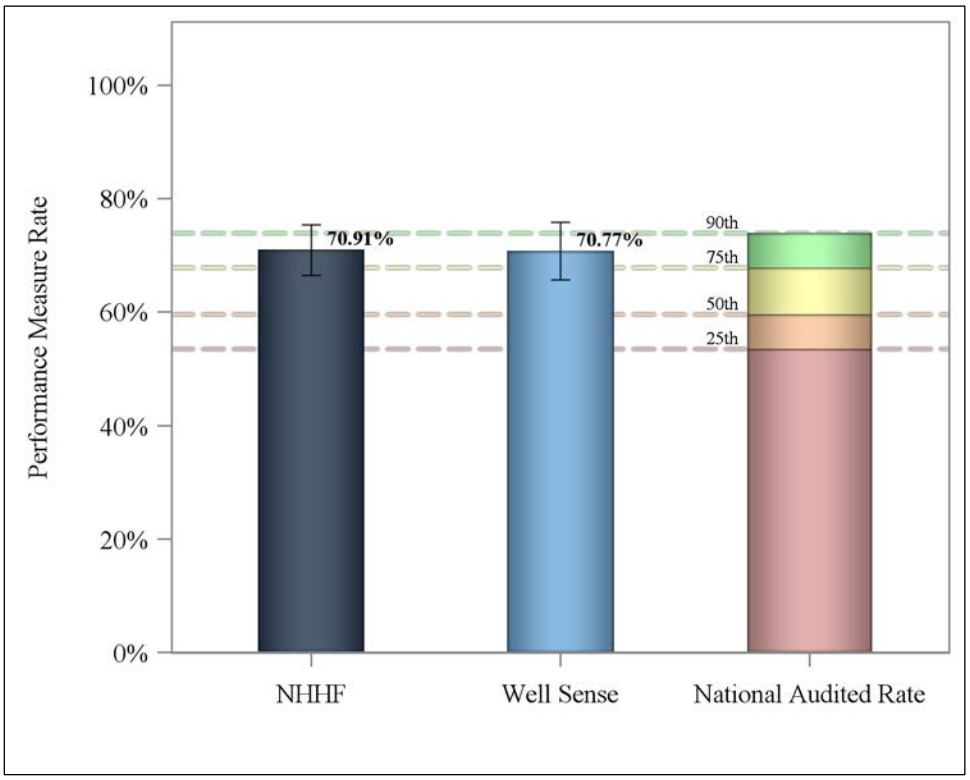


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016 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 4-17.

Figure 4-17—CY 2016 *W15—Six or More Visits* Measure Results

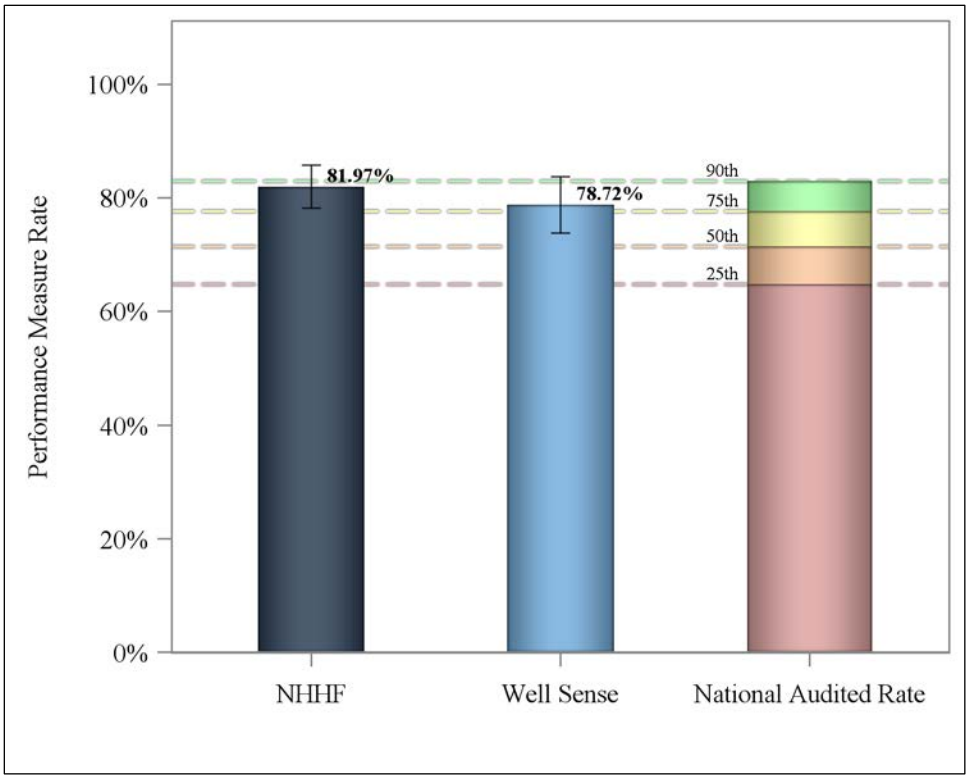


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *W34* measure results are shown in Figure 4-18.

Figure 4-18—CY 2016 *W34* Measure Results

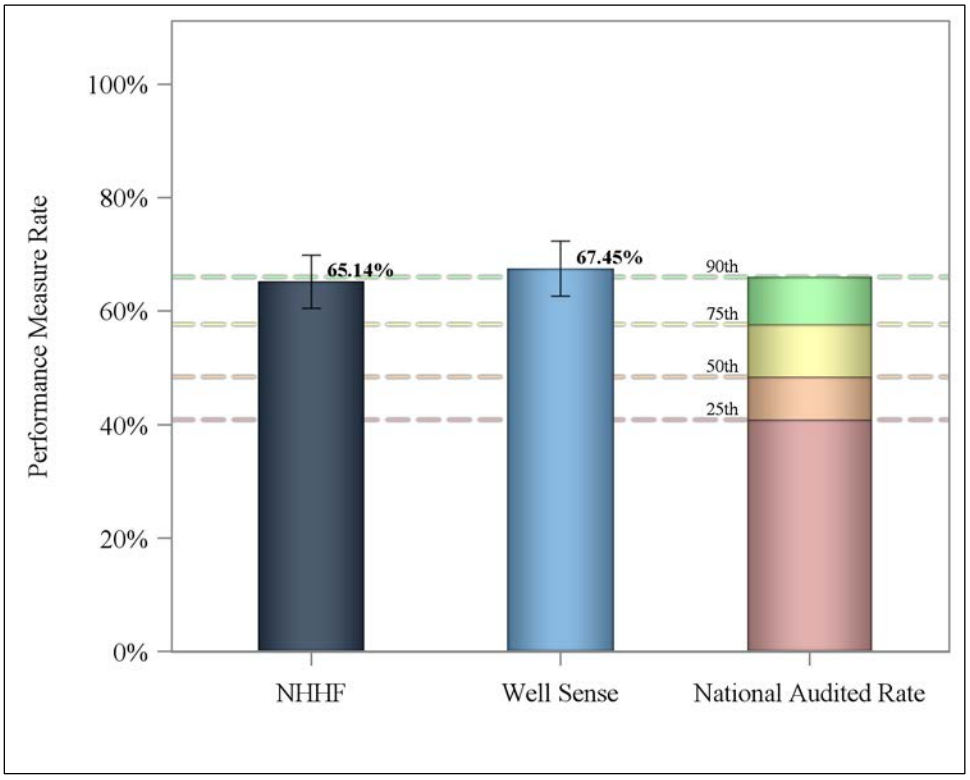


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. The *W34* measure is also a PIP topic for **NHHF** and **Well Sense**.

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 2016. **NHHF**'s and **Well Sense**'s *AWC* measure results are shown in Figure 4-19.

Figure 4-19—CY 2016 *AWC* Measure Results

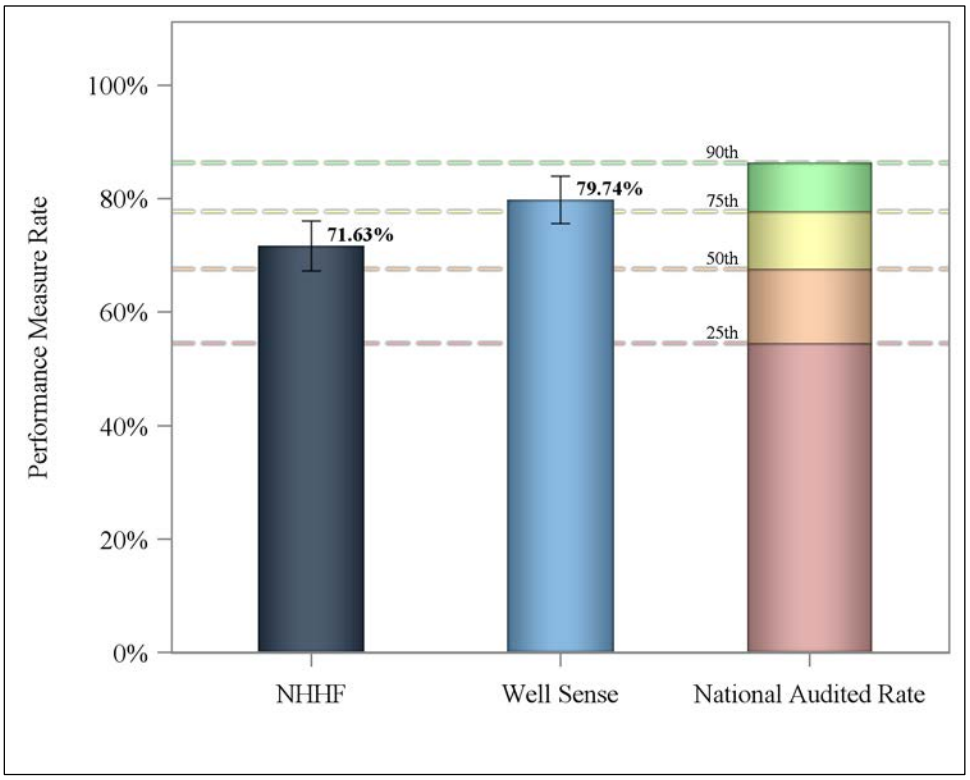


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate exceeded the 90th national Medicaid percentile.

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

WCC—BMI Percentile Documentation 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 2016. **NHHF**'s and **Well Sense**'s *WCC—BMI Percentile Documentation* measure results are shown in Figure 4-20.

Figure 4-20—CY 2016 *WCC—BMI Percentile Documentation* Measure Results

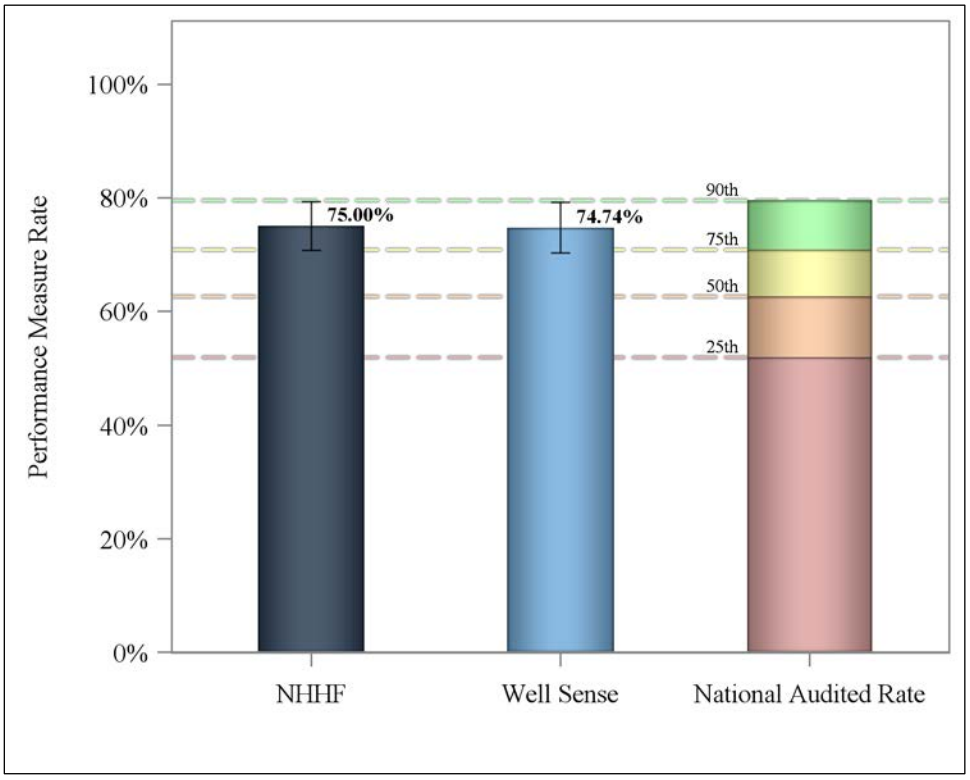


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. The *WCC—BMI Percentile Documentation* measure is also a PIP topic for **NHHF**.

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 2016. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Nutrition* measure results are shown in Figure 4-21.

Figure 4-21—CY 2016 *WCC—Counseling for Nutrition* Measure Results

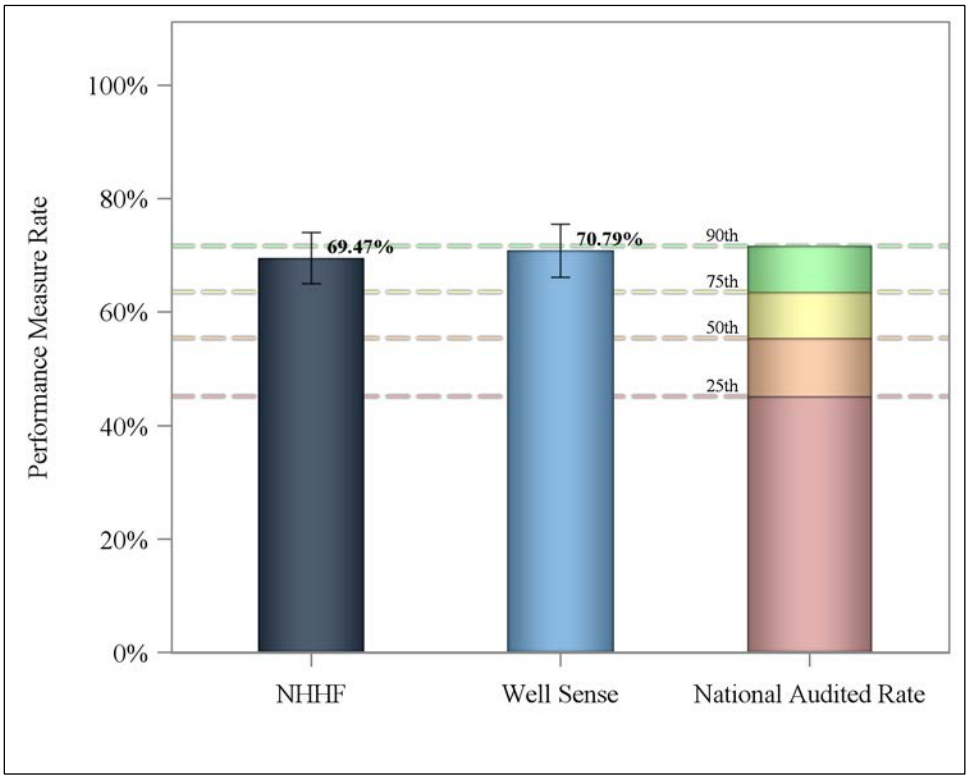


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. The *WCC—Counseling for Nutrition* measure is also a PIP topic for **NHHF**.

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 2016. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Physical Activity* measure results are shown in Figure 4-22.

Figure 4-22—CY 2016 *WCC—Counseling for Physical Activity* Measure Results

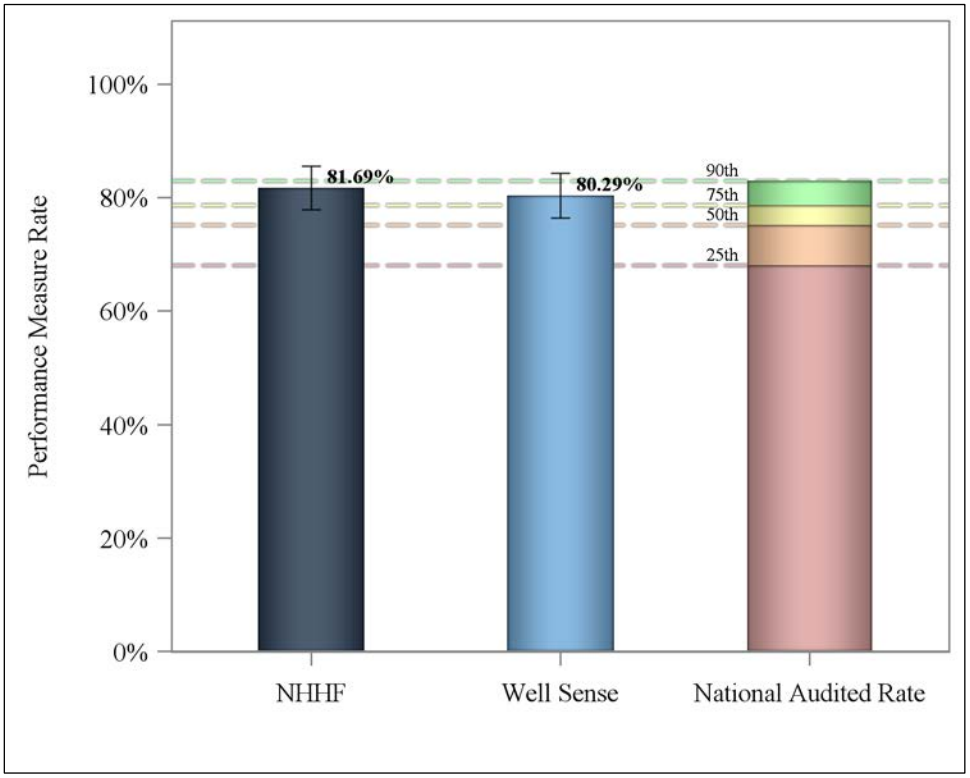


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. The *WCC—Counseling for Physical Activity* measure is also a PIP topic for **NHHF**.

Childhood Immunization Status (CIS)—Combination 2

CIS—Combination 2 measures the percentage of children 2 years of age during 2016 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 influenzae 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 4-23.

Figure 4-23—CY 2016 *CIS—Combination 2* Measure Results

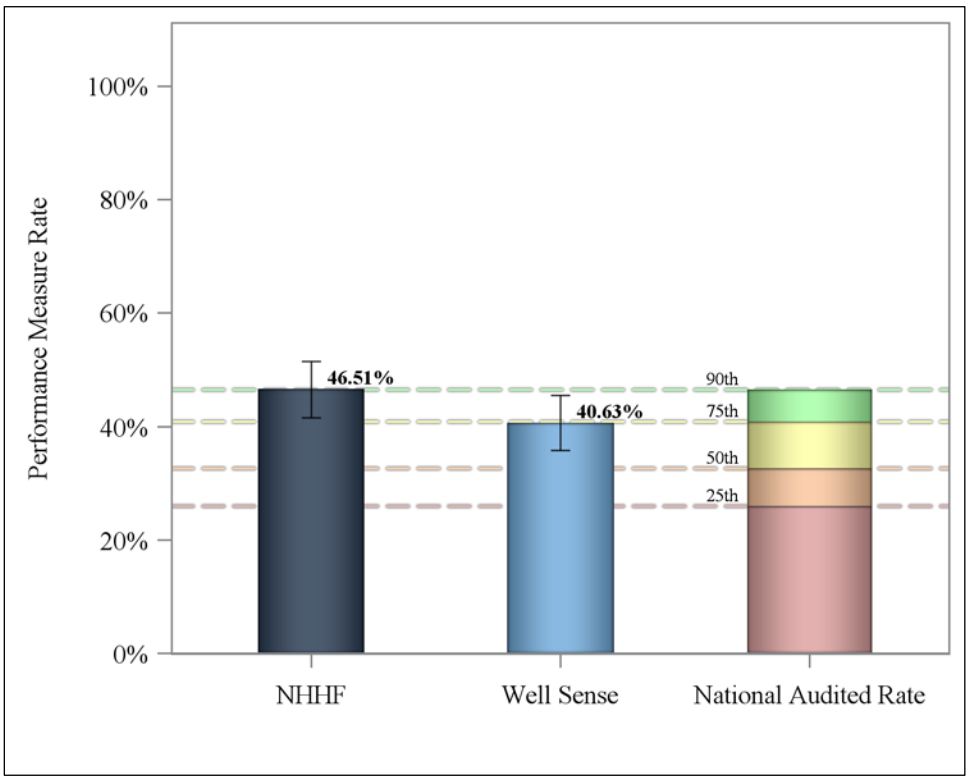


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Childhood Immunization Status (CIS)—Combination 10

CIS—Combination 10 measures the percentage of children 2 years of age during 2016 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 (flu). **NHHF**'s and **Well Sense**'s *CIS—Combination 10* measure results are shown in Figure 4-24.

Figure 4-24—CY 2016 *CIS—Combination 10* Measure Results

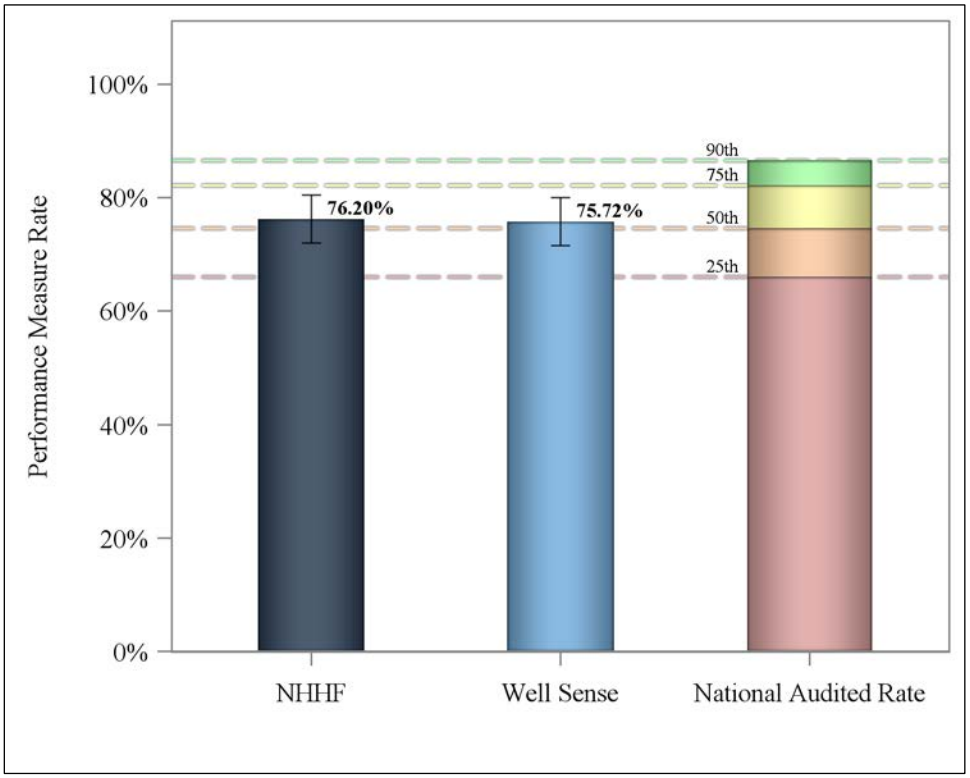


NHHF's reported rate exceeded the national Medicaid 90th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Immunizations for Adolescents (IMA)—Combination 1

IMA—Combination 1 measures the percentage of adolescents 13 years of age during 2016 who had appropriate vaccinations by their 13th birthday. Combination 1 prescribes the appropriate dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap). **NHHF**'s and **Well Sense**'s *IMA—Combination 1* measure results are shown in Figure 4-25.

Figure 4-25—CY 2016 *IMA—Combination 1* Measure Results

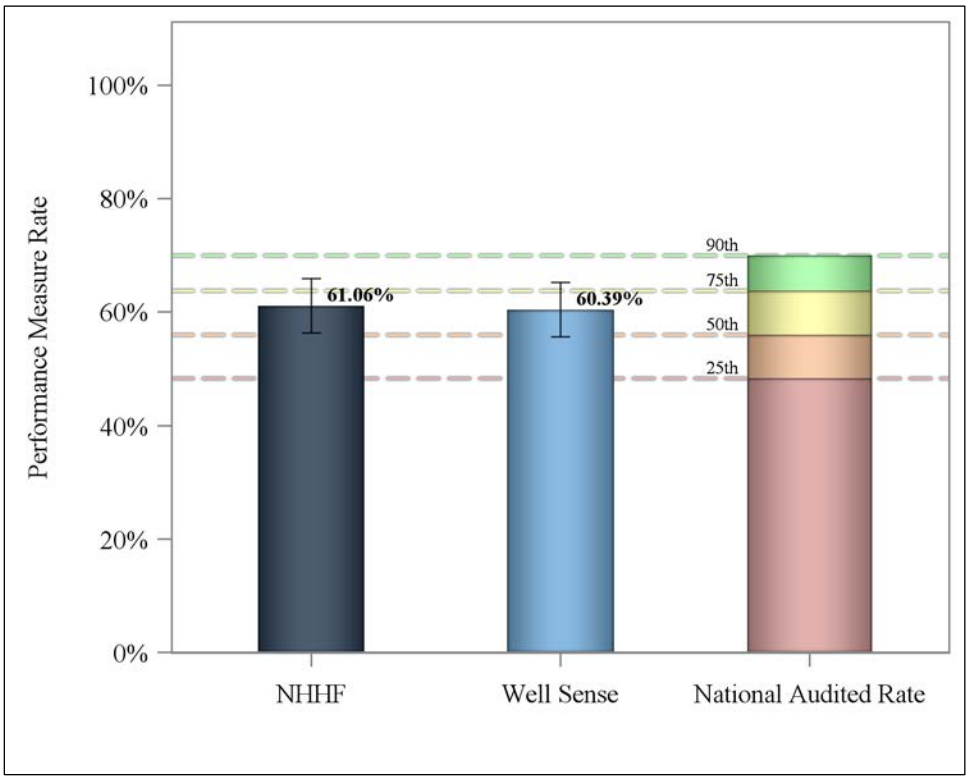


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CCS* measure results are shown in Figure 4-26.

Figure 4-26—CY 2016 *CCS* Measure Results

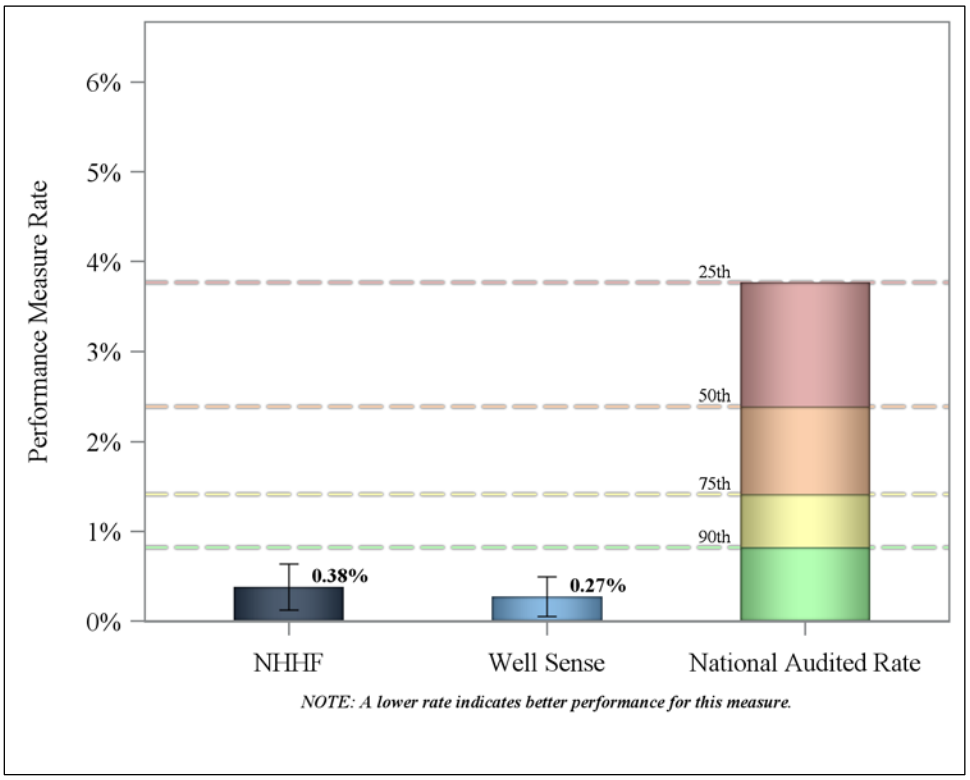


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *NCS* measure results are shown in Figure 4-27. Note, lower rates for this measure indicate better performance.

Figure 4-27—CY 2016 *NCS* Measure Results

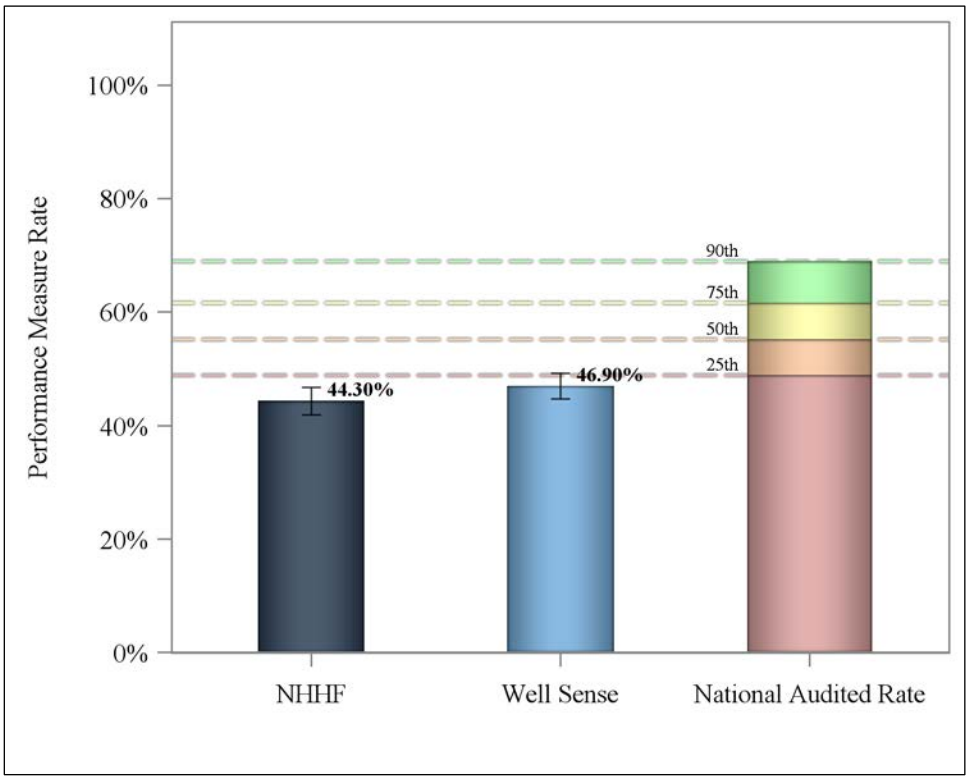


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CHL—Total* measure results are shown in Figure 4-28.

Figure 4-28—CY 2016 *CHL—Total* Measure Results

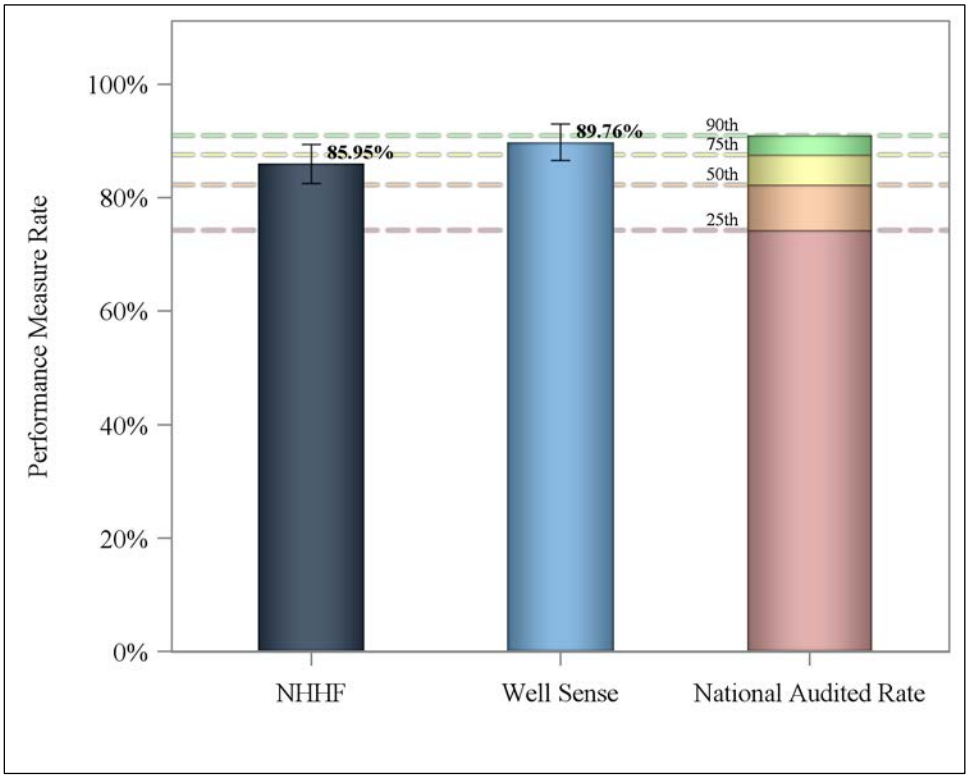


NHHF's and **Well Sense**'s reported rates fell below the national Medicaid 25th percentile. The *CHL—Total* measure is also a PIP topic for **Well Sense**.

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

PPC—Timeliness of Prenatal Care measures the percentage of deliveries of live births 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 2016. **NHHF**'s and **Well Sense**'s *PPC—Timeliness of Prenatal Care* measure results are shown in Figure 4-29.

Figure 4-29—CY 2016 *PPC—Timeliness of Prenatal Care* Measure Results

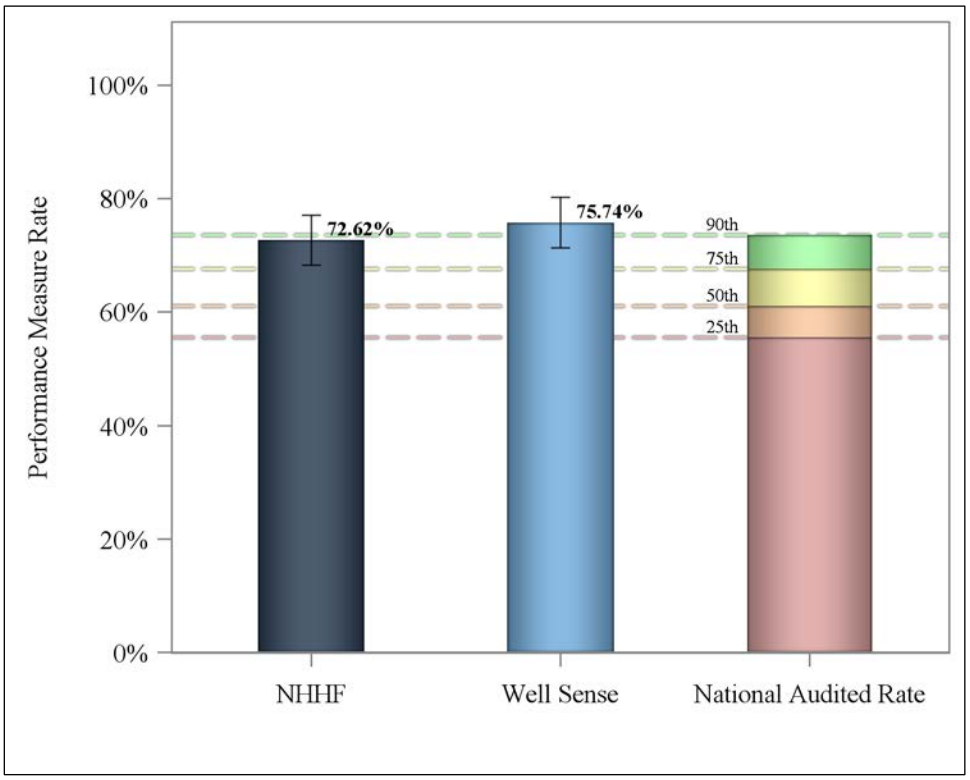


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Prenatal and Postpartum Care (PPC)—Postpartum Care

PPC—Postpartum Care measures the percentage of deliveries of live births that received a postpartum visit on or between 21 and 56 days after delivery during 2016. **NHHF**'s and **Well Sense**'s *PPC—Postpartum Care* measure results are shown in Figure 4-30.

Figure 4-30—CY 2016 *PPC—Postpartum Care* Measure Results

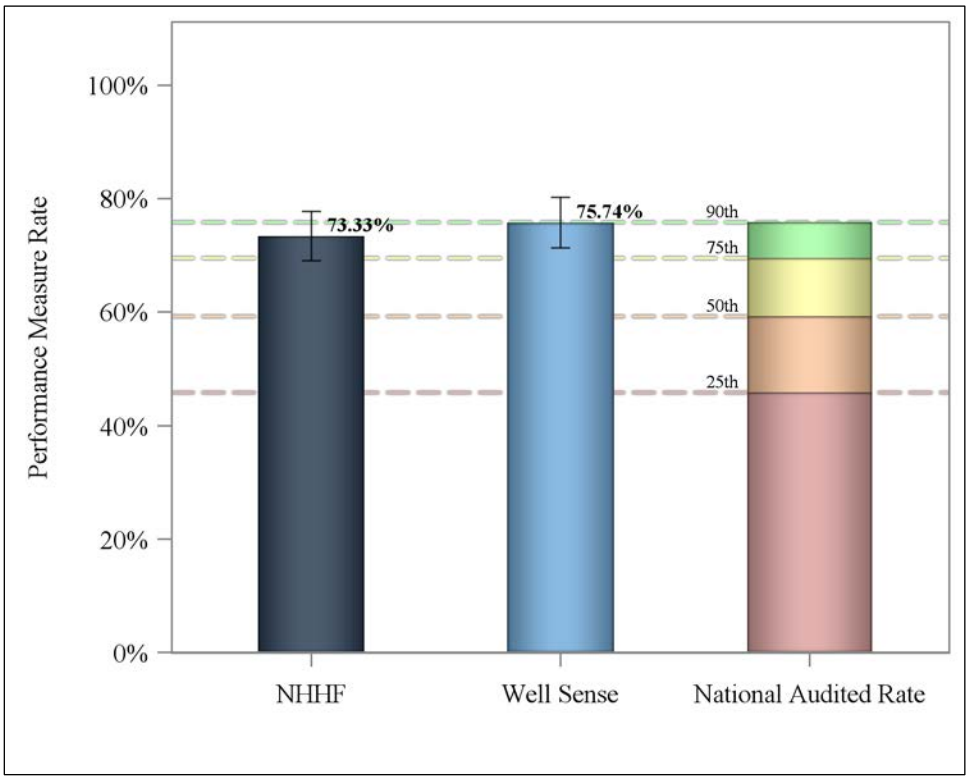


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate exceeded the national Medicaid 90th percentile.

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

FPC—≥ 81 Percent of Expected Visits measures the percentage of deliveries in which the mother had at least 81 percent of the expected number of prenatal visits during 2016. **NHHF**'s and **Well Sense**'s *FPC—≥ 81 Percent of Expected Visits* measure results are shown in Figure 4-31.

Figure 4-31—CY 2016 *FPC—≥ 81 Percent of Expected Visits* Measure Results



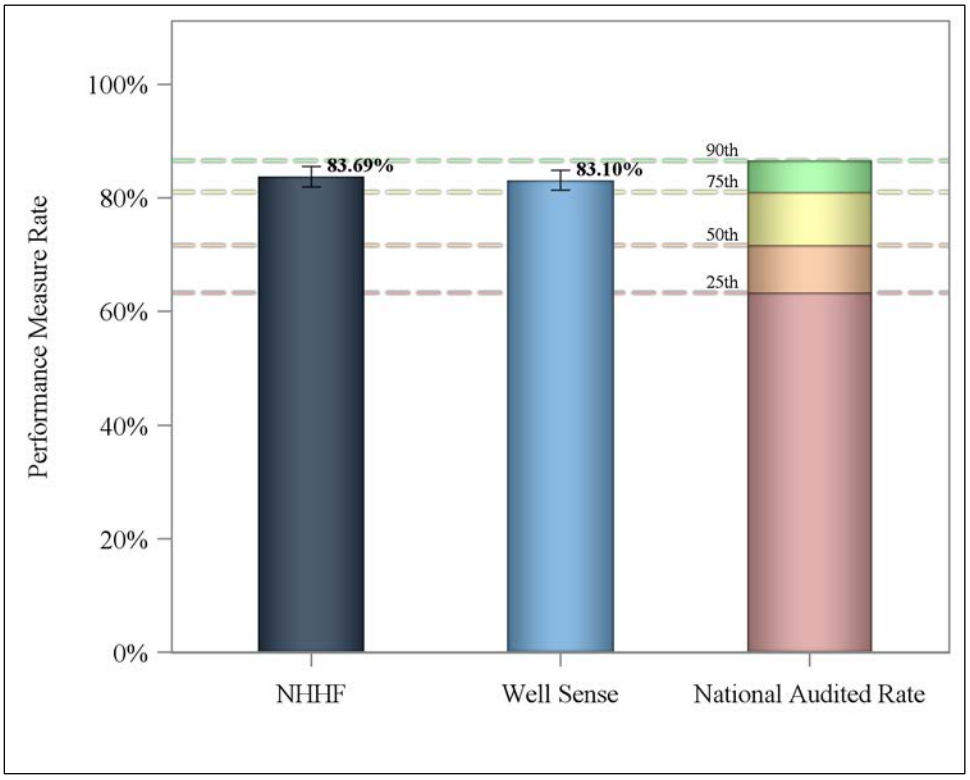
NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CWP* measure results are shown in Figure 4-32.

Figure 4-32—CY 2016 *CWP* Measure Results

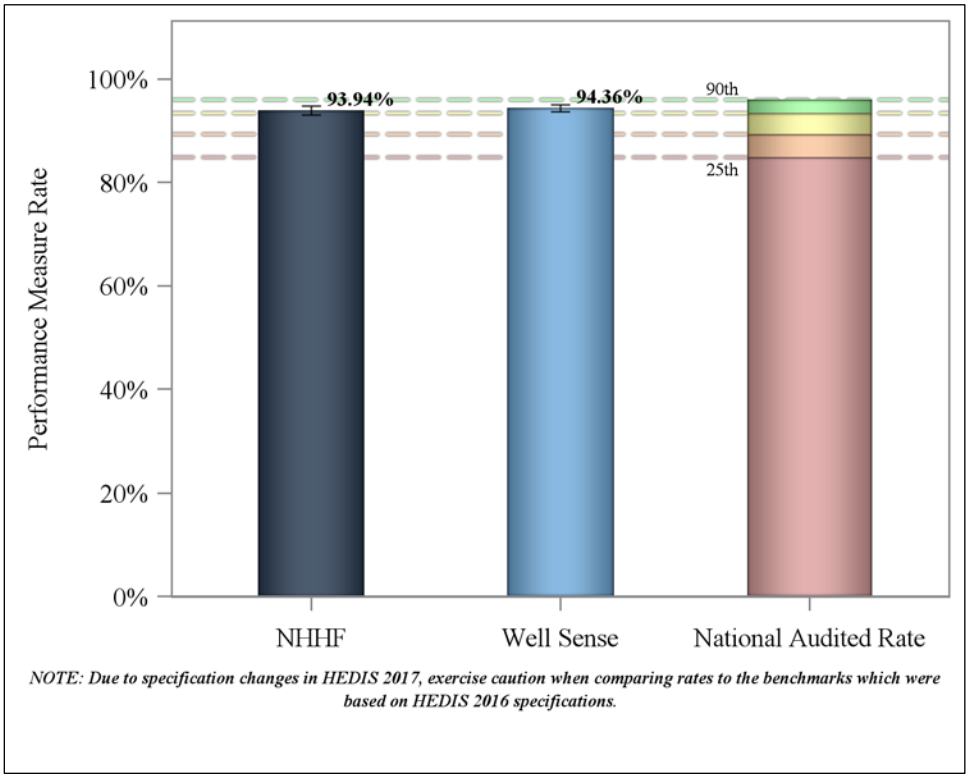


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *URI* measure results are shown in Figure 4-33.

Figure 4-33—CY 2016 *URI* Measure Results

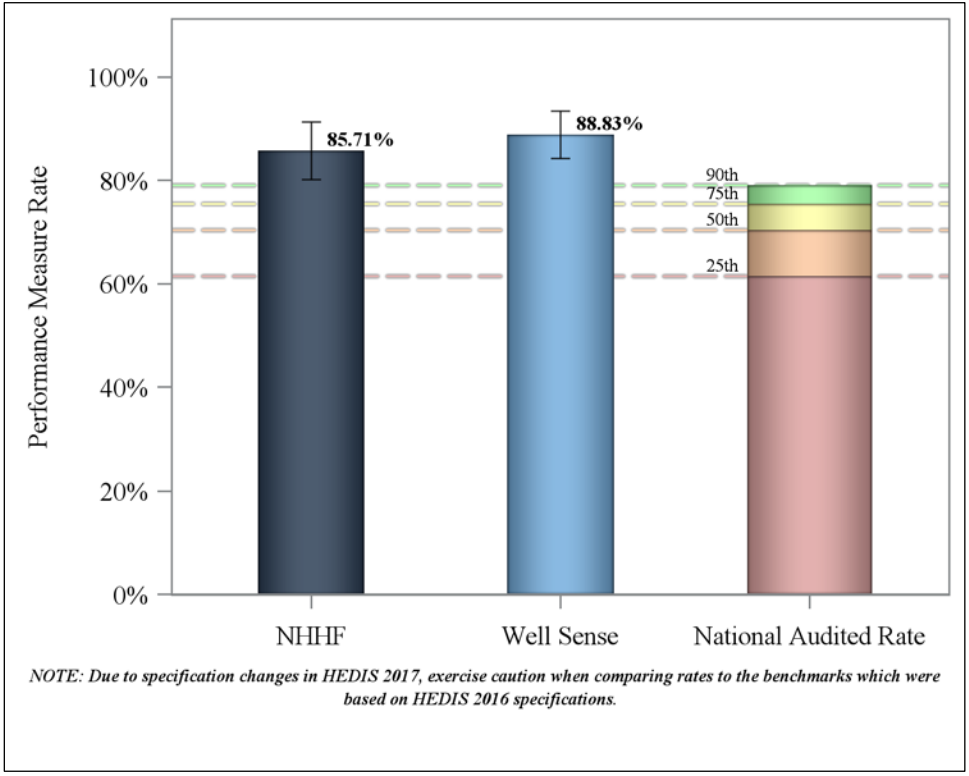


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid

PCE—Systemic Corticosteroid measures the percentage of chronic obstructive pulmonary disease (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 (or there was evidence of an active prescription) within 14 days of the event during 2016. **NHHF**'s and **Well Sense**'s *PCE—Systemic Corticosteroid* measure results are shown in Figure 4-34.

Figure 4-34—CY 2016 *PCE—Systemic Corticosteroid* Measure Results

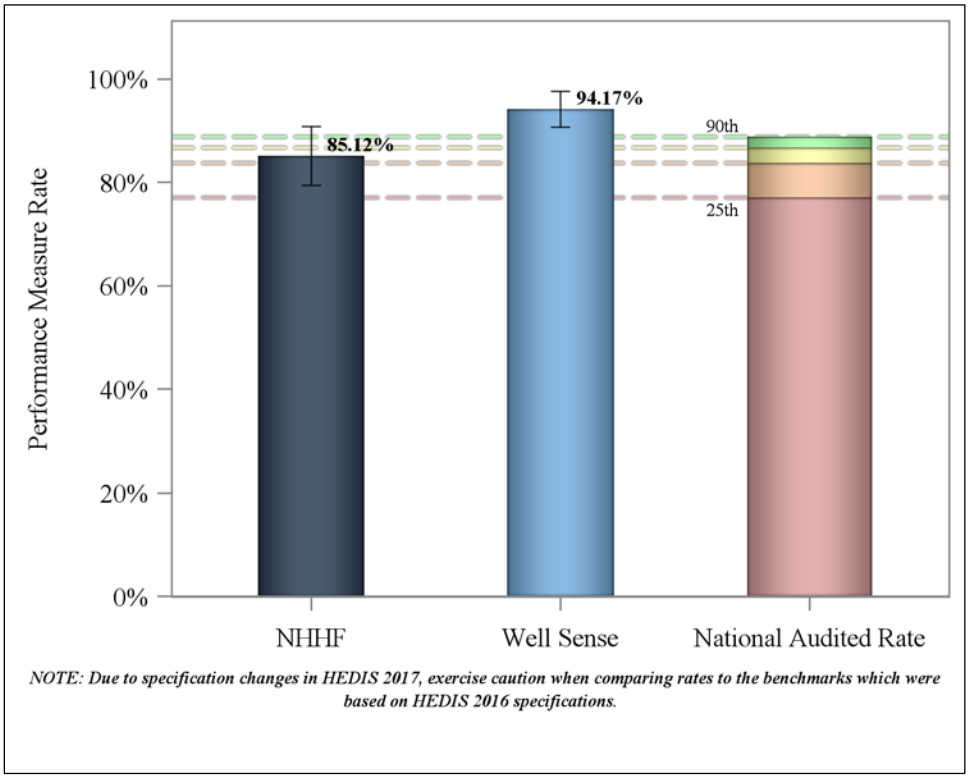


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

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 (or there was evidence of an active prescription) within 30 days of the event during 2016. **NHHF**'s and **Well Sense**'s *PCE—Bronchodilator* measure results are shown in Figure 4-35.

Figure 4-35—CY 2016 *PCE—Bronchodilator* Measure Results

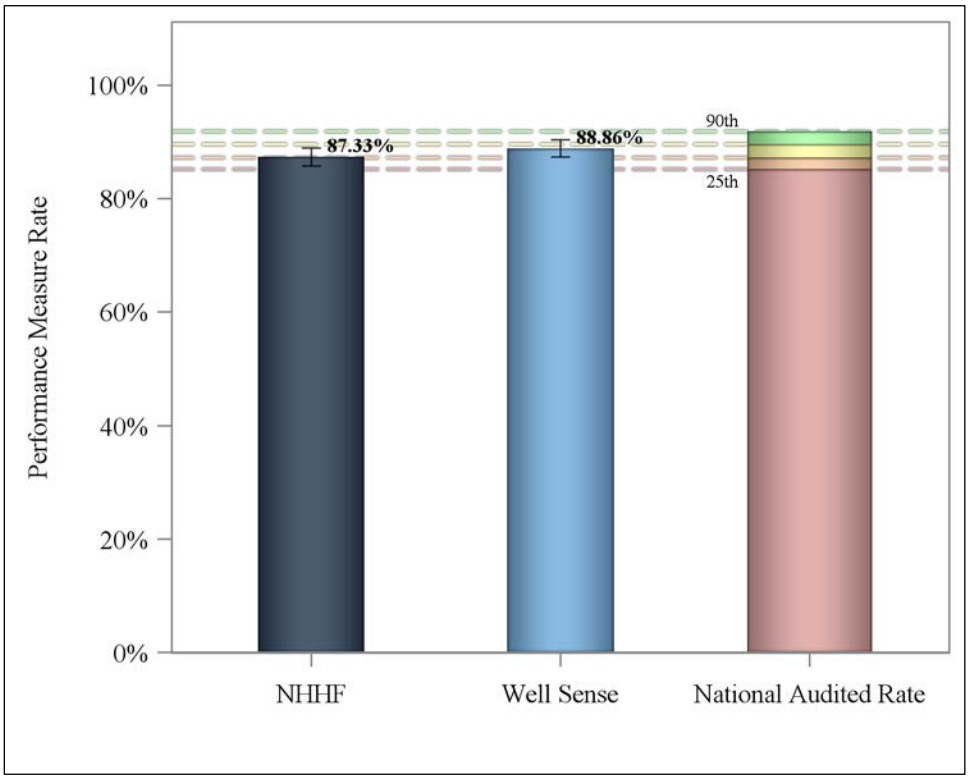


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate exceeded the national Medicaid 90th percentile.

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 blockers (ARB), digoxin, or diuretics and who received at least one therapeutic monitoring event for each appropriate medication during 2016. **NHHF**'s and **Well Sense**'s *MPM—Total* measure results are shown in Figure 4-36.

Figure 4-36—CY 2016 *MPM—Total* Measure Results

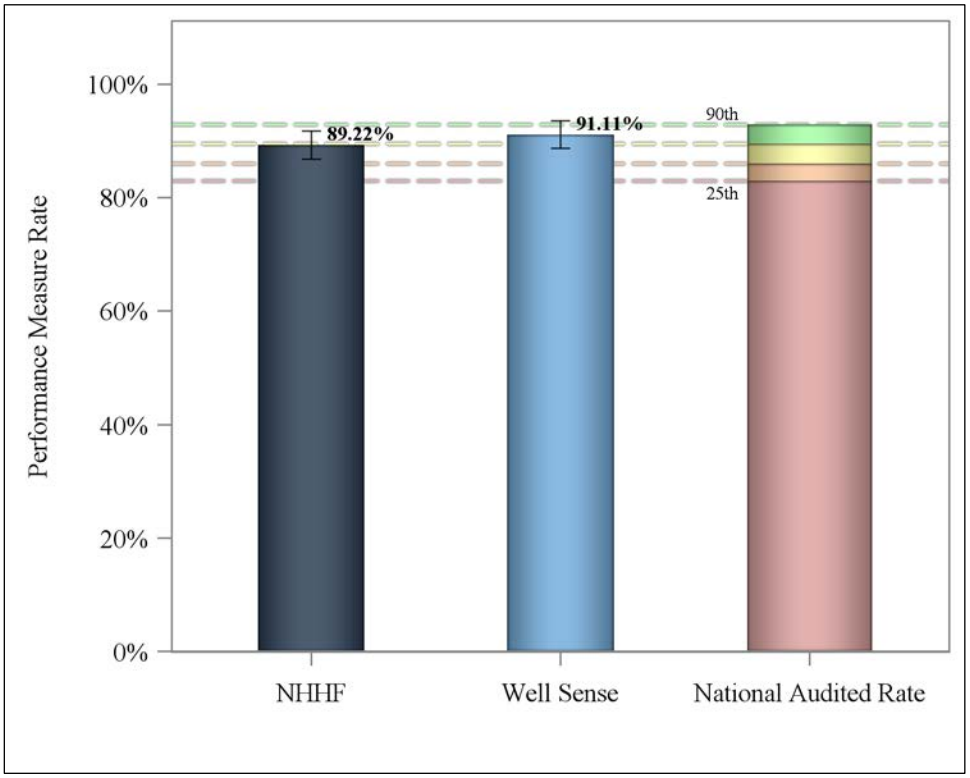


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Testing* measure results are shown in Figure 4-37.

Figure 4-37—CY 2016 *CDC—HbA1c Testing* Measure Results

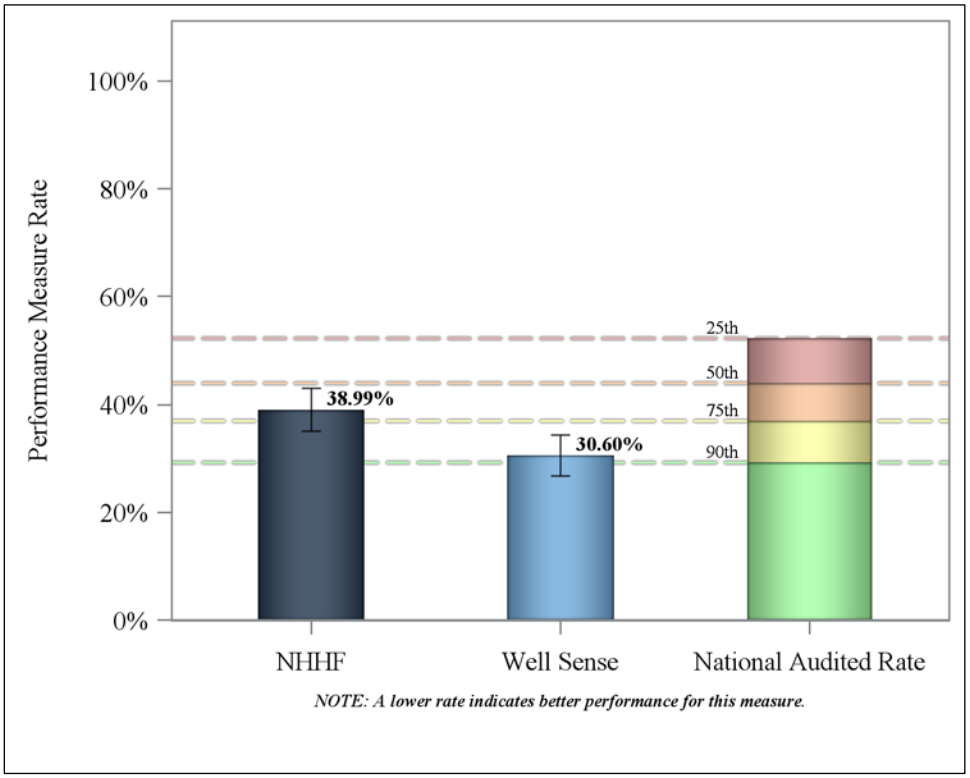


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Poor Control (>9.0%)* measure results are shown in Figure 4-38. Note, lower rates for this measure indicate better performance.

Figure 4-38—CY 2016 *CDC—HbA1c Poor Control (>9.0%)* Measure Results

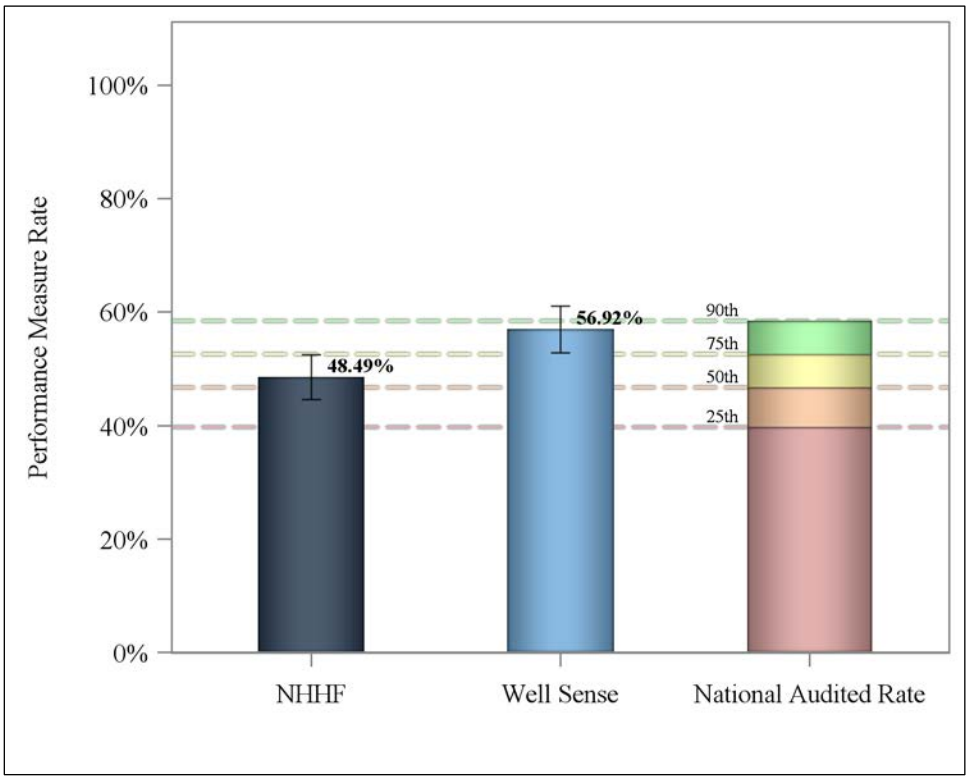


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Control (<8.0%)* measure results are shown in Figure 4-39.

Figure 4-39—CY 2016 *CDC—HbA1c Control (<8.0%)* Measure Results

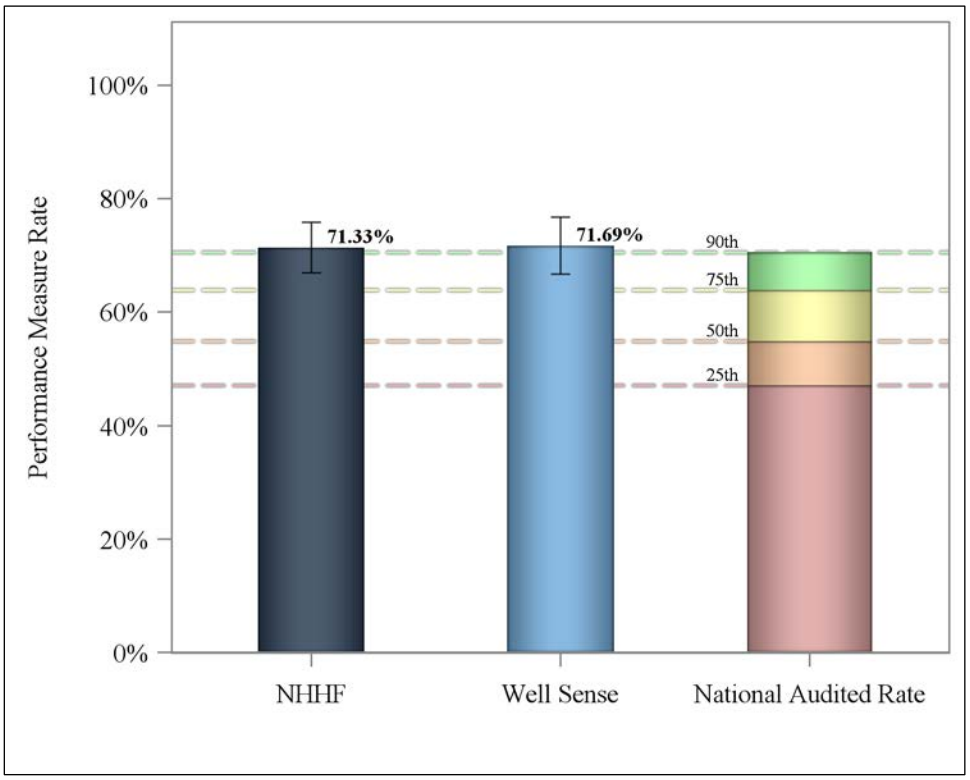


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Controlling High Blood Pressure (CBP)

CBP measures the percentage of members 18 to 85 years of age diagnosed with hypertension whose blood pressure was adequately controlled during 2016. **NHHF**'s and **Well Sense**'s *CBP* measure results are shown in Figure 4-40.

Figure 4-40—CY 2016 *CBP* Measure Results

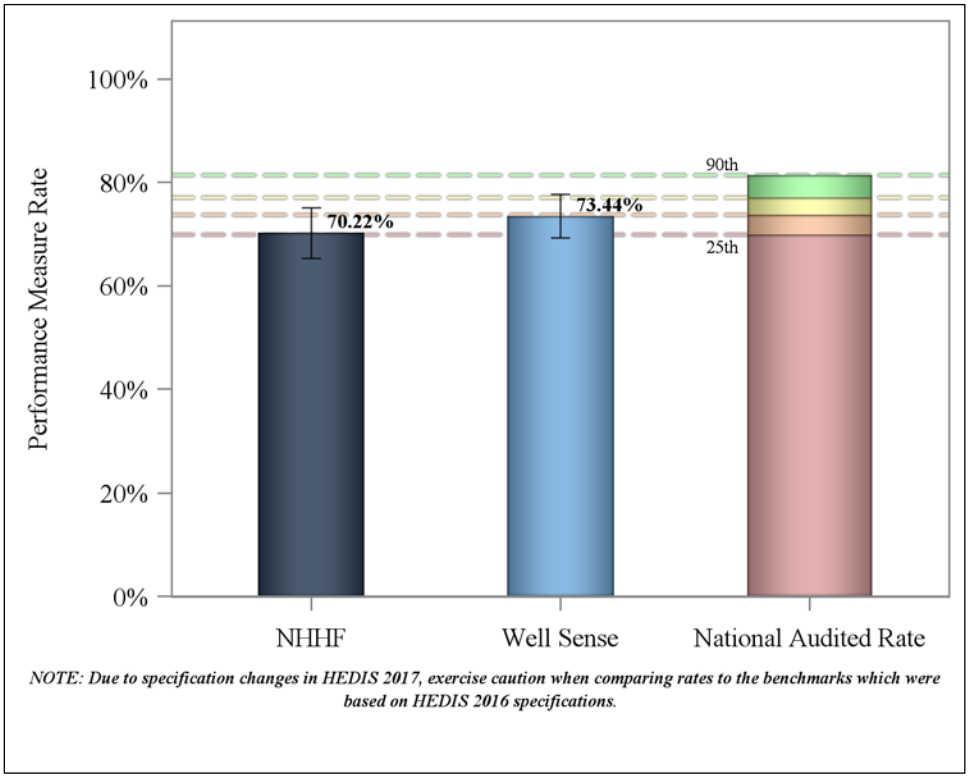


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

Use of Imaging Studies for Low Back Pain (LBP)

LBP measures the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, magnetic resonance imaging [MRI], computerized tomography [CT] scan) within 28 days of diagnosis during 2016. **NHHF**'s and **Well Sense**'s *LBP* measure results are shown in Figure 4-41.

Figure 4-41—CY 2016 *LBP* Measure Results

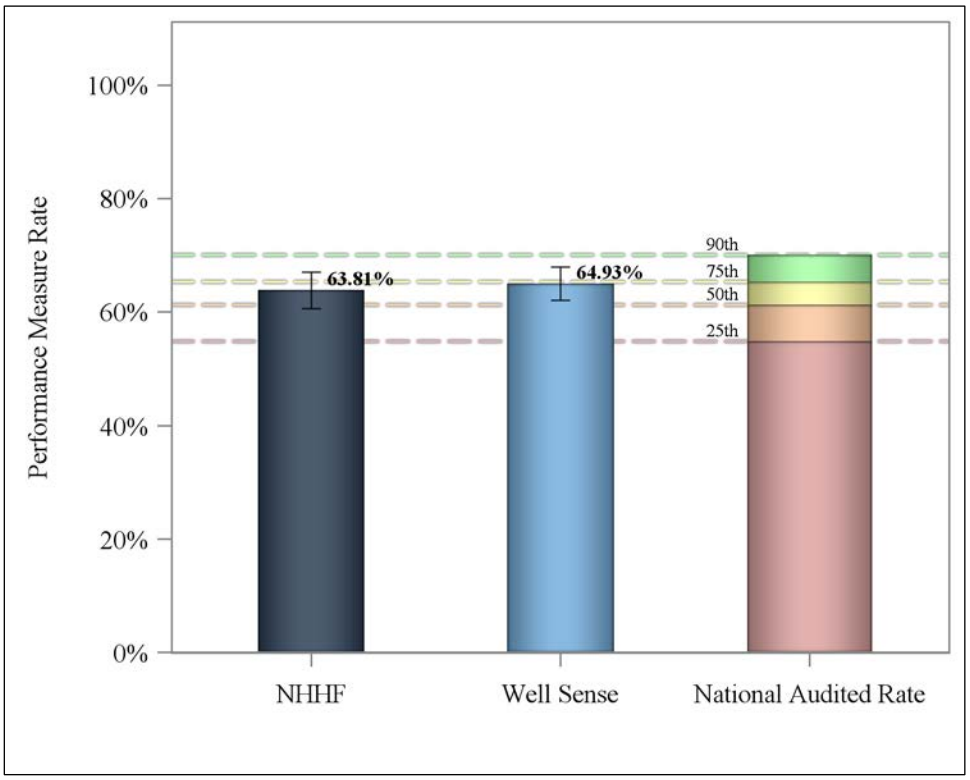


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *AMR—Total* measure results are shown in Figure 4-42.

Figure 4-42—CY 2016 *AMR—Total* Measure Results

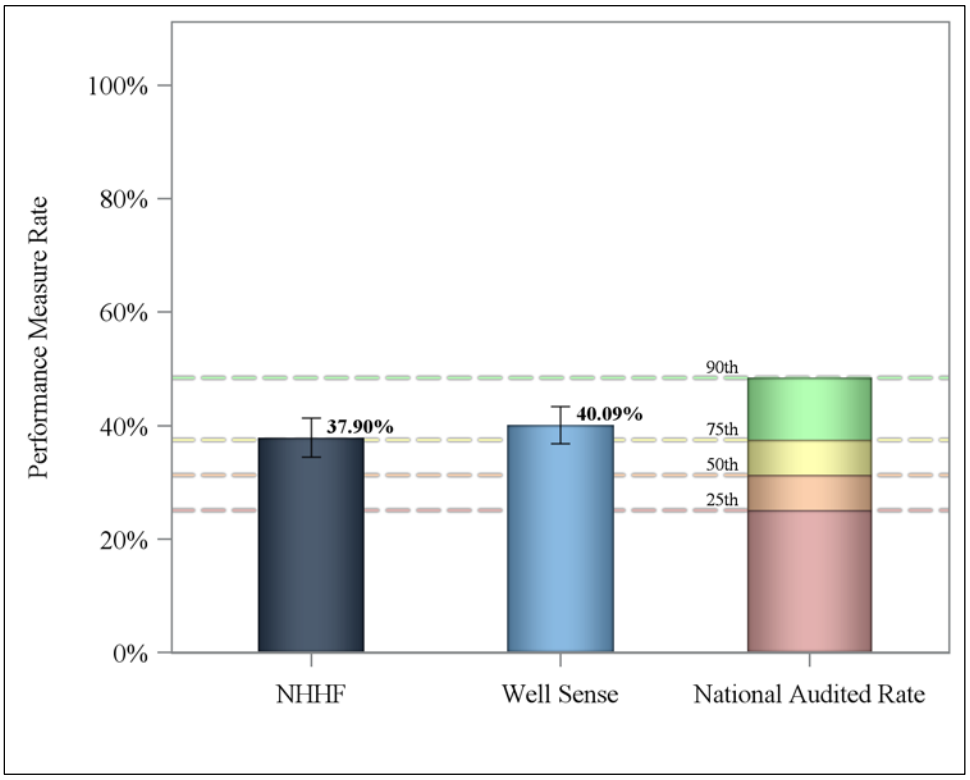


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 4-43.

Figure 4-43—CY 2016 *MMA—Medication Compliance 75%—Total* Measure Results

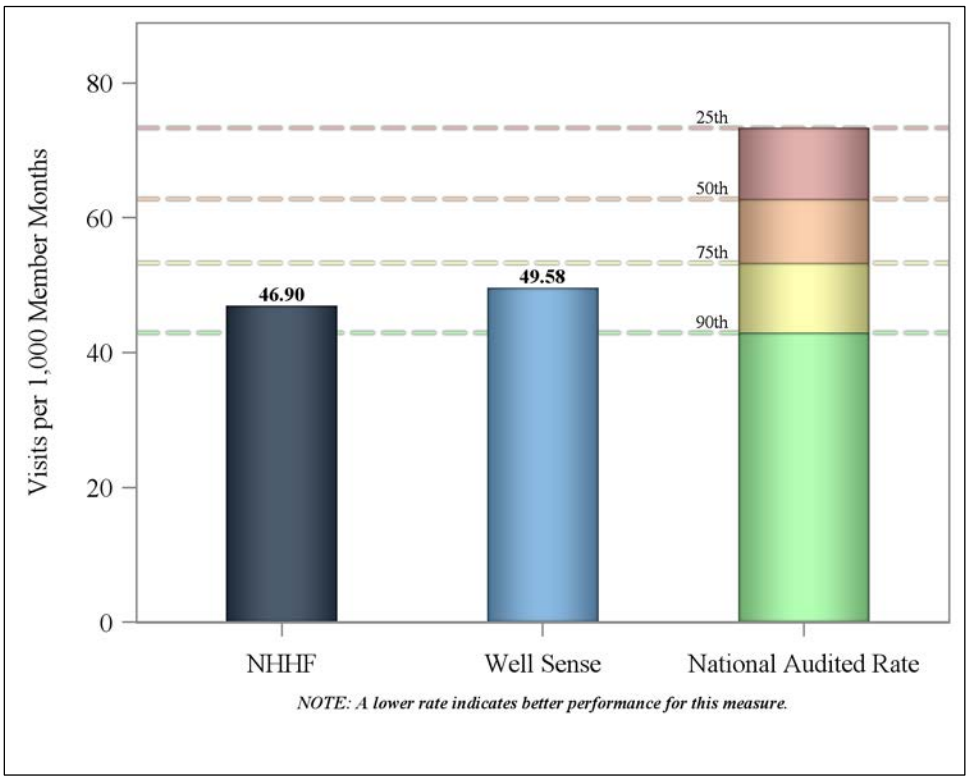


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

AMB—ED Visits measures the utilization of ED visits among the member population during 2016. **NHHF**'s and **Well Sense**'s *AMB—ED Visits* measure results are shown in Figure 4-44.[4-11] A lower rate may indicate better performance for this measure, and HSAG reversed the order of the national Medicaid percentiles to be applied to this measure consistent 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 4-44—CY 2016 *AMB—ED Visits* Measure Results



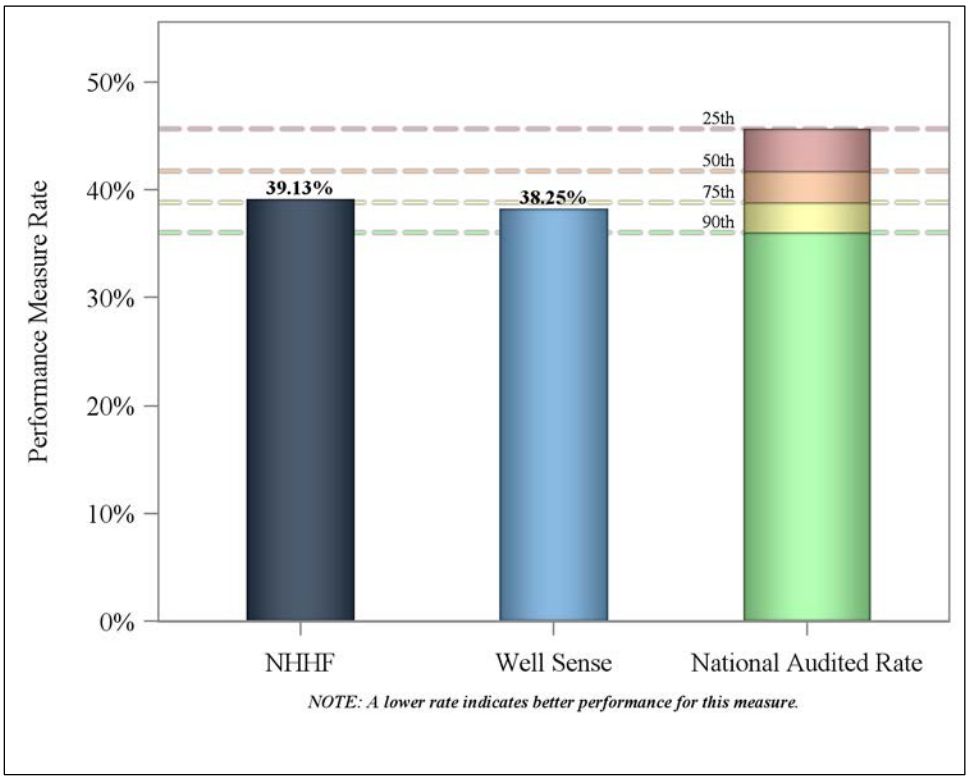
NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

[4-11] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions

ABX—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 2016. **NHHF**'s and **Well Sense**'s *ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* measure results are shown in Figure 4-45.[4-12] 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 consistent 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 4-45—CY 2016 *ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* Measure Results



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

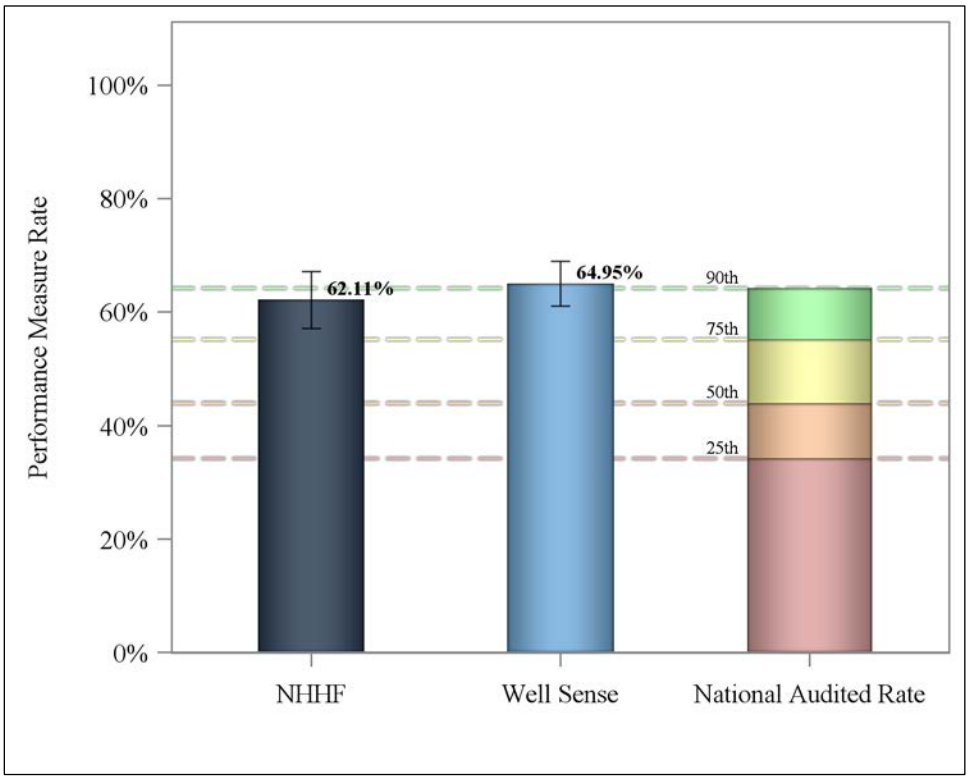
[4-12] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

BH

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 2016. **NHHF**'s and **Well Sense**'s *FUH—7-Day Follow-Up* measure results are shown in Figure 4-46.

Figure 4-46—CY 2016 *FUH—7-Day Follow-Up* Measure Results

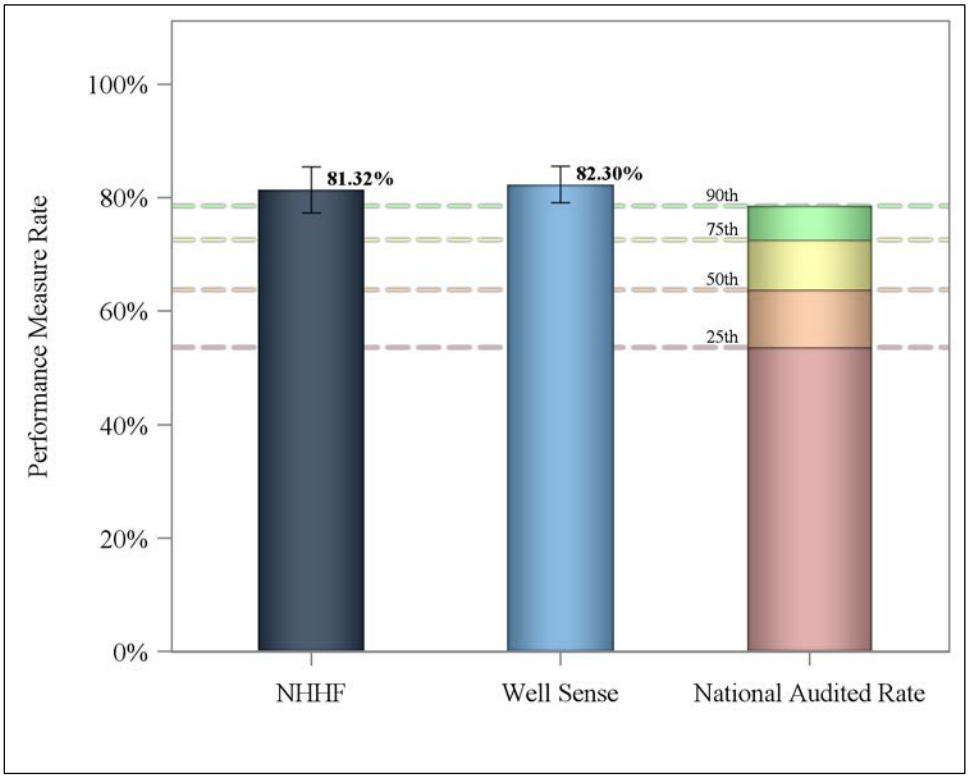


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate exceeded the national Medicaid 90th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *FUH—30-Day Follow-Up* measure results are shown in Figure 4-47.

Figure 4-47—CY 2016 *FUH—30-Day Follow-Up* Measure Results

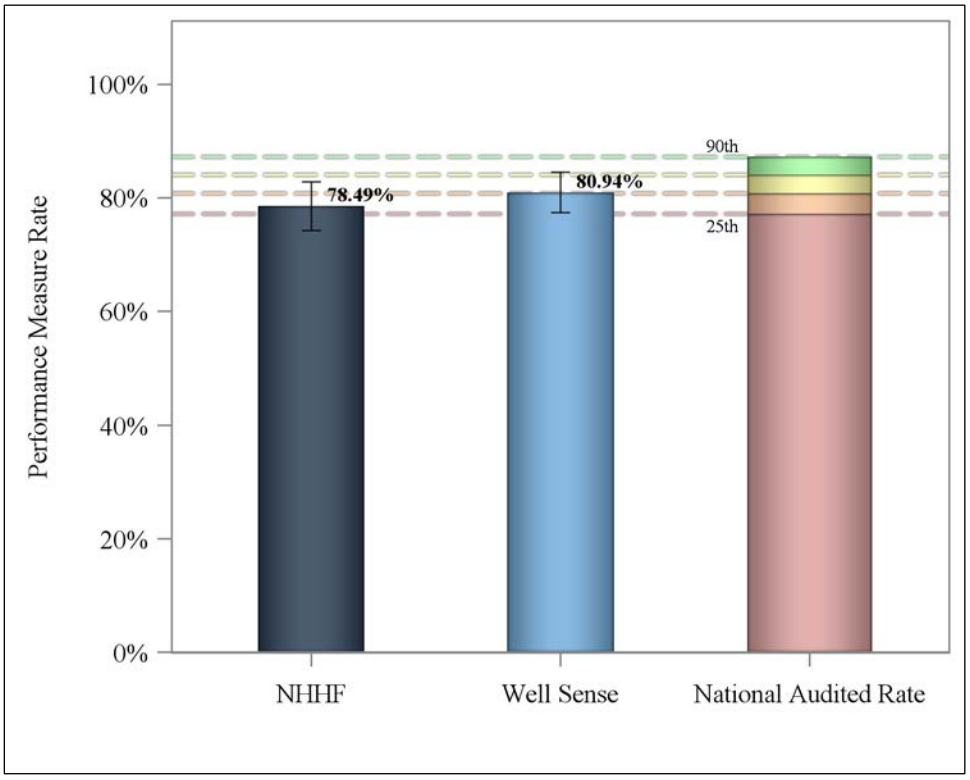


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

SSD measures the percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during 2016. **NHHF**'s and **Well Sense**'s *SSD* measure results are shown in Figure 4-48.

Figure 4-48—CY 2016 *SSD* Measure Results

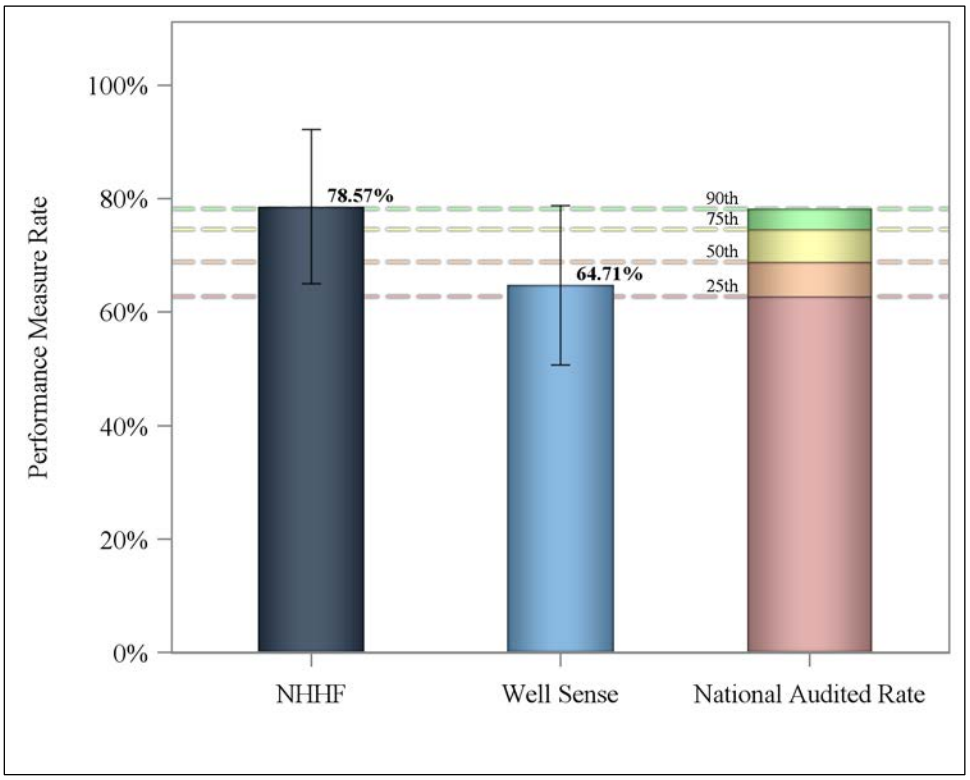


NHHF's reported rate ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile. The *SSD* measure is also a PIP topic for **NHHF**.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

SMD measures the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein-cholesterol (LDL-C) test and an HbA1c test during 2016. **NHHF**'s and **Well Sense**'s *SMD* measure results are shown in Figure 4-49.

Figure 4-49—CY 2016 *SMD* Measure Results

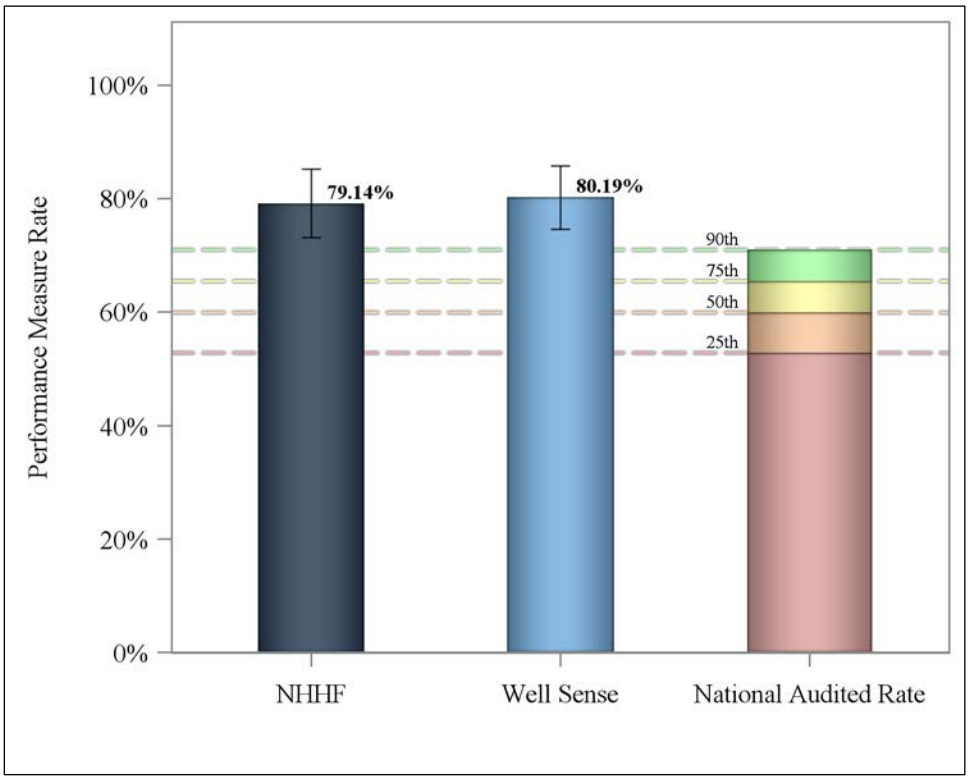


NHHF's reported rate exceeded the national Medicaid 90th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 2016. **NHHF**'s and **Well Sense**'s *SAA* measure results are shown in Figure 4-50.

Figure 4-50—CY 2016 *SAA* Measure Results

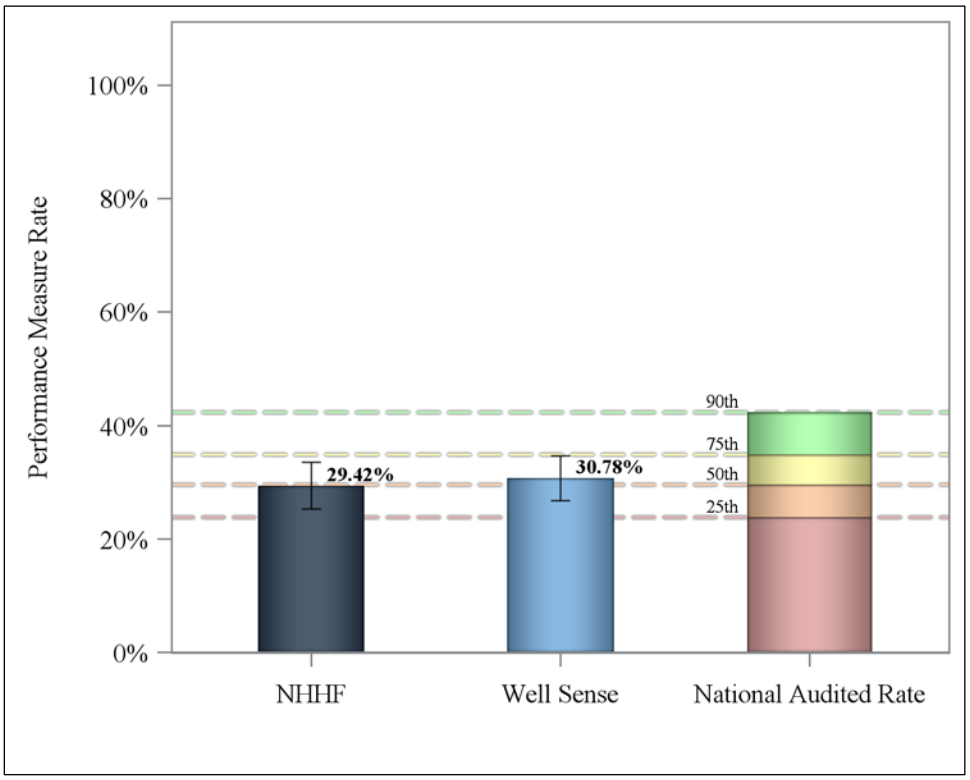


NHHF's and **Well Sense**'s reported rates exceeded the national Medicaid 90th percentile.

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

APM—Total measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during 2016. **NHHF**'s and **Well Sense**'s *APM—Total* measure results are shown in Figure 4-51.

Figure 4-51—CY 2016 *APM—Total* Measure Results

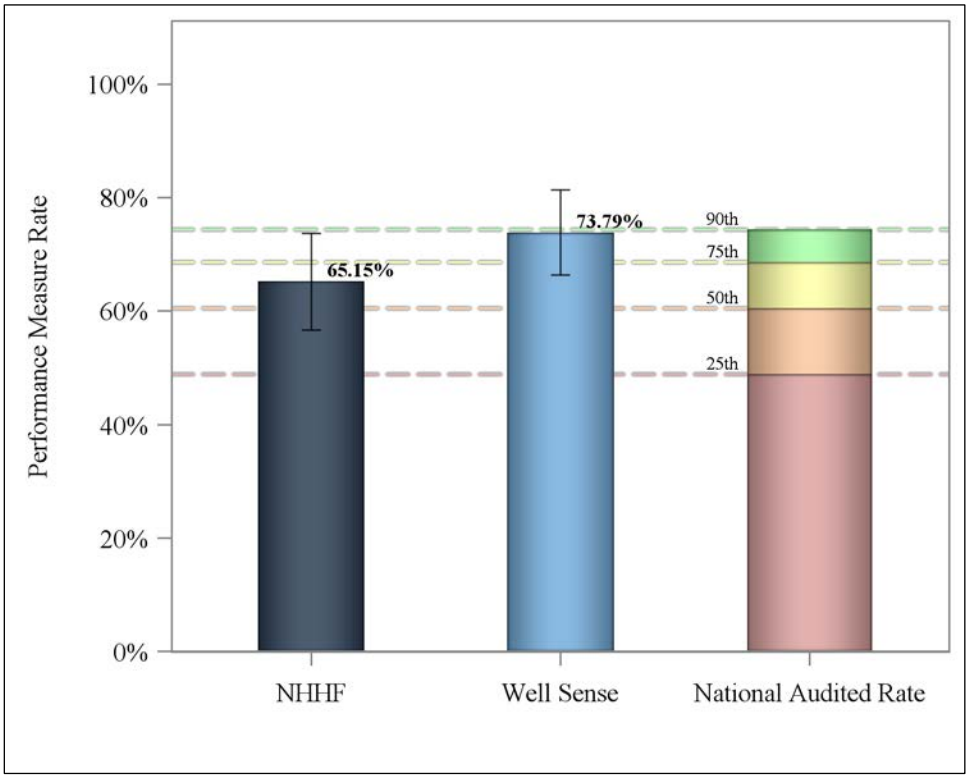


NHHF's reported rate ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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

APP—Total measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment during 2016. **NHHF**'s and **Well Sense**'s *APP—Total* measure results are shown in Figure 4-52.

Figure 4-52—CY 2016 *APP—Total* Measure Results

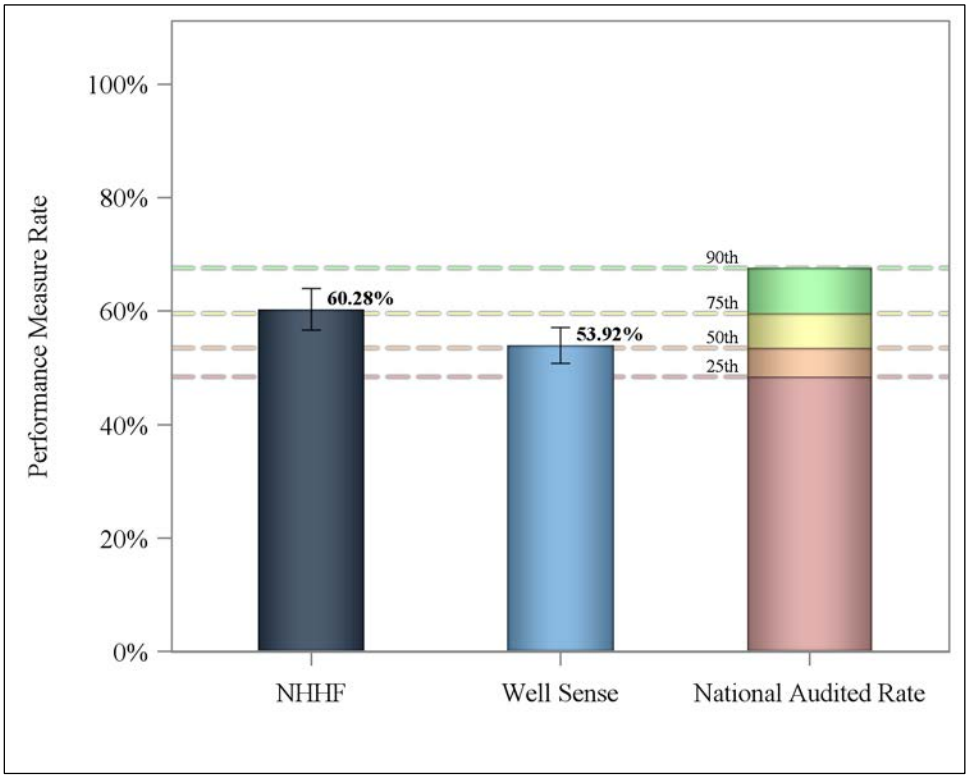


NHHF's reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 4-53.

Figure 4-53—CY 2016 *AMM—Effective Acute Phase Treatment* Measure Results

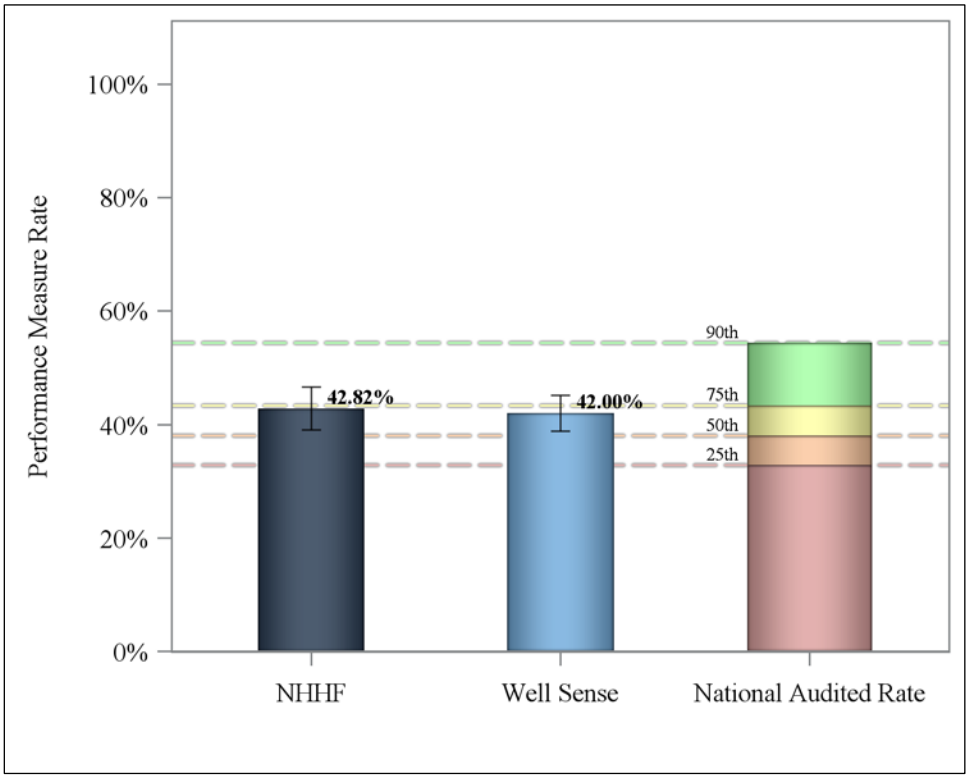


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment

AMM—Effective Continuation 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 180 days (6 months). **NHHF**'s and **Well Sense**'s *AMM—Effective Continuation Phase Treatment* measure results are shown in Figure 4-54.

Figure 4-54—CY 2016 *AMM—Effective Continuation Phase Treatment* Measure Results

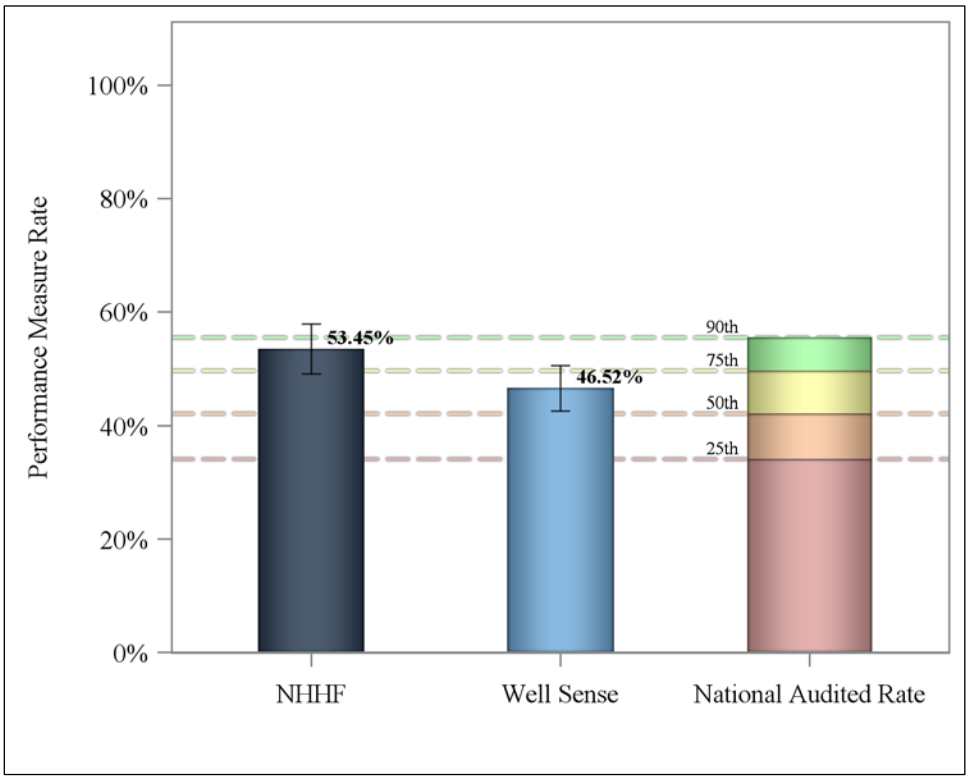


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase

ADD—Initiation Phase measures the percentage of members 6 to 12 years of age who were newly prescribed 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 4-55.

Figure 4-55—CY 2016 *ADD—Initiation Phase* Measure Results

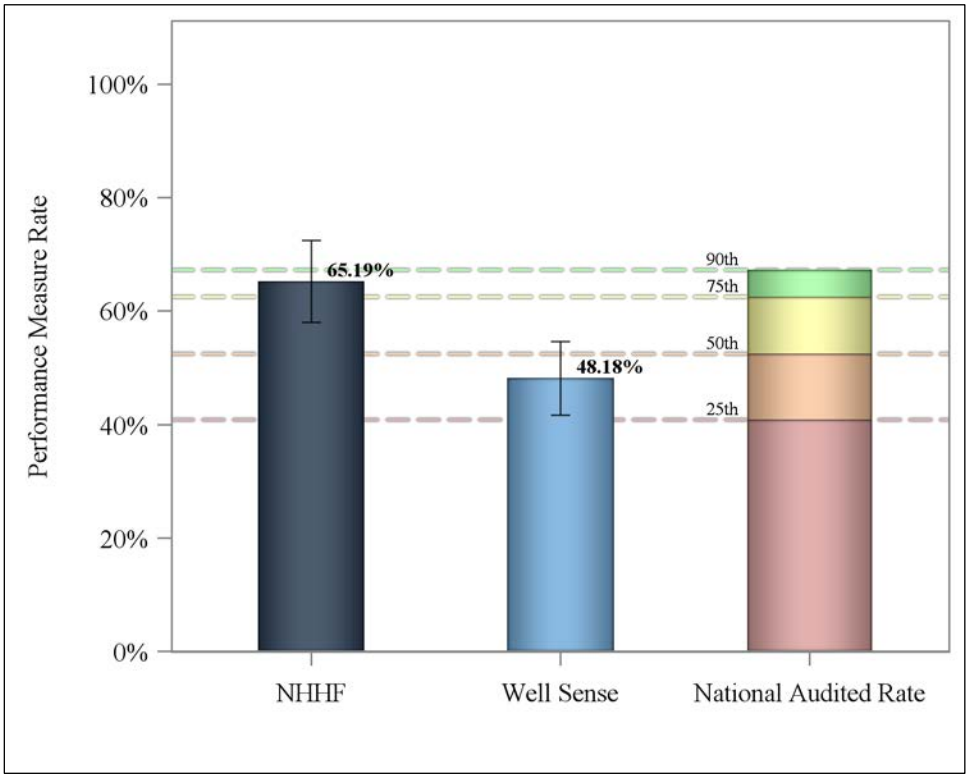


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 270 days (9 months) 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 4-56.

Figure 4-56—CY 2016 *ADD—Continuation and Maintenance Phase* Measure Results

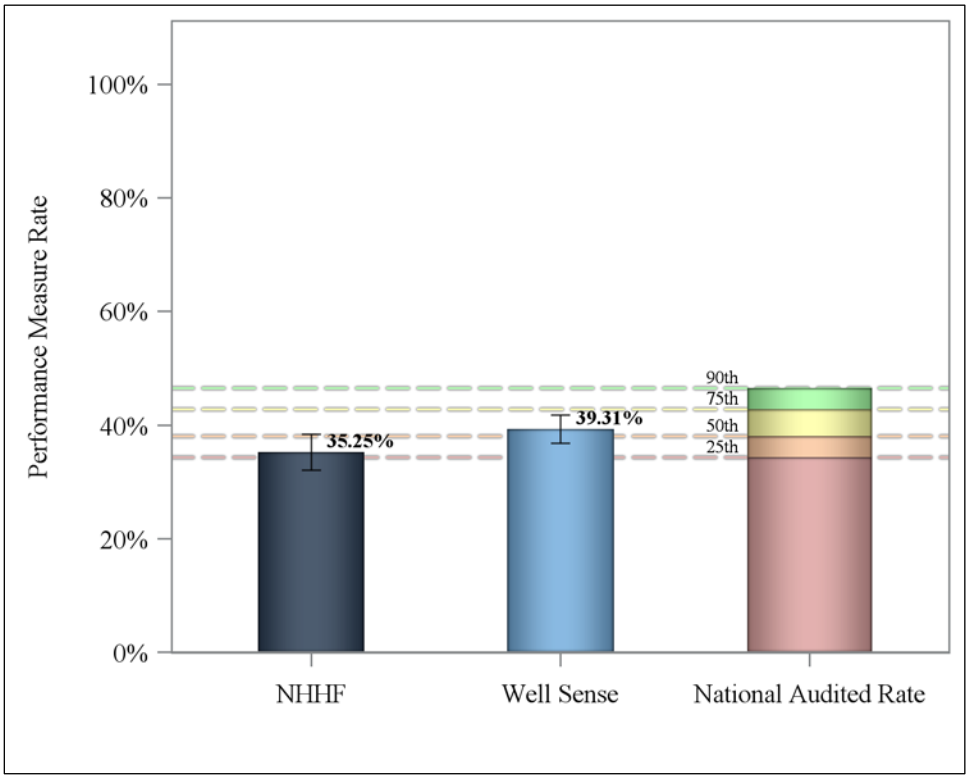


NHHF's reported rate ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 AOD who initiated appropriate AOD treatment within 14 days of the diagnosis during 2016. **NHHF**'s and **Well Sense**'s *IET—Initiation of AOD Treatment* measure results are shown in Figure 4-57.

Figure 4-57—CY 2016 *IET—Initiation of AOD Treatment* Measure Results

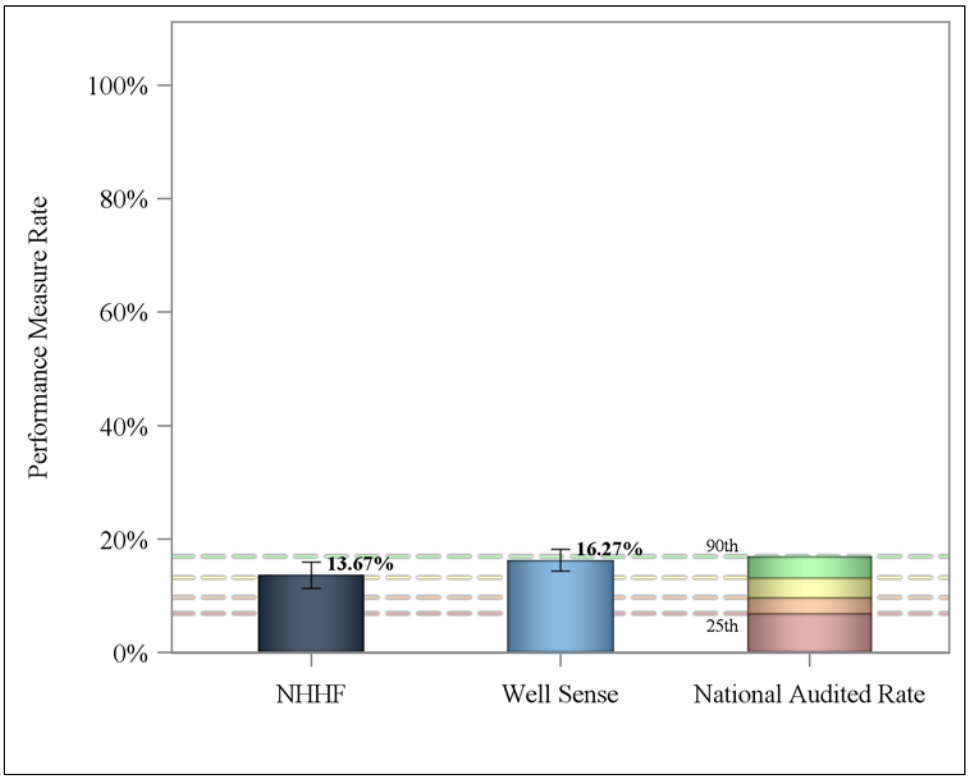


NHHF's reported rate ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 AOD 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 2016. **NHHF**'s and **Well Sense**'s *IET—Engagement of AOD Treatment* measure results are shown in Figure 4-58.

Figure 4-58—CY 2016 *IET—Engagement of AOD Treatment* Measure Results

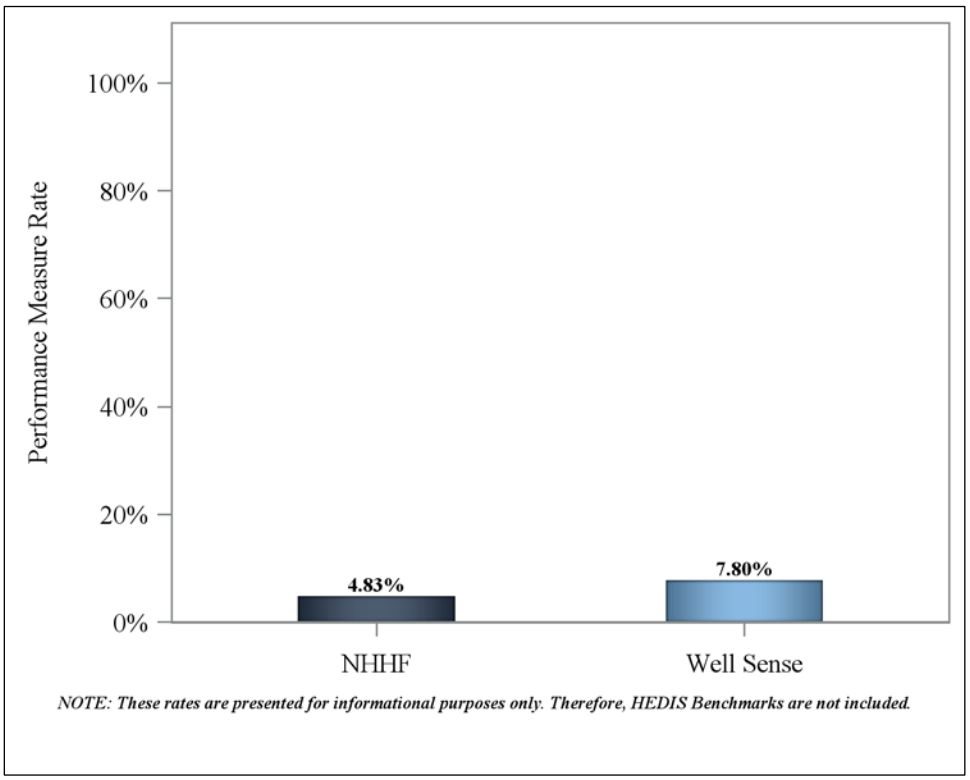


NHHF's and **Well Sense**'s reported rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

IAD—Any Service measures the percentage of members with an alcohol or other drug claim who received any chemical dependency services during 2016. **NHHF**'s and **Well Sense**'s *IAD—Any Service* measure results are shown in Figure 4-59.[4-13] Since the rates reported for this measure do not take into consideration the demographic and clinical characteristics of each MCO's members, comparisons to national benchmarks are not performed. These utilization rates in isolation do not correlate with the quality of services provided. Therefore, these rates are provided strictly for informational purposes.

Figure 4-59—CY 2016 *IAD—Any Service* Measure Results



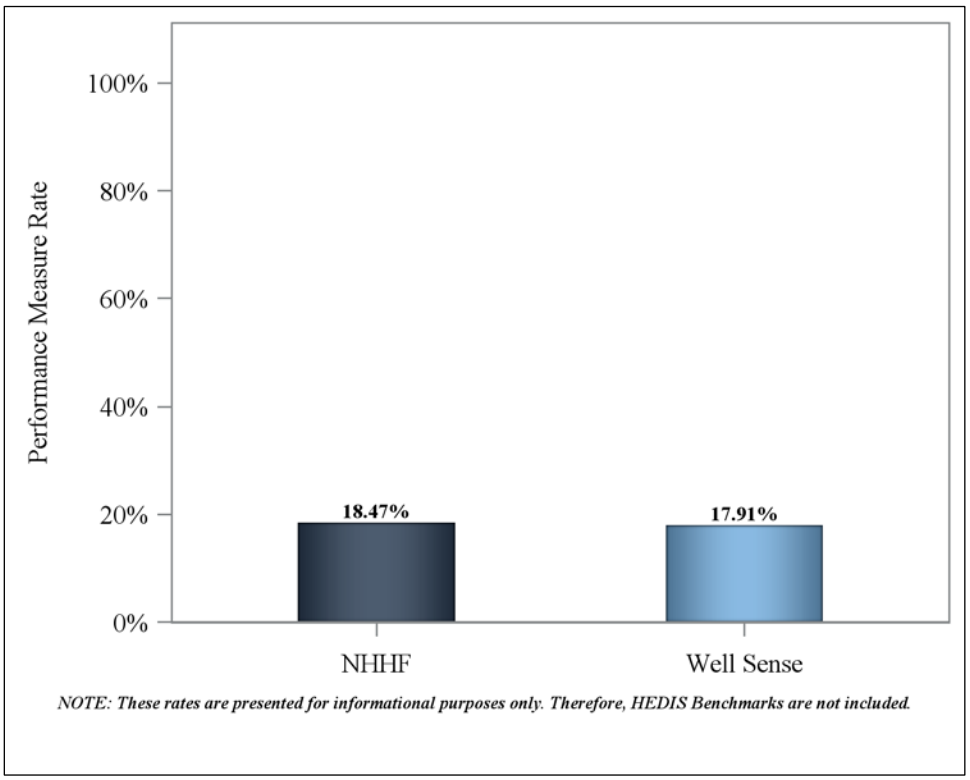
Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-13] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Mental Health Utilization (MPT)—Any Service

MPT—Any Service measures the percentage of members receiving any mental health services during 2016. **NHHF**'s and **Well Sense**'s *MPT—Any Service* measure results are shown in Figure 4-60.[4-14] Since the rates reported for this measure do not take into consideration the demographic and clinical characteristics of each MCO's members, comparisons to national benchmarks are not performed. These utilization rates in isolation do not correlate with the quality of mental health services provided. Therefore, these rates are provided strictly for informational purposes.

Figure 4-60—CY 2016 *MPT—Any Service* 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.

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 recommendation was identified:

- HSAG recommends that **NHHF** improve Roadmap development processes to ensure sufficient details are included to minimize Roadmap documentation concerns.

Based on the MCO's performance measure results, **NHHF** scored at or above NCQA's Audit Means and Percentiles National Medicaid HMO 75th percentile for HEDIS 2016 for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

- *AAP—Adults' Access to Preventive/Ambulatory Health Services**
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *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—Counseling for Nutrition—Total*
- *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *CIS—Childhood Immunization Status—Combination 2*
- *CIS—Childhood Immunization Status—Combination 10**
- *NCS—Non-Recommended Cervical Cancer Screening in Adolescent Females**
- *PPC—Prenatal and Postpartum Care—Postpartum Care*
- *FPC—Frequency of Ongoing Prenatal Care—>81 Percent of Expected Visits*

Acute and Chronic Care

- *CWP—Appropriate Testing for Children with Pharyngitis*
- *URI—Appropriate Treatment for Children with Upper Respiratory Infection*
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid**
- *CBP—Controlling High Blood Pressure**
- *MMA—Medication Management for People With Asthma—Medication Compliance 75%—Total*

- *AMB—Ambulatory Care (Per 1,000 Member Months)—ED Visits*

BH

- *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*
- *FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up**
- *SMD—Diabetes Monitoring for People with Diabetes and Schizophrenia**
- *SAA—Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
- *AMM—Antidepressant Medication Management—Effective Acute 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*
- *IET—Initiation and Engagement of AOD Treatment—Engagement of AOD Treatment*

NHHF scored below the national Medicaid 25th percentile for the following measure and should focus future QI activities in this area:

Prevention

- *CHL—Chlamydia Screening in Women—Total*

Well Sense

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

- **Well Sense** was unable to report hybrid group E; the chart provided by the plan did not meet the requirements for a valid hit. In addition, the plan did not provide detailed documentation of its data mapping between the internal data warehouse and the software vendor data format. HSAG recommends that **Well Sense** improve internal processes for mapping documentation and submit additional measures for hybrid group E to identify valid hits.

Based on the MCO's performance measure results, **Well Sense** scored at or above NCQA's Audit Means and Percentiles National Medicaid HMO 75th percentile for HEDIS 2016 for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

- *AAP—Adults' Access to Preventive/Ambulatory Health Services**
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *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 Documentation—Total*
- *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
- *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *CIS—Childhood Immunization Status—Combination 2*
- *NCS—Non-Recommended Cervical Cancer Screening in Adolescent Females**
- *PPC—Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *PPC—Prenatal and Postpartum Care—Postpartum Care**
- *FPC—Frequency of Ongoing Prenatal Care—>81 Percent of Expected Visits*

Acute and Chronic Care

- *CWP—Appropriate Testing for Children with Pharyngitis*
- *URI—Appropriate Treatment for Children with Upper Respiratory Infection*
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid**
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator**
- *CDC—Comprehensive Diabetes Care—HbA1c Testing*
- *CDC—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *CBP—Controlling High Blood Pressure**
- *MMA—Medication Management for People With Asthma—Medication Compliance 75%—Total*
- *AMB—Ambulatory Care (Per 1,000 Member Months)—ED Visits*
- *ABX—Antibiotic Utilization—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions*

BH

- *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**
- *AAP—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *IET—Initiation and Engagement of AOD Treatment—Engagement of AOD Treatment*

Well Sense scored below the national Medicaid 25th percentile for the following measure and should focus future QI activities in this area:

Prevention

- *Chlamydia Screening in Women—Total*

EDV

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 SFY 2017, DHHS contracted HSAG to use the EDQRS to evaluate the quality of 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' 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 HSAG and DHHS (and Xerox), 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/encounters 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' 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.

Measures in the EDQRS

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

- **Domain 1—Submission Accuracy and Completeness**: Measures in the domain 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. These measures examine whether the submitted encounters pass X12 EDI compliance edits, and if they meet DHHS' 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 the MCOs.

- **Domain 2—Encounter Data Completeness**: Measures in the domain demonstrate the MCOs' trends in encounter submission volume over time. These metrics 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 professional visits by place of service category, and monthly proportions of distinct institutional visits by type of bill category. Monthly trends in MCO paid amounts are assessed in terms of the 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).
- **Domain 3—Encounter Data Accuracy**: Measures in the domain demonstrate the overall quality of submitted encounters, specifically, examining the proportion of submitted encounters 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.
- **Domain 4—Encounter Data Timeliness**: Measures in the domain assess the MCOs' compliance with time-based submission standards for encounter data. These metrics focus on the overall regularity with which encounters 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 domain 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 Implementation

During SFY 2017, the EDQRS was in production mode[4-15] to generate weekly reports and monthly supplemental reports.

[4-15] HSAG began producing weekly reports in August 2016. In addition, DHHS provided specifications for denied and void encounters in August 2017; therefore, HSAG incorporated appropriate changes into the EDQRS so that the system can process denied/void encounters and identify final adjudication encounters for results listed in this report and reports produced in SFY 2018.

Findings From Files Received in SFY 2017

For encounters received from MCOs in SFY 2017 (i.e., July 1, 2016, to June 30, 2017), this section presents the aggregate rates for five standards within Exhibit A-Amendment #7 of the MCM Contract.[4-16]

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 4-15 shows that all 837 P and 837 I encounters received in SFY 2017 passed X12 EDI compliance edits for both **NHHF** and **Well Sense**.

Table 4-15—Percentage of Encounters Passing X12 EDI Compliance Edits

Encounter Type	Standard	NHHF	Well Sense
837 P Encounters	98.0%	100.0%	100.0%
837 I Encounters	98.0%	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 4-16 shows that the member identification numbers were present on 100 percent of encounters. In addition, more than 99 percent of member identification numbers were valid for all three encounter types for **NHHF**, which was slightly lower than the standard (i.e., 100 percent). However, for **Well Sense**, the percentages of valid member identifications numbers were 97.6 percent, 96.9 percent, and 99.9 percent for 837 P, 837 I, and NCPDP encounters, respectively. Further investigation shows that the majority of invalid member identification numbers in the 837 P and 837 I encounters from **Well Sense** occurred because members were not eligible on the dates of service.

Table 4-16—Percentage Present and Percentage Valid for Member Identification Numbers

Encounter Type	Standard	NHHF		Well Sense	
		% Present	% Valid*	% Present	% Valid*
837 P Encounters	100.0%	100.0%	99.4%	100.0%	97.6%
837 I Encounters	100.0%	100.0%	99.5%	100.0%	96.9%
NCPDP Encounters	100.0%	100.0%	99.9%	100.0%	99.9%

* 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 4-17 shows that the servicing provider numbers were present for 100 percent of encounters 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

[4-16] New Hampshire Department of Health and Human Services. (2015). *Medicaid Managed Care Organization Contract Amendment #7.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: Dec 13, 2016.

encounters were 1.7 and 3.7 percentage points below the standard for **NHHF** and **Well Sense**, respectively.

Table 4-17—Percentage Present and Percentage Valid for Servicing Provider Information†

Encounter Type	Standard	NHHF		Well Sense	
		% Present	% Valid*	% Present	% Valid*
837 P Encounters	98.0%	100.0%	97.7%	100.0%	97.8%
837 I Encounters	98.0%	100.0%	96.3%	100.0%	94.3%
NCPDP Encounters	98.0%	100.0%	98.2%	100.0%	98.1%

† 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.

Standard 25.2.24.3.1 states that "Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment." The following two measures were used to evaluate this timeliness standard:

- Measure EDT.1: Percentage of weeks with at least one file submission in SFY 2017
- Measure EDT.2: Percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date

Table 4-18 shows the percentage of the 52 weeks in SFY 2017 with at least one file submission. **NHHF** submitted all three types of encounters to DHHS for all weeks in SFY 2017 except one week. For **Well Sense**, there were less than seven weeks without a file submission, and those non-submission weeks generally were not consecutive.

Table 4-18—Percentage of Weeks With at Least One File Submission

Encounter Type	Standard	NHHF	Well Sense
837 P Encounters	100.0%	98.1%	90.4%
837 I Encounters	100.0%	98.1%	88.5%
NCPDP Encounters	100.0%	98.1%	96.2%

Table 4-19 presents the percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date, and the list below shows the findings. Of note, all encounters submitted to DHHS were included in the evaluation. If an encounter was missing a claim payment date, it was considered to not meet the standard.

- For 837 P encounters, 70.7 percent of **NHHF**'s encounters were submitted to DHHS within 30 days of the claim payment date. The rate for **Well Sense** was much lower (i.e., 39.4 percent) due to missing claim payment dates in the submitted encounter data.

- For 837 I encounters, 62.5 percent and 42.8 percent of encounters were submitted to DHHS within 30 days of the claim payment date for **NHHF** and **Well Sense**, respectively. Like 837 P encounters, the low rate for **Well Sense** was primarily due to missing claim payment dates in the submitted data.
- For NCPDP encounters, while the rate for **NHHF** was 90.8 percent, the rate for **Well Sense** was much lower (i.e., 3.3 percent). However, when increasing the lag days from 30 calendar days to 40 calendar days, more than 95 percent of **Well Sense**'s NCPDP encounters were submitted to DHHS within 40 calendar days.

Table 4-19—Percentage of Encounters Submitted to DHHS Within 30 Calendar Days of Claim Payment

Encounter Type	Standard	NHHF	Well Sense
837 P Encounters	100.0%	70.7%	39.4%
837 I Encounters	100.0%	62.5%	42.8%
NCPDP Encounters	100.0%	90.8%	3.3%

Conclusions and Recommendations

NHHF

NHHF's submitted encounters met the standards for X12 EDI compliance edits and the accuracy for servicing providers in NCPDP encounters.

HSAG recommends that **NHHF** focus on three areas to improve encounter data submissions: data accuracy related to member identification numbers for all three encounter types, data accuracy related to servicing provider information for 837 P/I encounters, and timely encounter data submissions including both weekly submissions to DHHS and submissions to DHHS within 30 days of the claim payment date.

Well Sense

Well Sense's submitted encounters met the standards for X12 EDI compliance edits and the accuracy for servicing providers in NCPDP encounters.

HSAG recommends that **Well Sense** focus on three areas to improve encounter data submission: data accuracy related to member identification numbers for all three encounter types, data accuracy related to servicing provider information for 837 P/I encounters, and timely encounter data submissions including both weekly submissions to DHHS and submissions to DHHS within 30 days of the claim payment date. To improve the percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date, **Well Sense** should ensure that claim payment dates are included in the encounters submitted to DHHS.

Other EQR Activities

Focus Groups

Horn Research conducted focus groups in fall 2016 and spring 2017. 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

Horn Research conducted the fall focus group activities by telephone with 28 Medicaid beneficiaries to explore four key points of inquiry including Access to Case Management, Experience with Care Management, Elements of an Ideal MCO, and Suggested Improvements. The population included individuals who were enrolled with Medicaid care management on the first of every month between July 2015 to August 2016.

Results

The results of the fall focus groups are shown below for each key point of inquiry.

Access to Case Management

Participants were divided on whether they thought there were an adequate number of PCPs in the MCO's network, but the majority indicated they either had enough or multiple choices. The key issue participants identified concerning specialists was a lack of local providers. Most participants indicated they had either minor or no issues with prescription coverage, x-rays, diagnostic tests, and physical therapy through their MCO. A small number of participants said they faced challenges receiving access to needed medical equipment.

Experience With Care Management

Some participants indicated that their MCO provided case management support and proactive assistance. Nearly all participants said they believed help was available from their MCO, but the majority said they had not yet needed to use the services. Of the participants who said they or their child had a chronic health condition, half said their care was more consistent and comprehensive while the other half said their care was equally as consistent and comprehensive as it was before enrolling.

Elements of an Ideal MCO

Dental care and vision care coverage for adults continued to be a priority with participants. Participants indicated that continued coverage of medications, well visits, and emergency room coverage would be necessary benefits of an ideal MCO. Participants said that having a sufficient number of local providers accepting their insurance and an expanded list of specialists providing care were very important to them. Participants also wanted to be able to contact a person at the MCO who was knowledgeable about their situation and could provide options and alternatives for services.

Suggested Improvements

About a third of participants said they could not think of any improvements they would make to their current health care coverage. The remaining participants said they would like enhanced dental and vision coverage, improved communication with their MCO, additional prescription coverage, better mental health coverage and specialist care, and an improved billing and eligibility process. Nearly half of participants said they would like access to a gym membership for their family, and a few participants would like nutritional counseling.

Conclusions and Recommendations

Overall, participants said their experience with their MCO was positive, and they reported fewer incidents of pre-authorization delays and denials than in previous years. Participants also described easy access to referrals for specialists and other needed medical care, and they continued to request increased dental care options and vision care coverage as well as expanded eligibility for Medicaid.

Recommendation topics provided by the study participants include:

- Improved Coverage to include dental care, vision care, prescriptions, and mental health care.
- Clear Channels of Communication that included providing contact information of an individual familiar with their case and offering alternative options when services or medications were denied.
- More Local Providers to include additional PCPs and specialists to decrease travel times and reduce appointment wait times.
- More Healthy Family Benefits to include access to gym memberships and nutritional counseling for members and their families.

Spring Focus Groups

Horn Research conducted the spring focus groups by telephone and included 30 members who were enrolled statewide with the MCM Program through the CFI Waiver (i.e., seniors or adults who medically qualify for the level of care provided in nursing facilities). Four key points of inquiry were identified to explore during this period's data collection efforts: members' experience with their MCO, access to care, quality of care management, and suggested improvements.

Results

The results of the spring focus groups are shown below for each key point of inquiry.

Members' Experience With Their MCO

Nearly all participants had positive experiences in obtaining support when they had questions about their plan; however, a third of those participants received help from a caseworker from a community organization instead of their MCO. Participants receiving help from their MCO were satisfied and felt that support was available when they needed it. Participants said the level of coverage, the transportation benefit, and case management they received were the most positive aspects of their MCO. The most frequently noted problems were with not having needed medical equipment and supplies covered through their health plan, difficulty with transportation services, and administrative issues.

Access to Care

Approximately half of participants said their MCO offered adequate choices for PCPs, although some attributed the lack of access to their rural location or the lack of doctors accepting Medicaid. Nearly all participants said they did not have any problems accessing specialist care. Most participants said they had not experienced any challenges with access to medications, although some participants mentioned delays due to pre-authorization, a need to change the dosage of the medication, or not having a medication covered by insurance. A third of participants noted that they had challenges with their MCO covering needed medical supplies and equipment as well as having difficulty getting medical equipment repaired or replaced.

Quality of Care Management

More than half of participants were unaware of the care coordination support provided by their MCO, but over two-thirds of participants noted that they had other case management support through community organizations. All participants said their doctors work well together in coordinating their care. Nearly all participants said they believed the care for their chronic illness had either remained the same or improved since enrolling in their MCO. The primary transportation challenges included the time it took to reserve a ride through the centralized reservation process, being late for appointments, and not receiving adequate physical support from drivers.

Suggested Improvements

Several participants said they were very satisfied with their coverage and could not think of any enhancements to their care. Suggested improvements included an increase in the amount of home care available to them, assurances that their coverage will continue, assistance resolving administrative issues, improved transportation support, dental care, wellness options (i.e., nutritional support and gym memberships), improved communication from their MCO, better mental health care coverage, and increased access to medical supplies and equipment.

Conclusions and Recommendations

Overall, participants had positive experiences with their MCO and were satisfied with the availability of doctors and specialist care through their network as well as the process for accessing medication. Some participants were dissatisfied with their access to needed medical equipment and supplies as well as home care support. Transportation was an important issue, and some participants noted challenges with the centralized reservation process used by their MCO.

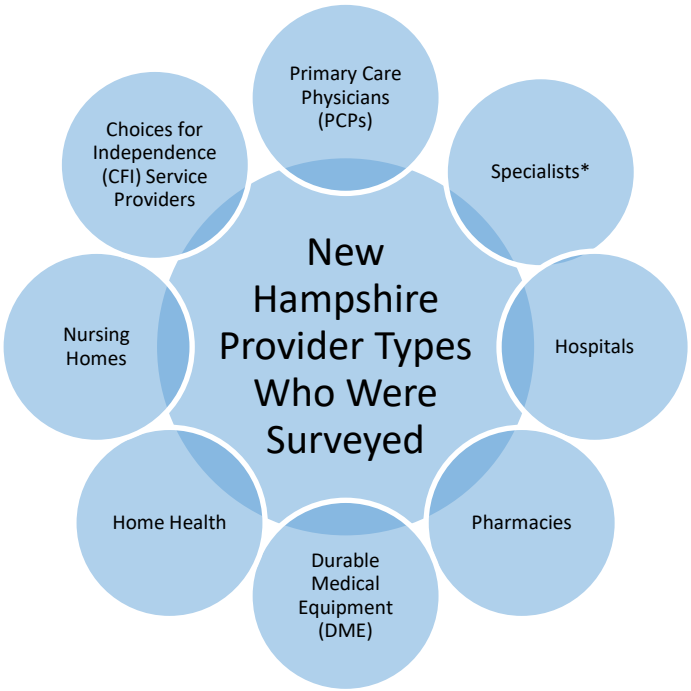
Provider Satisfaction Survey

The contract between the MCOs and DHHS requires that the MCOs conduct an annual provider satisfaction survey to determine the providers' level of satisfaction with the MCOs. Previously, the two MCOs administered different provider satisfaction surveys to their providers. DHHS contracted with HSAG to review the provider satisfaction surveys administered by the MCOs, research current and/or existing provider satisfaction surveys, and recommend one consolidated, comprehensive survey and sampling methodology that meets DHHS' requirements.

Findings

The various provider types that DHHS requires to be included in the provider survey are displayed in Figure 4-61.

Figure 4-61—Provider Types Required to Be Surveyed in the Annual MCO Provider Satisfaction Survey



* The term "specialists" refers to both medical and BH specialists.

DHHS requires that the MCOs include a statistically valid sample of each of the eight provider types. The MCOs must ensure that the provider satisfaction survey tool meets requirements for accreditation by the NCQA; however, at the time of this report, no nationally recognized provider satisfaction surveys were available. Because the same survey was not administered by both MCOs, providers rendering care to members in both MCOs potentially received two different provider surveys each year, and DHHS could not compare the results of the two surveys.

In 2015 and 2016, both MCOs administered the SPHA Provider Satisfaction Survey with varying supplemental questions, and as a requirement of administering that survey, both MCOs contracted with SPHA for the survey administration and analysis. The standard SPHA Provider Satisfaction Survey tool included 41 questions in eight composite measure categories. Table 4-20 displays the eight composite measure categories included in the SPHA Provider Satisfaction Survey tool.

Table 4-20—Composite Measure Categories Included in the SPHA Provider Satisfaction Survey Tool

Composite Measure Categories in the SPHA Provider Satisfaction Survey
Overall satisfaction
All Other Plans (comparative rating)
Finance Issues
Utilization and Quality Management
Network/Coordination of Care
Pharmacy
Health Plan Call Center Service Staff
Provider Relations

In past surveys, **NHHF** administered a mixed-mode methodology (i.e., mail/Internet and telephone follow-up), and **Well Sense** elected to survey the providers by telephone.

Recommendations for the MCOs

HSAG developed a Custom Provider Satisfaction Survey instrument to be used by the MCOs. The advantages of a custom survey include emphasizing specific areas of interest related to New Hampshire providers; modifying the survey instrument over time, if needed; obtaining provider feedback on multiple MCOs using one survey instrument; and developing a condensed survey to reduce provider burden. HSAG's custom survey instrument includes specific areas of interest related to New Hampshire providers and allows for modification to the survey instrument over time. The Custom Provider Satisfaction Survey consists of 23 questions including 11 write-in questions specific to the domains shown in Table 4-21.

Table 4-21—Custom Provider Satisfaction Survey Domains Developed by HSAG

Custom Provider Satisfaction Survey Domains	Description of Domains
General Position	Level of satisfaction with timeliness of claims payments and overall satisfaction
Providing Quality Care	Level of satisfaction with the MCOs' prior authorization process and formulary in terms of the impact on providers' ability to deliver quality care
Non-formulary drugs	Level of satisfaction with access to non-formulary drugs
Service Coordination	Level of satisfaction with the assistance given by service coordinators at the MCO
Specialists	Level of satisfaction with the MCOs' number of medical and BH specialists

HSAG recommended that the MCOs administer the survey to six of the eight provider types (i.e., PCPs, specialists, hospitals, pharmacies, durable medical equipment (DME) suppliers, and home health providers).[4-17] The other two provider types could be added to the survey once they begin providing services to the MCM members. Because the current contract between the MCOs and DHHS requires all eight provider types, DHHS would need to approve this specific recommendation before it could be implemented by the MCOs. The sampling methodology recommended by HSAG included a stratified sample of PCPs and specialists, as well as all hospitals, pharmacies, DMEs, and home health providers due to the limited number of those providers in the State.

HSAG recommended that the MCOs use a mixed-mode methodology (i.e., mail/Internet and telephone follow-up) for future survey administrations to maximize response rates. HSAG recommended administering a mixed-mode methodology with the option to complete a paper-based survey, web-based survey, or telephone survey, and encouraged the MCOs to contract with the same third-party vendor to administer the survey. HSAG strongly encouraged the MCOs to collaborate to hire the same third-party vendor to conduct the administration of the Custom Provider Satisfaction Survey. Using the same third-party survey vendor would allow for the possibility to perform de-duplication of the providers, reduce the number of surveys received by the providers, and possibly improve the response rates from prior years.

BH Member Survey

In SFY 2017, DHHS requested that HSAG research the BH surveys currently administered in New Hampshire and recommend one consolidated, comprehensive BH survey that could be administered by

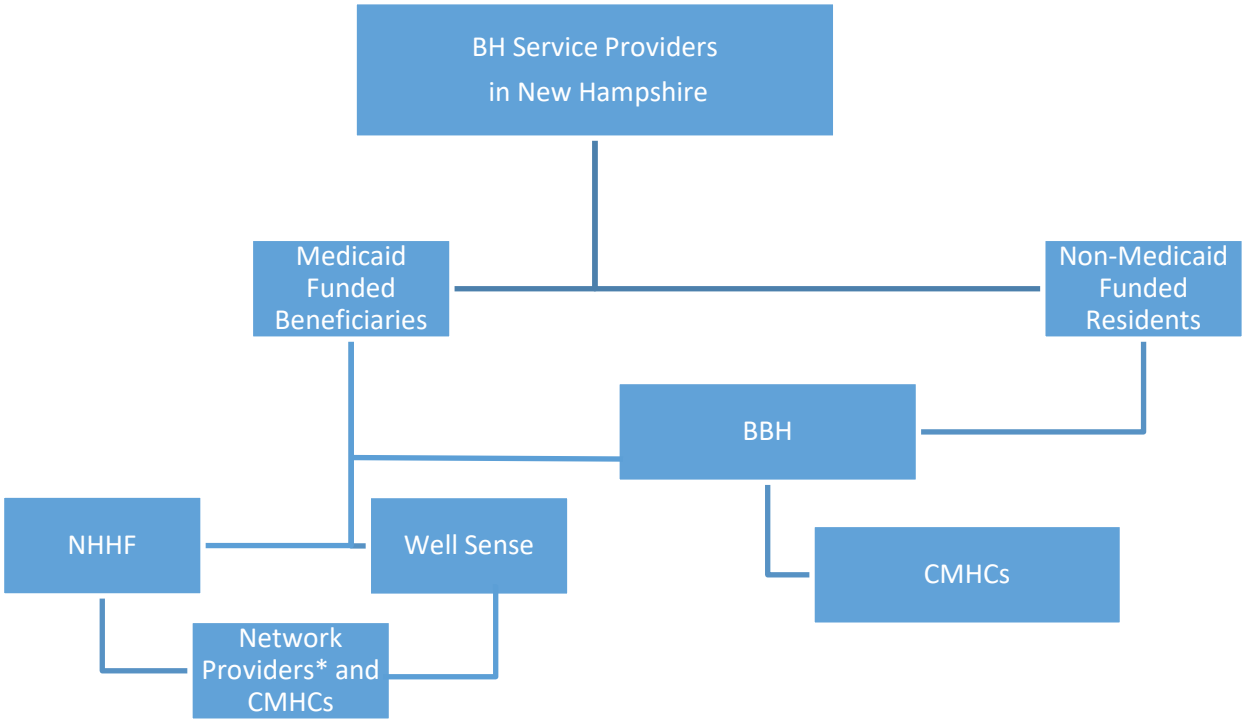
[4-17] DHHS advised HSAG that MCOs are not required to survey nursing facilities or CFI service providers because those provider types are not currently providing services to members in the MCM Program.

all entities. DHHS is required to administer a survey to recipients of BH services to fulfill the requirements of the SAMHSA MHBG requirements.[4-18] **NHHF** and **Well Sense** also are required to administer a survey to members receiving BH services to fulfill requirements for NCQA Health Plan Accreditation. The purpose of the survey is to determine consumer satisfaction with the services received and to ensure that quality and appropriate BH care is being delivered to beneficiaries. DHHS required that the survey meet both NCQA Health Plan Accreditation and SAMHSA requirements.

Background

Three different entities provide BH services to Medicaid beneficiaries in New Hampshire: **NHHF**, **Well Sense**, and the BBH. Figure 4-62 displays the relationship of funding sources to the services provided by the three entities. The MCOs furnish BH services to Medicaid members through network providers (i.e., PCPs, specialist providers, and other BH professionals) and CMHCs. The BBH furnishes BH services to Medicaid and non-Medicaid recipients (e.g., commercially insured, private pay, non-funded) through the 10 CMHCs located throughout the State of New Hampshire.

Figure 4-62—BH Service Providers in New Hampshire by Funding Source



* Network providers include PCPs, specialist providers, and other professionals.

4-18 Substance Abuse and Mental Health Services Administration. Substance Abuse and Mental Health Block Grants. 2017. Available at: https://www.samhsa.gov/grants/block-grants. Accessed on: Oct 30, 2017.

MCOs furnish care to Medicaid beneficiaries with severe and persistent mental illnesses and those with low service utilization. The services provided by CMHCs include 24-hour emergency services, assessment and evaluation, individual and group therapy, case management, community-based rehabilitation services, psychiatric services, and community disaster mental health support. All CMHCs have specialized programs for older adults, children, and families. The CMHCs also provide services and referrals for short-term counseling and support.[4-19]

HSAG reviewed the surveys used by the MCOs and interviewed the New Hampshire MHBG state planner at the Bureau of Mental Health Services, Division for BH, to determine the contents of the current BH surveys used in the State. Table 4-22 displays the DHHS-required BH surveys and compares the surveys currently administered by the three entities providing BH services in New Hampshire.

Table 4-22—Comparison of DHHS Required BH Survey Areas and the MCOs and BBH Administered Surveys

DHHS Required BH Survey Areas	BBH (Modified MHSIP Survey)	NHHF (Modified MHSIP Survey)	Well Sense (Custom BH Survey)
SAMHSA Community MHBG Requirements	X	X	
NCQA Health Plan Survey Accreditations*,[4-20]	X	X	X
Addresses Services Received From CMHCs	X	X	X
Addresses Services Received From Private Treatment or Counselor			X
Addresses Managed Care Services	X	X	X

** To meet the NCQA Health Plan Accreditation requirements, an organization must administer a BH survey. NCQA's specifications do not mandate the use of a particular survey instrument.*

To better understand the types of questions BH survey participants are asked, HSAG evaluated the structure, content, and domains of four BH surveys: the MHSIP survey, the YSS and YSS-F surveys, the ECHO Adult Survey, and the CAHPS HCBS Adult Survey.[4-21,4-22]

4-19 New Hampshire Department of Health and Human Services. 2016. *Community Mental Health Centers.* Available at: https://www.dhhs.nh.gov/dcbcs/bbh/centers.htm. Accessed on: Oct 30, 2017.

4-20 National Committee for Quality Assurance (NCQA). *Standards and Guidelines for the Accreditation of Managed Behavioral Healthcare Organizations: Effective for Surveys Beginning on or after July 1, 2016.*

4-21 Experience of Care and Health Outcomes (ECHO) is a trademark of the Agency for Healthcare Research and Quality (AHRQ). The ECHO Survey is one of the survey products available through AHRQ's CAHPS User Network that assesses BH services provided by managed care plans and managed BH organizations.

4-22 CAHPS® is a registered trademark of AHRQ.

Survey Research

MHSIP, YSS, and YSS-F Survey Overview

The MHSIP survey is developed by MHSIP in collaboration with SAMHSA. Two surveys were modeled after the MHSIP survey: the YSS-F survey that assesses caregivers' perceptions of BH services received by their children ages 17 and under, and the YSS survey that allows adolescents ages 15–17 years of age to assess the BH services they received.[4-23] These three surveys (MHSIP, YSS-F, and YSS) fulfill the SAMHSA MHBG requirements and are available to be to modified, rearranged, and expanded to include additional supplemental questions to meet specific needs of the BH organization.

ECHO Survey Overview

The ECHO surveys were developed under cooperative agreements among NCQA, the BH Measurement Advisory Panel, the MHSIP development team, the Consumer Assessment of BH Services (CABHS) instrument development team, and Harvard Medical School. In 2000, the ECHO development team used the results of the comparison study to formulate recommendations from the original CABHS Survey and the MHSIP for the design and content of the current survey instrument.[4-24,4-25]

CAHPS HCBS Survey Overview

The CAHPS HCBS survey was developed by CMS for voluntary use by state Medicaid programs and is the first cross-disability survey of beneficiaries' experiences in receiving home and community-based LTSS. This survey focuses on participants' experiences in receiving home-based services, not their satisfaction with services received. The HCBS survey is available to be administered via telephone interview or in person.

Recommendations for the MCOs

HSAG recommended that the MCOs implement an enhanced version of the MHSIP Consumer Survey, and the YSS-F/YSS surveys when administering to families or youth with additional supplemental items. HSAG recommended 16 additional supplemental items based on modified questions from the nationally recognized ECHO survey to accompany the MHSIP survey. The enhanced MHSIP Consumer Survey will create a more robust survey instrument that will assist the MCOs in improving BH services to its Medicaid members.

4-23 Block Grant Reporting Section. *Fiscal Years 2018–2019*. 2017. Available at: https://www.samhsa.gov/sites/default/files/grants/fy18-19-mhbg-report.pdf. Accessed on: Oct 30, 2017.

4-24 ECHO Development Team. Shaul JA, Eisen SV, Clarridge BR, Stringfellow VL, Fowler FJ Jr, Cleary PD. *Experience of care and health outcomes (ECHO) survey. Field test report: survey evaluation*. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2001.

4-25 Agency for Healthcare Research and Quality. *Read About the ECHO Survey*. 2015. Available at: https://www.ahrq.gov/cahps/surveys-guidance/echo/about/index.html. Accessed on: Oct 30, 2017.

The recommended enhanced MHSIP Consumer Survey is applicable to all members, regardless of mental illness severity or payor type (i.e., Medicaid or non-Medicaid). The supplemental items from the ECHO survey will support the MHSIP Consumer Survey questions by capturing more detailed information concerning members' experience with BH services, specifically related to a member's counseling and the frequency of counseling. The recommended supplemental questions were designed to evaluate if the member experienced personal problems, family problems, emotional illness, mental illness, or issues with alcohol or drug abuse.

5. Follow-Up on Prior Recommendations

The following section presents HSAG's recommendations made in the prior year's EQR report and an assessment of the actions that were implemented to correct the areas of improvement.

New Hampshire Healthy Families

MCO Contractual Compliance

The CAPs from the **NHHF** SFY 2016 compliance review included 13 elements, and the MCO created policies, procedures, and processes to rectify the deficiencies. Interviews with staff and a review of plan documents during the SFY 2017 compliance review validated that **NHHF** successfully implemented the CAPs for the noncompliant elements identified during the prior year's compliance review.

PIPs

NHHF met 100 percent of the requirements across the four PIPs validated in the prior year for SFY 2016. HSAG provided **NHHF** *Points of Clarification* from some evaluation elements in the final SFY 2016 validation tools, and all but two were addressed by the MCO for this year's SFY 2017 validation.

The *Points of Clarification* for **NHHF** that were not addressed during the SFY 2017 validation were provided to the MCO in the SFY 2016 validation tools for the *Weight Assessment and Counseling for Nutrition* and *Physical Activity for Children/Adolescents* and *Well-Child Visits for 3-to-6-Year-Olds* PIPs. For each PIP, HSAG provided a *Point of Clarification* in Activity VIII (Improvement Strategies), which reminded the MCO that the SFY 2017 PIP submissions would need to include evaluation results specific to each intervention and documentation of how intervention-specific evaluation results were used to refine improvement efforts. When the two PIPs were validated for the SFY 2017 validation, HSAG determined that the MCO had documented evaluation of some but not all implemented interventions; therefore, HSAG assigned a *Partially Met* score for one evaluation element in Activity VIII for both PIPs.

PMV

The prior year's technical report included findings from the SFY 2015 and SFY 2016 PMV audits. The findings from the 2015 audit indicated that **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. In the SFY 2016 PMV audit, 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. 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. After HSAG concluded the findings for SFYs' 2015 and 2016 PMV audits, **NHHF** understood the required revisions and was working to correct the measures for future submissions to DHHS.

CAHPS

NHHF needed to focus QI efforts on the child Medicaid population since all the rates for the adult Medicaid population exceeded the 2015 NCQA adult Medicaid national averages. HSAG recommended that **NHHF** focus on *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service* since the rates for these child measures were below NCQA's 2015 CAHPS national average. The 2017 *Rating of All Health Care* rate for the child population exceeded the 2016 national average by a statistically significant amount while the 2017 *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service* rates for the child population were neither statistically significantly higher nor lower than the 2016 national averages.

HEDIS

For **NHHF**, the HEDIS recommendations in the 2016 technical report included improving rates for eight measures that fell below the national Medicaid 25th percentile: *Cervical Cancer Screening (CCS)*, *Chlamydia Screening in Women (CHL)—Total*, *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid* and *Bronchodilator*, *Annual Monitoring for Patients on Persistent Medications (MPM)—Total*, *Use of Imaging Studies for Low Back Pain (LBP)*, and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*. Seven of the eight rates demonstrated positive improvement. Of note, rates for *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid* and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* met or exceeded the national Medicaid 90th percentile. In contrast, the *Chlamydia Screening in Women (CHL)—Total rate* remained below the national Medicaid 25th percentile, indicating opportunities for improvement in this area.

EDV

In 2016, HSAG generated two EDV reports that included encounters submitted by the MCOs between December 1, 2013, and May 2, 2016. The evaluations in SFY 2016 included three standards: passing X12 EDI compliance edits, accuracy and validity of member identification numbers, and accuracy and validity of servicing provider information. The results from the SFY 2016 EDV activities indicated that **NHHF** needed to focus on improving data accuracy related to member identification numbers and servicing provider information. The SFY 2017 evaluation included the same three standards evaluated in SFY 2016 and two additional timeliness standards: submitting encounter data weekly and submitting encounter data within 30 calendar days of claim payment. The current year's results revealed continuing

opportunities for improvement in data accuracy related to member identification numbers and servicing provider information as well as new opportunities for improvement in the two timeliness standards.

Well Sense

MCO Contractual Compliance

The CAPs from the **Well Sense** SFY 2016 compliance review included 16 elements, and the MCO created policies, procedures, and processes to rectify the deficiencies. Interviews with staff and a review of plan documents during the SFY 2017 compliance review validated that **Well Sense** successfully implemented the CAPs for the noncompliant elements identified during the prior year's compliance review.

PIPs

Well Sense met 100 percent of the requirements across the four PIPs validated in the prior year for SFY 2016. HSAG did not provide **Well Sense** any *Points of Clarification* in the final SFY 2016 validation tools because the MCO addressed all HSAG feedback for that validation year in the PIP resubmissions.

PMV

The prior year's technical report included findings from the SFY 2015 and SFY 2016 PMV audits. The findings from the 2015 audit indicated that **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. In the SFY 2016 PMV audit, **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. **Well Sense** was granted additional time during the PMV audit to recalculate the measure and research scenarios that would have met the measure criteria. Despite its effort, **Well Sense** was still unable to capture the essence of the measure's intent. After HSAG concluded the findings for the SFYs 2015 and 2016 PMV audits, **Well Sense** understood the required revisions and was working to correct the measures for future submissions to DHHS.

CAHPS

From the 2016 CAHPS survey results, HSAG recommended that **Well Sense** focus QI 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. The results from the current survey indicated that the adult **Well Sense** rate for *Rating of Health Plan* is now above the national average, while the *Rating of All Health Care* rate is neither statistically significantly higher nor lower than the national average. For

Well Sense's general child Medicaid population, HSAG recommended 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 average. The child **Well Sense** rate for *Getting Needed Care* is now above the national average, while the *Rating of All Health Care* rate is neither statistically significantly higher nor lower than the national average.

HEDIS

For **Well Sense**, the HEDIS recommendations in the 2016 technical report included improving rates for four measures that fell below the national Medicaid 25th percentile: *Cervical Cancer Screening (CCS)*, *Chlamydia Screening in Women—Total (CHL)*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*, and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).* Rates for three of the four measures demonstrated positive improvement, including *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*, which met or exceeded the national Medicaid 90th percentile. Conversely, the *Chlamydia Screening in Women (CHL)—Total* rate remains below the national Medicaid 25th percentile, indicating opportunities for improvement in this area.

EDV

HSAG generated two EDV reports in 2016 that included encounters submitted by the MCOs between December 1, 2013, and May 2, 2016. The evaluations in SFY 2016 included three standards: passing X12 EDI compliance edits, accuracy and validity of member identification numbers, and accuracy and validity of servicing provider information. The results from the SFY 2016 EDV activities indicated that **Well Sense** needed to focus on improving data accuracy related to member identification numbers and servicing provider information. The SFY 2017 evaluation included the same three standards evaluated in SFY 2016 and an additional two timeliness standards: submitting encounter data weekly and submitting encounter data within 30 calendar days of claim payment. The current year's results revealed continuing opportunities for improvement in data accuracy related to member identification numbers and servicing provider information as well as new opportunities for improvement in the two timeliness standards.

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
- **ABX—**Antibiotic Utilization
- **ACE—**angiotensin converting enzyme
- **ADD—**Follow-up Care for Children Prescribed ADHD Medication
- **ADHD—**attention deficit/hyperactivity disorder
- **AHRQ—**Agency for Healthcare Research and Quality
- **AMB—**Ambulatory Care
- **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
- **BBH—**Bureau of Behavioral Health
- **BCCP—**Breast and Cervical Cancer Program
- **BH—**behavioral health
- **BMI—**body mass index
- **CABHS—**Consumer Assessment of Behavioral Health Services
- **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
- **CCS—**Cervical Cancer Screening
- **CDC—**Comprehensive Diabetes Care
- **CFI—**Choice for Independence

- **CFR—**Code of Federal Regulations
- **CHCA—**Certified HEDIS compliance auditor
- **CHL—**Chlamydia Screening in Women
- **CIS—**Childhood Immunization Status
- **CMHC—**community mental health center
- **CMS—**Centers for Medicare & Medicaid Services
- **COPD—**chronic obstructive pulmonary disease
- **CT—**Computerized Tomography
- **CWP—**Appropriate Testing for Children with Pharyngitis
- **CY—**calendar year
- **DHHS—**State of New Hampshire, Department of Health and Human Services
- **DME—**durable medical equipment
- **DTaP—**diphtheria, tetanus, and pertussis vaccine
- **ECHO—**Experience of Care and Health Outcomes
- **ED—**emergency department
- **EDI—**electronic data interchange
- **EDQRS—**Encounter Data Quality Reporting System
- **EDV—**encounter data validation
- **EQR—**external quality review
- **EQRO—**external quality review organization
- **FAR—**final audit report
- **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
- **HCBS—**Home and Community-Based Services
- **HEDIS—**Healthcare Effectiveness Data and Information Set
- **HepA—**hepatitis A vaccine
- **HepB—**hepatitis B vaccine
- **HiB—**Haemophilus influenzae type B
- **HMO—**Health Maintenance Organization
- **HSAG—**Health Services Advisory Group, Inc.
- **I—**institutional
- **IAD—**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
- **IPV—**polio vaccine
- **IS—**information system
- **ISCAT—**Information System Capability Assessment Tool
- **LBP—**Use of Imaging Studies for Low Back Pain
- **LDL-C—**Low-density lipoprotein-cholesterol
- **LO—**National Committee for Quality Assurance-Licensed Organization
- **LTSS—**long-term services and supports
- **MCM—**Medicaid Care Management
- **MCO—**managed care organization
- **MHBG—**Mental Health Services Block Grant
- **MHSIP—**Mental Health Statistics Improvement Program
- **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
- **MPT—**Mental Health Utilization
- **MRI—**Magnetic Resonance Imaging
- **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
- **PAHP—**prepaid ambulatory health plan
- **PAP—**Premium Assistance Program

- **PCCM—**primary care case management
- **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
- **QHP—**Qualified Health Plan
- **QI—**quality improvement
- **R—**report
- **RV—**rotavirus
- **SAA—**Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **SAMHSA—**Substance Abuse and Mental Health Services Administration
- **SFY—**state fiscal year
- **SMD—**Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SPHA—**Symphony Performance Health Analytics
- **SSD—**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- **SUD—**substance use disorder
- **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
- **YSS—**Youth Services Survey
- **YYS-F**—Youth Services Survey for Families

Appendix B. Methodologies for Conducting EQR Activities

MCO Contractual Compliance

According to 42 CFR §438.358, a review to determine an MCO's, PIHP's, PAHP's, or PCCM'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] 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 of care, timeliness of care, 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.
- Collect data and documents from the MCOs and review the information before and during the on-site review.

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.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Jan 4, 2018.

- 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.**
	HSAG works with DHHS and the MCOs before the review to establish the on-site review schedule and assigns 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 Compliance Information Letter the MCOs.**
	HSAG prepares and forwards a letter to the MCOs and requests that they submit information and documents to HSAG within a specified number of days of the request. The letter 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:	**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 5:	**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 6:	**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 7:	**Conduct the on-site portion of the review.**
	Staff members from the MCO answer questions during the on-site review 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 8:	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 9:	**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. The 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*.

Information Reviewed During the 2014–2017 Compliance Reviews

The SFY 2014 compliance activities consisted of reviewing all 14 standards containing 294 applicable elements. Since that time, HSAG has reviewed one-third of the elements in each standard during the 2015, 2016, and 2017 compliance reviews as shown in the Table B-2. Due to changes in contract requirements, there were 332 elements included in the 2015, 2016, and 2017 reviews.

Table B-2—Elements Included in the NHHF and Well Sense Compliance Reviews from 2014–2017

Compliance Reviews	Compliance Standards	Number of Elements	
		NHHF	Well Sense
2014	14	294	295
2015	14	92	91
2016	15	130	129
2017	14	110	111

HSAG included 14 standards in three of the four years. In 2016, DHHS requested that HSAG include the SUD standard which increased the number of standards to 15. Table B-3 displays the names of the standards and displays their inclusion in the compliance reviews from 2014–2017.

Table B-3—Standards Included in the NHHF and Well Sense Compliance Reviews

	Standard Name	2014	2015	2016	2017
I.	Delegation and Subcontracting	X	X	X	X
II.	Plans Required by the Contract	X	X	X	X
III.	Emergency and Post-stabilization Care	X	X	X	X
IV.	Care Management/Care Coordination	X	X	X	X
V	Wellness and Prevention	X	X	X	X
VI.	BH	X	X	X	X

	Standard Name	2014	2015	2016	2017
VII.	Member Enrollment and Disenrollment	X	X	X	X
VIII.	Member Services	X	X	X	X
IX.	Cultural Considerations	X	X	X	X
X.	Grievances and Appeals	X	X	X	X
XI.	Access	X	X	X	X
XII.	Network Management	X	X	X	X
XIII.	Utilization Management	X	X	X	X
XIV.	Quality Management	X	X	X	X
XV.	Substance Use Disorder			X	

HSAG developed checklists to review items that are required in a specific area or a specific document. Table B-4 illustrates the 10 checklists created for the New Hampshire compliance reviews. The 2014 review included all 10 checklists, and HSAG included nine of the checklists in the 2016 and 2017 review. The checklist for Culturally and Linguistically Appropriate Services was retired due to changing requirements in the contract between the MCOs and DHHS.

Table B-4—Checklists Included in the NHHF and Well Sense Compliance Reviews

	Checklist	2014	2015*	2016	2017
1.	Access Standards	X		X	
2.	Call Center	X			X
3.	Culturally and Linguistically Appropriate Services**	X			
4.	Provider Directory	X		X	
5.	Member Handbook	X		X	
6.	ID Cards	X			X
7.	MCO Web Site	X		X	
8.	Network Management	X			X
9.	Notice Requirements	X			X
10.	Member Rights	X		X	

* No checklists were included in the 2015 Compliance Review

** Requirements included in this checklist were revised in the contract between the MCOs and DHHS, and the checklist was retired.

HSAG included file reviews for grievances, appeals, denials of service, credentialing, and recredentialing in the 2014 compliance review. After 2015, the five file reviews were dispersed between the compliance review in 2016 and the compliance review in 2017 as shown in Table B-5.

Table B-5— File Reviews Included in the NHHF and Well Sense Compliance Reviews

	File Reviews	2014	2015*	2016	2017
1.	Grievances	X		X	
2.	Appeals	X		X	
3.	Denials of Service	X		X	
4.	Credentialing	X			X
5.	Recredentialing	X			X

* No file reviews were included in the 2015 Compliance Review.

PIPs

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

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.

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. The 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 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*.

PMV

Validation of performance measures, as set forth in 42 CFR §438.358,[B-3] 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.

Table B-6 presents the state-selected performance measure for the 2017 validation activities. HSAG completed the reports for this activity in August 2017.

Table B-6—Performance Measure Audited by HSAG for SFY 2017

Performance Measures
AMBCARE.10: Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by Subpopulation. This measure will be reported by 63 separate subpopulations.

[B-3] U. S. Government Printing Office. (n.d.). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl. Accessed on: Dec 13, 2016.

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 three designation categories listed in Table B-7.

Table B-7—Designation Categories for Performance Measures Audited by HSAG

Report (R)	Measure was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which the MCO rate was materially biased.
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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. 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.

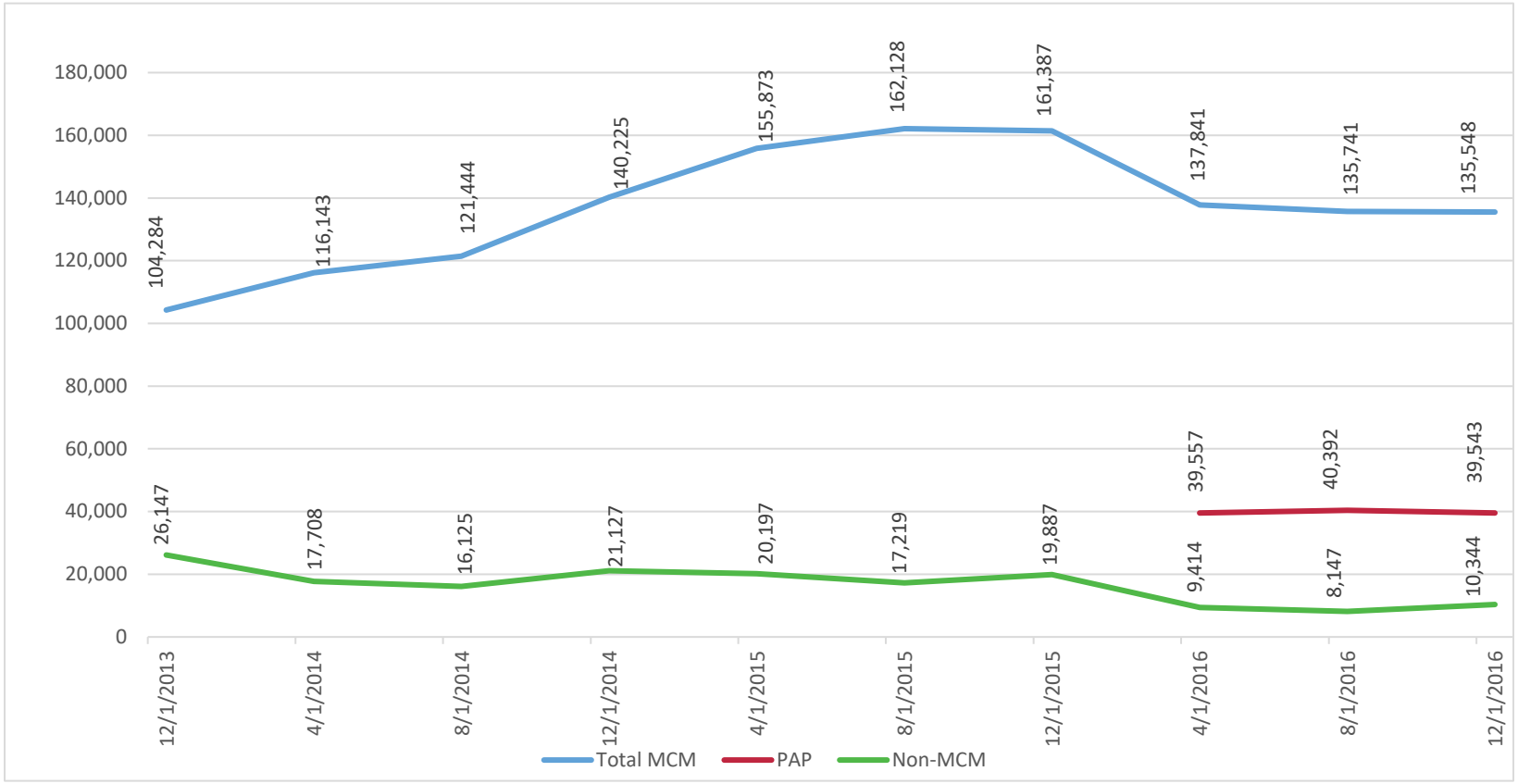
After completing the validation process, HSAG prepared a final report detailing the PMV findings and any associated recommendations for each MCO. These reports were provided to DHHS and to each MCO.

Appendix C. Demographics of the New Hampshire MCM Program

DHHS furnished the demographic information displayed in this section of the report.

The following figures provide information concerning enrollment in the New Hampshire MCM Program from its inception on December 1, 2013, to December 1, 2016. Charts also are included to indicate the eligibility categories for the **NHHF** and **Well Sense** membership on December 2, 2016, and the distribution of enrollment by county and by MCO. The average quarterly enrollment for the seven eligibility categories is shown in the tables at the end of this section.

Figure C-1—New Hampshire MCM Enrollment and Non-MCM Enrollment from December 1, 2013, to December 1, 2016



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 (PAP) beginning on 1/1/2016, when they were placed in a Qualified Health Plan (QHP).

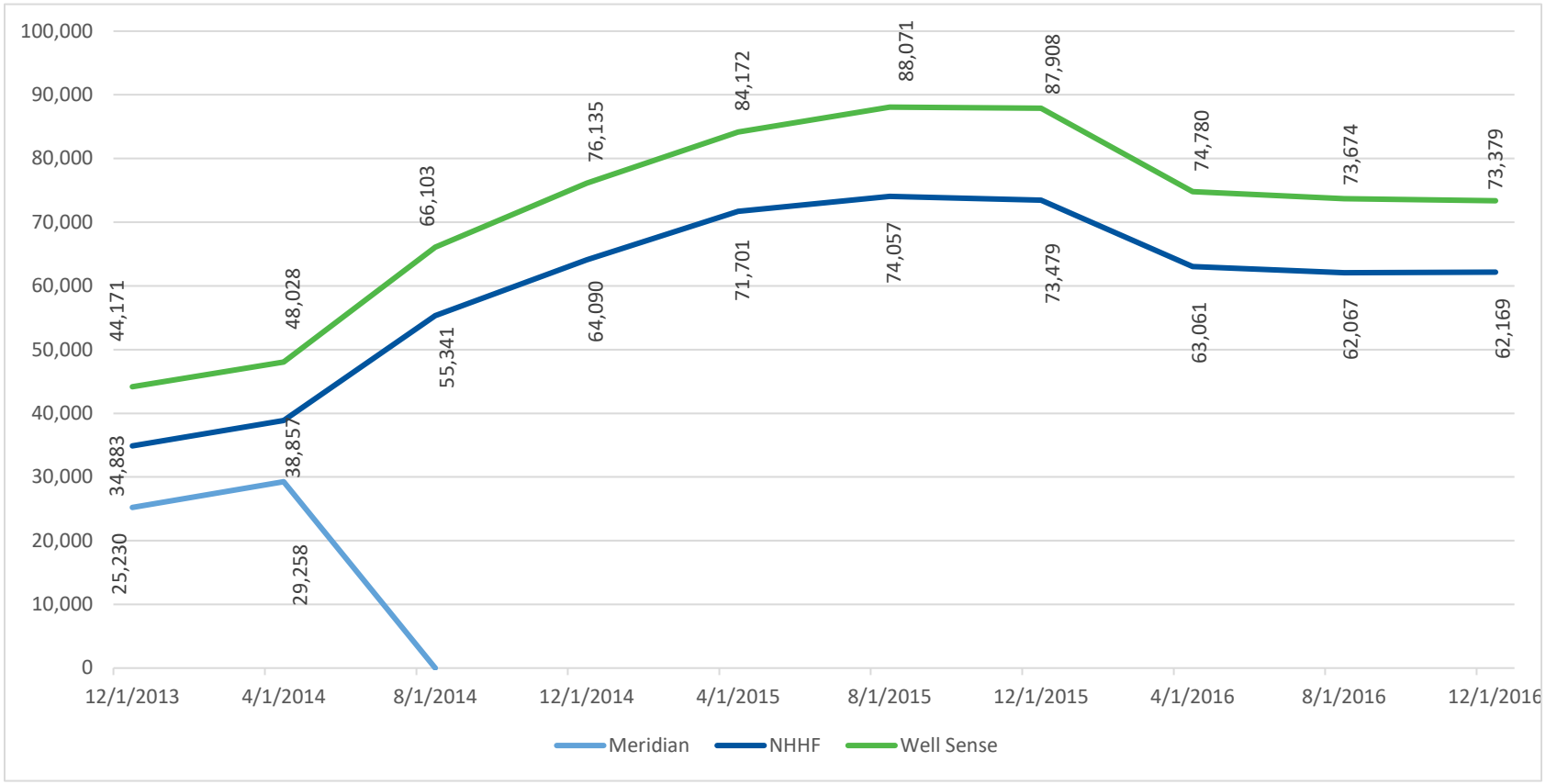
The NHHPP PAP began 1/1/2016, when members were moved from MCM or Non-MCM/PAP to a PAP QHP.

The 1915(b) population that began as voluntary in the MCM Program transitioned to mandatory as of 2/1/2016.

Source: New Hampshire MMIS as of 12/2/2016 for the most current period; data subject to revision.

Figure C-2 displays the enrollment in the MCOs since the inception of the MCM Program in New Hampshire.

Figure C-2—Enrollment in the New Hampshire MCM by MCO as of December 2, 2016



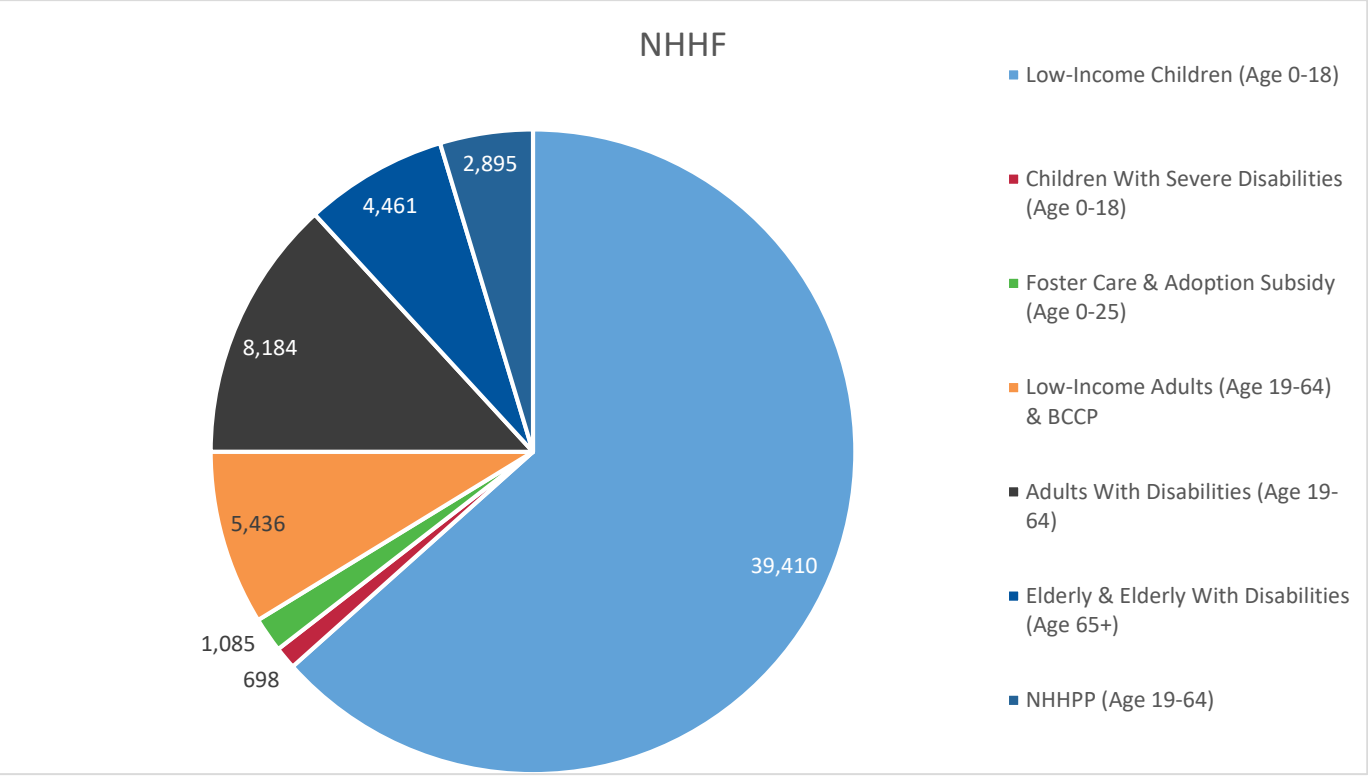
New NHHPP members who enrolled after 10/1/2016 were temporarily assigned to a Non-MCM benefit plan in anticipation of the PAP beginning on 1/1/2016, when they were placed in a QHP.

The NHHPP PAP began 1/1/2016, when members were moved from MCM or Non-MCM/PAP to a PAP QHP.

Source: New Hampshire MMIS as of 12/2/2016 for the most current period; data subject to revision.

Figure C-3 displays the **NHHF** eligibility categories of MCO members as of December 2, 2016.

Figure C-3—Point-in-Time Eligibility Category by MCO as of December 2, 2016



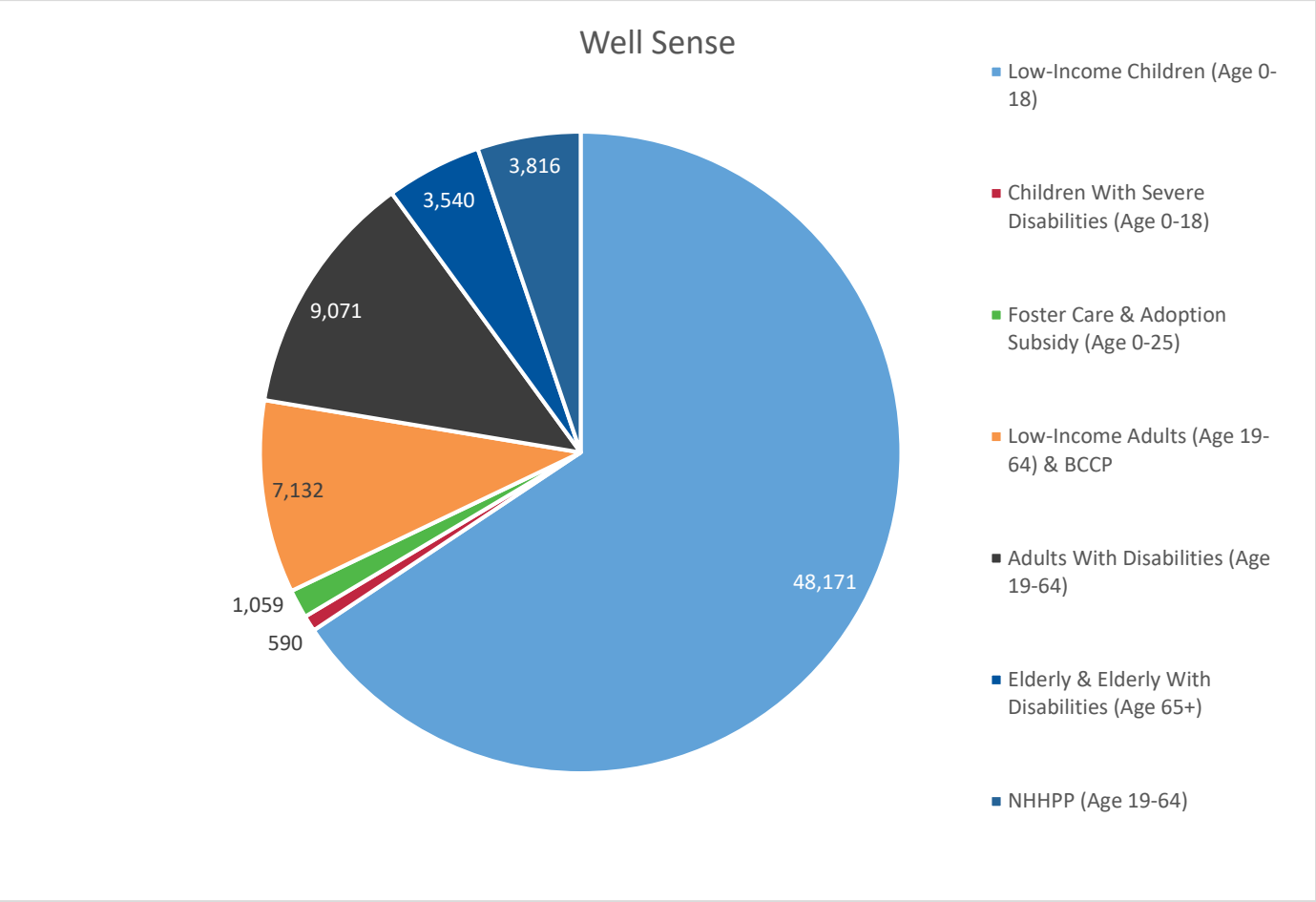
Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.

Source: New Hampshire MMIS as of 12/2/2016; data subject to revision.

The largest eligibility category, low-income children, represented 63.4 percent of **NHHF** members. The smallest eligibility category, children with severe disabilities, represented 1.1 percent of **NHHF** members. Total **NHHF** membership on December 1, 2016, in the seven eligibility categories was 62,169.

Figure C-4 displays the **Well Sense** eligibility categories of MCO members as of December 2, 2016.

Figure C-4—Point-in-Time Eligibility Category by MCO as of December 2, 2016



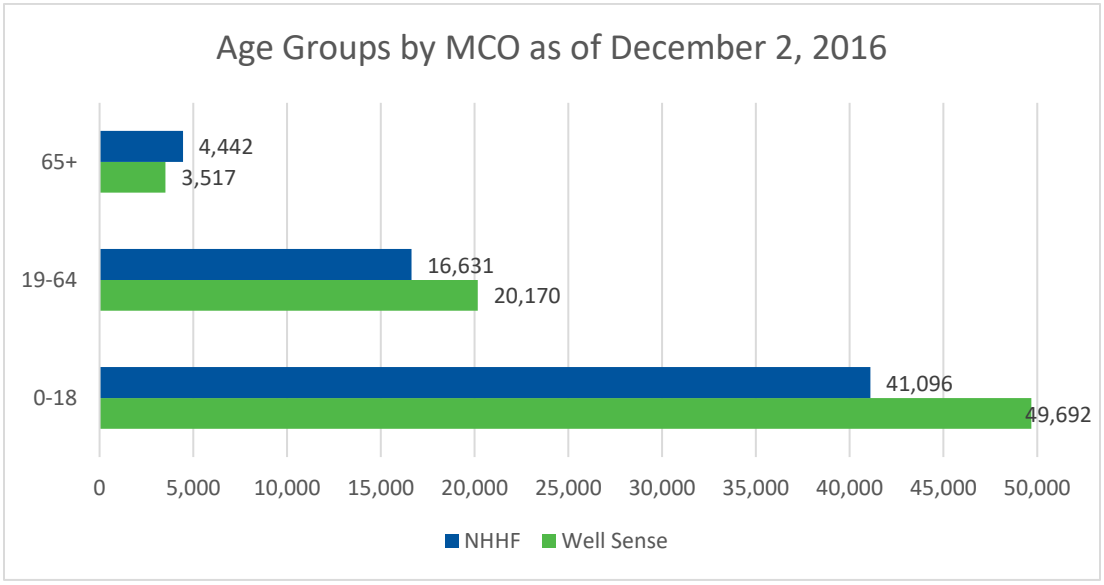
Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.

Source: New Hampshire MMIS as of 12/2/2016; data subject to revision.

The largest eligibility category, low-income children, represented 65.6 percent of **Well Sense** members. The smallest eligibility category, children with severe disabilities, represented 0.8 percent of **Well Sense** members. Total **Well Sense** membership on December 1, 2016, in the seven eligibility categories was 73,379.

Figure C-5 displays information concerning the age groups of the Medicaid members in **NHHF** and **Well Sense** as of December 2, 2016.

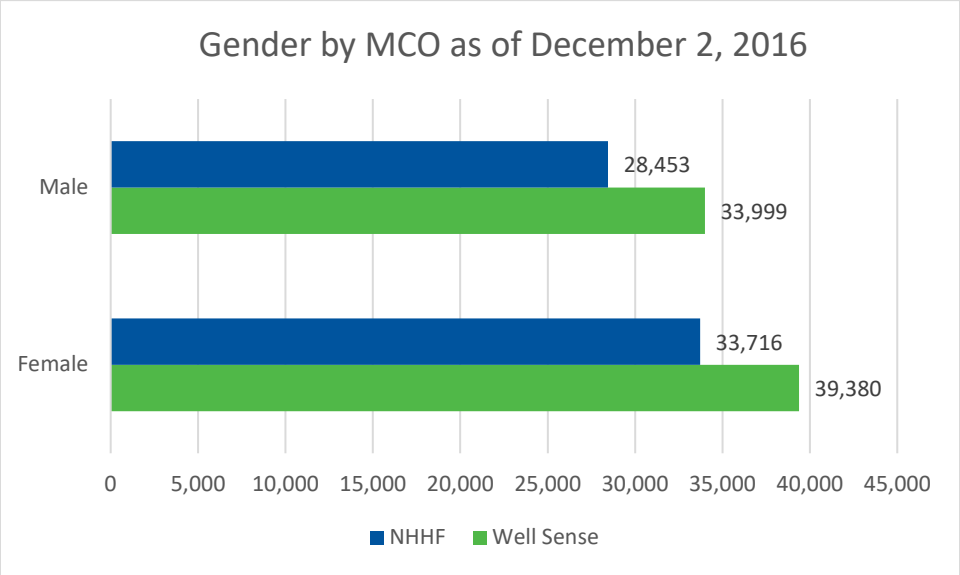
Figure C-5—Point-in-Time Age Groups by MCO as of December 2, 2016



The age distribution across the two MCOs was very similar. A total of 66.1 percent of the **NHHF** population was 0–18 years old as was 67.7 percent of the **Well Sense** population. A total of 26.8 percent of the **NHHF** population was 19–64 years old as was 27.5 percent of the **Well Sense** population. The **NHHF** population 65 years of age and older totaled 7.1 percent, and the **Well Sense** population 65 years of age and older totaled 4.8 percent.

Figure C-6 presents the gender distribution of the MCO members as of December 2, 2016.

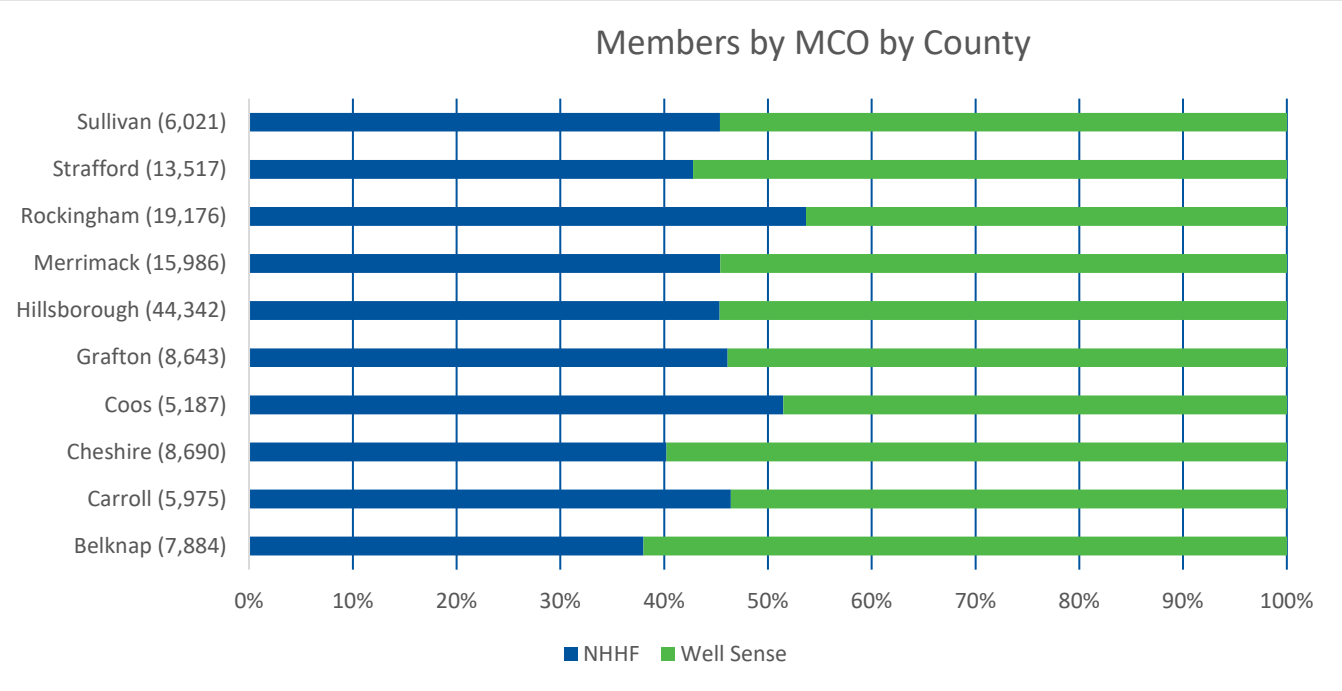
Figure C-6—Point-in-Time Gender by MCO as of December 2, 2016



The gender distribution across both plans was very similar. Female members comprised 54.2 percent of the membership in **NHHF** and 53.7 percent of the membership in **Well Sense**. Male members comprised 45.8 percent of the membership in **NHHF** and 46.3 percent of the membership in **Well Sense**.

Figure C-7 shows the percentage of membership in the two MCOs for the 10 counties in New Hampshire as of December 2, 2016. The numbers listed next to the county name show the total MCM enrollment by county.

Figure C-7—Point-in-Time County Breakout by MCO as of December 2, 2016

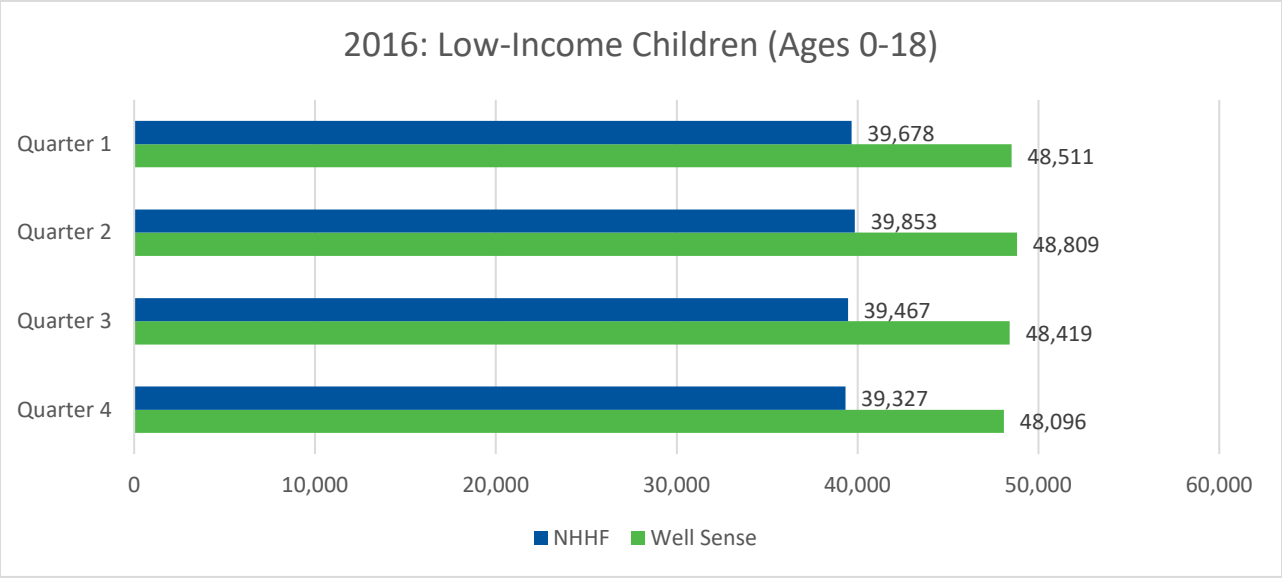


The **NHHF** membership percentages across counties varied between 38.0 percent in Belknap County to 53.7 percent in Rockingham County. The **Well Sense** membership percentages across counties varied between 46.3 percent in Rockingham County to 62.0 percent in Belknap County. An additional 127 members could not be categorized by county because of issues identifying their addresses.

Figure C-8 through Figure C-14 provide information concerning the average quarterly MCO enrollment in seven eligibility categories during the four quarters of 2016. 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.

Figure C-8 shows the average quarterly enrollment for low-income children by MCO during 2016.

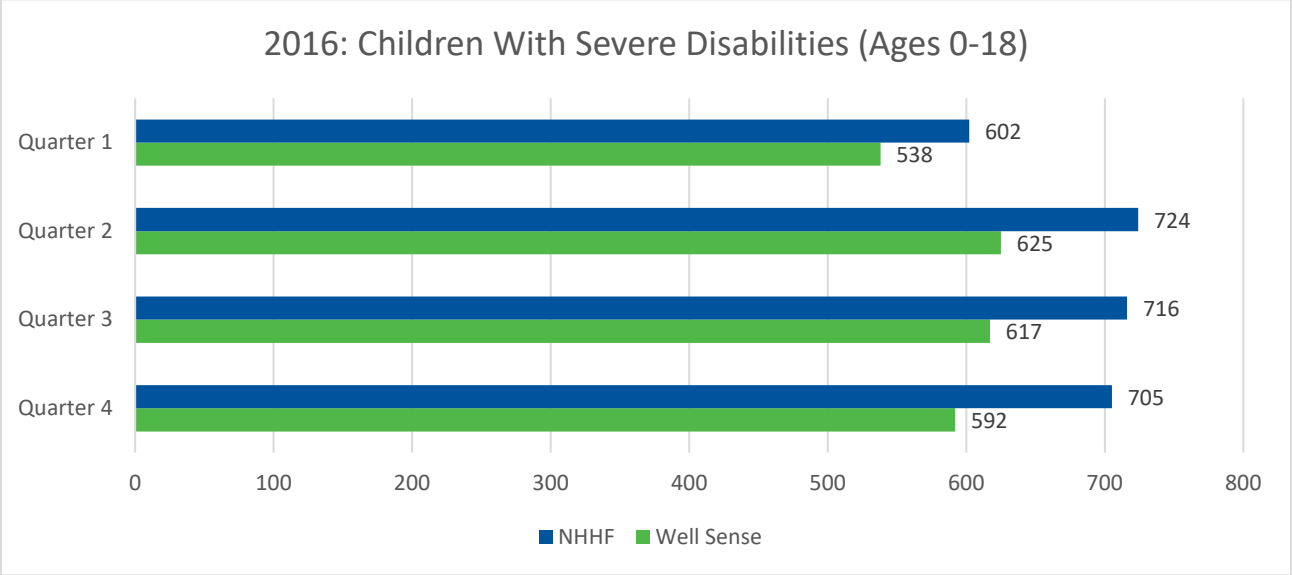
Figure C-8—Average Quarterly Enrollment for Low-Income Children (Ages 0–18) by MCO During 2016



The average quarterly enrollment of low-income children in the MCOs remained relatively constant in each quarter of 2016, with Quarter 1 enrollment at 88,189 and Quarter 4 enrollment at 87,423.

Figure C-9 displays the average quarterly enrollment for children with severe disabilities by MCO during 2016.

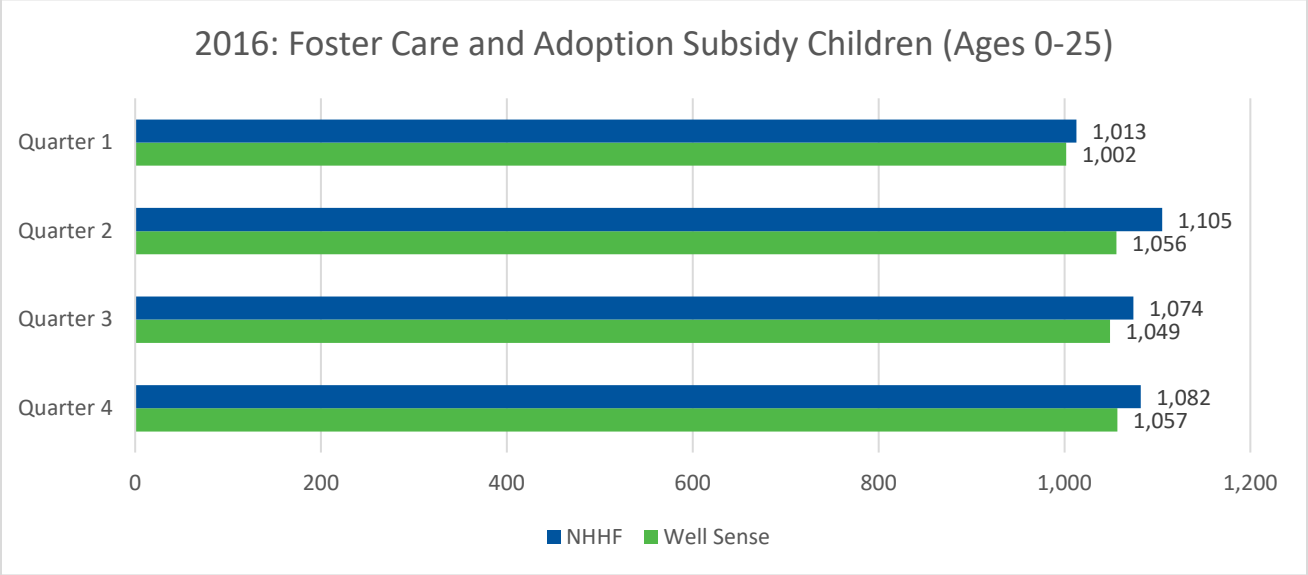
Figure C-9—Average Quarterly Enrollment for Children With Severe Disabilities (Ages 0–18) by MCO During 2016



The overall number of children with severe disabilities enrolled in the MCOs increased in 2016, with an average quarterly enrollment of 1,140 children during first quarter 2016 and an average quarterly enrollment of 1,297 children during fourth quarter 2016.

Figure C-10 shows the average quarterly enrollment for foster care children and children with adoption subsidies by MCO during 2016.

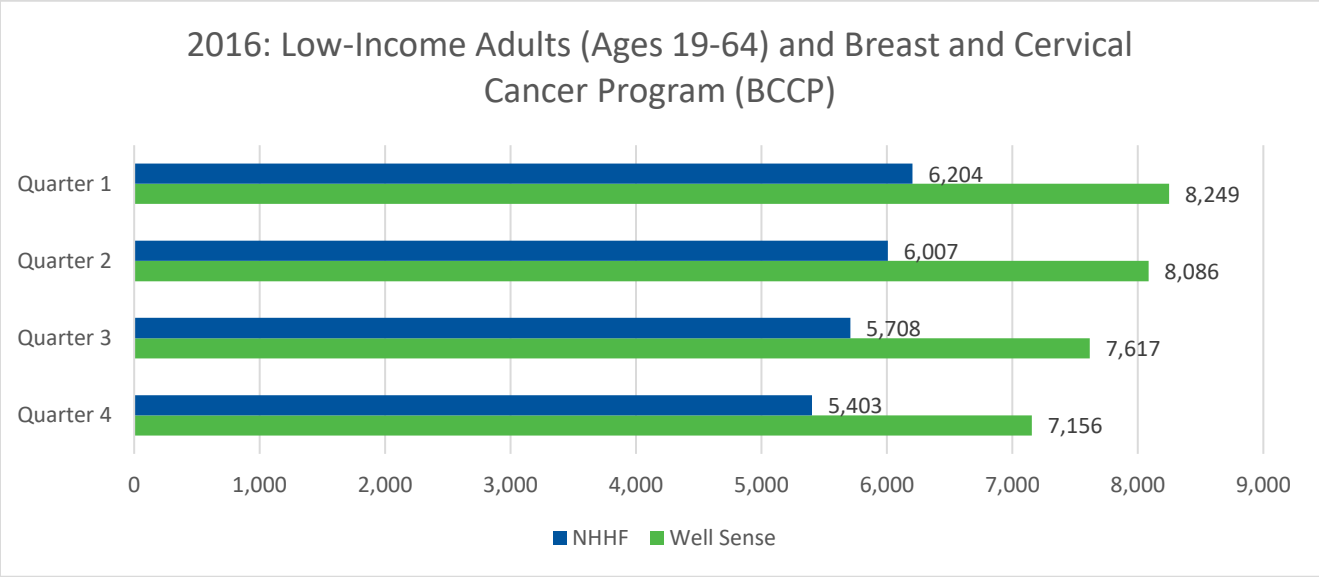
Figure C-10—Average Quarterly Enrollment for Foster Care and Adoption Subsidy Children (Ages 0–25) by MCO During 2016



Overall participation in the MCM program by beneficiaries in foster care and with adoption subsidies included an average enrollment of 2,015 children during first quarter 2016 and an average enrollment of 2,139 children during fourth quarter 2016.

Figure C-11 displays the average quarterly enrollment for low-income adults and members in the BCCP by MCO during 2016.

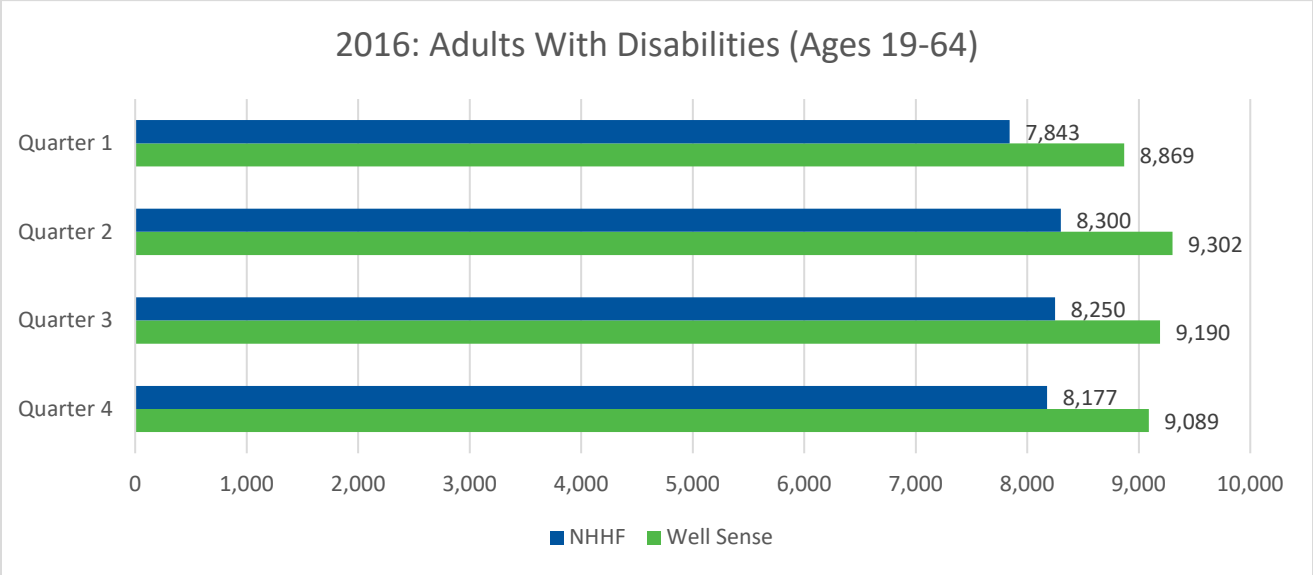
Figure C-11—Average Quarterly Enrollment for Low-Income Adults (Ages 19–64) and BCCP by MCO During 2016



The average number of low-income adults and adults in the BCCP enrolled in the MCOs during 2016 decreased from 14,453 during first quarter to 12,559 during fourth quarter.

Figure C-12 shows the average quarterly enrollment for adults with disabilities by MCO during 2016.

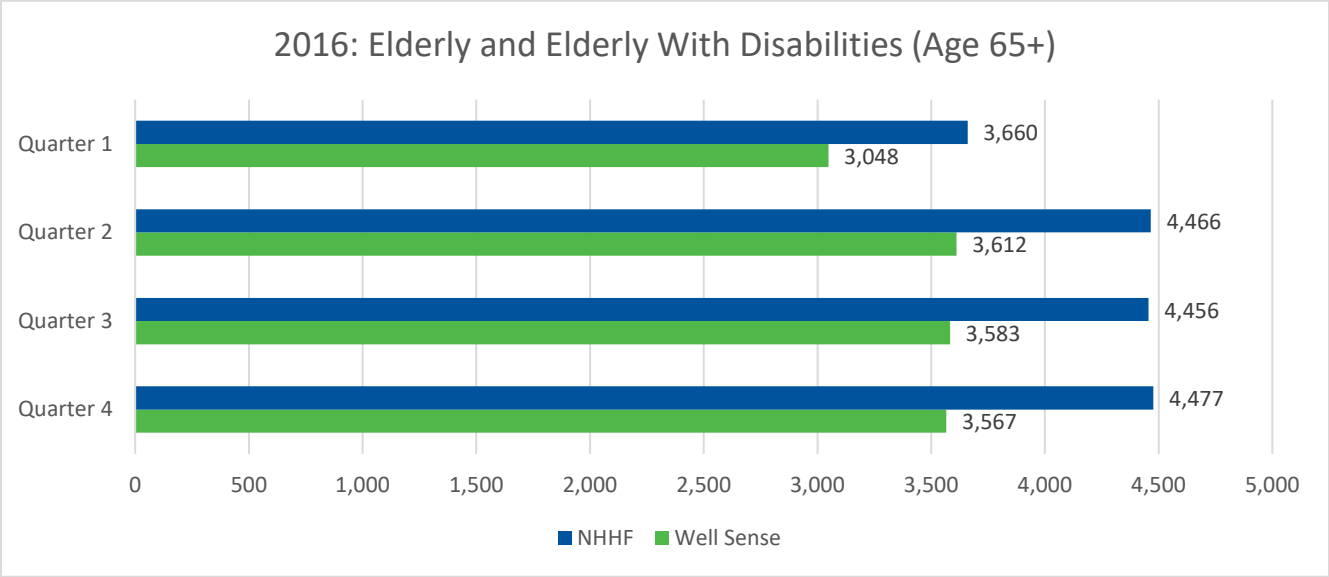
Figure C-12—Average Quarterly Enrollment for Adults With Disabilities (Ages 19–64) by MCO During 2016



The average quarterly enrollment of adults with disabilities in the New Hampshire MCM program during 2016 increased from 16,712 in first quarter to 17,266 in fourth quarter.

Figure C-13 shows the average quarterly enrollment for the elderly/elderly with disabilities by MCO during 2016.

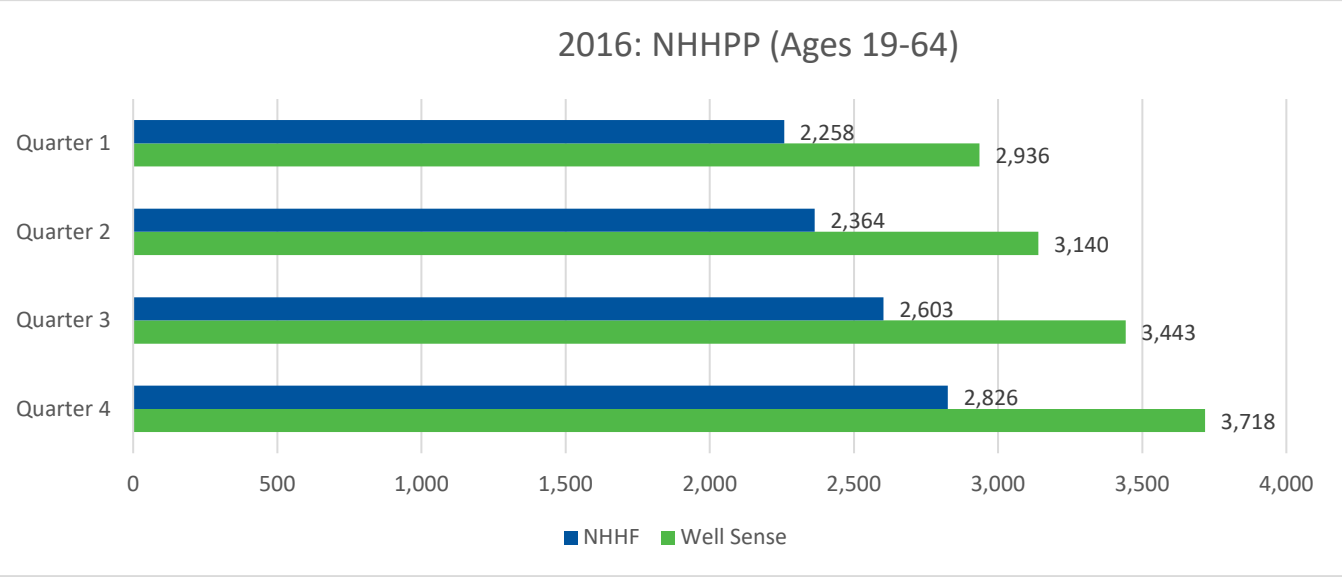
Figure C-13—Average Quarterly Enrollment for Elderly and Elderly With Disabilities (Age 65+) by MCO During 2016



The average quarterly enrollment for the elderly/elderly with disabilities increased from 6,708 in first quarter 2016 to 8,044 in fourth quarter 2016.

Senate Bill 413 created the NHHPP in 2014. The bill included the Medicaid expansion population resulting from New Hampshire's implementation of the Affordable Care Act.[C-1] Enrollment in the Medicaid MCOs began in fall 2014 and continued through 2015. On January 1, 2016, members were moved from MCM or non-MCM/PAP to a QHP. NHHPP members who were medically frail could elect to remain in the Medicaid MCOs. Figure C-14 shows the average enrollment of NHHPP members by MCO for the four quarters of 2016.

Figure C-14—Average Enrollment for NHHPP (Ages 19–64) by MCO During 2016



The average quarterly NHHPP enrollment increased in the MCOs during 2016 from 5,194 in first quarter to 6,544 in fourth quarter.

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.