State of New Hampshire
Department of Health and Human Services

2020 New Hampshire External Quality Review Technical Report

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Since December 1, 2013, New Hampshire Department of Health and Human Services (DHHS) has operated the Medicaid Care Management (MCM) Program which is a statewide comprehensive risk-based capitation managed care program. At the end of calendar year (CY) 2019, there were 172,751 New Hampshire Medicaid beneficiaries enrolled in the MCM Program.[1-1] During state fiscal year (SFY) 2020, beneficiaries enrolled in the program received services through one of three managed care organizations (MCOs): **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), or **Well Sense Health Plan** (**WS**). **ACNH** began operating in the New Hampshire MCM Program on September 1, 2019. All three 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 the New Hampshire MCM Quality Strategy[1-2] which includes:

- Monitoring over 200 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 (QAPI) program.
- Participating in a program evaluation conducted by the external quality review organization (EQRO).

The SFY 2020 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 2019, HSAG also conducted semi-structured member interviews at the MCM Program level and a secret shopper provider survey.

In SFY 2020, the EQRO's activities revealed positive results as well as areas for improvement for the MCM Program. At the request of DHHS, HSAG used two strategies to conduct the SFY 2020 compliance reviews. In keeping with the process established in SFY 2014 when MCOs were beginning operation in the MCM Program, HSAG reviewed all 16 compliance standards for **ACNH** because this was the first compliance review conducted for that health plan. The cycle of reviewing one-third of the standards established in SFY 2015 continued for **NHHF** and **WS** with the review of five standards.

[1-1] The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with New Hampshire Medicaid Management Information System (MMIS) demographics as of August 12, 2020.

[1-2] New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy for SFY 2020*. Available at: https://medicaidquality.nh.gov/care-management-quality-strategy. Accessed on: Sept 8, 2020.

ACNH achieved an overall compliance score of 86.9 percent, **NHHF** scored 94.3 percent, and **WS** scored 94.5 percent. The scores for **NHHF** and **WS** were slightly lower than the previous year when **NHHF** scored 95.7 percent and **WS** scored 96.2 percent.

In SFY 2020 HSAG initiated a rapid-cycle PIP process, and all three MCOs progressed through the first two modules: Module 1—PIP Initiation, and Module 2—Intervention Determination. The MCOs will continue working through subsequent modules for the PIPs in the next fiscal year and the final outcomes and PIP validation status for each PIP will be reported in SFY 2022. PMV rates were successfully approved for reporting for the three MCOs as they were in the prior year for **NHHF** and **WS**.

New Hampshire requires the MCOs to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-3] survey. **ACNH** was not included in the CAHPS survey this year because members enrolled in **ACNH** did not meet the enrollment and eligibility criteria. This year, one composite measure, *Shared Decision Making*, was eliminated from the CAHPS survey, which changed the number of total measures displayed in this report from nine to eight. The comparison to last year's rates will eliminate the rates achieved in SFY 2019 for *Shared Decision Making*. For the CAHPS surveys in 2020, all eight **NHHF** adult Medicaid rates were neither statistically significantly higher nor lower than the national average. Last year, **NHHF** had six adult Medicaid rates that were statistically significantly higher than the national average. The current eight **NHHF** child Medicaid rates included four rates that were statistically significantly higher than the national average, and four rates that were neither statistically significantly higher nor lower than the national average. Last year, **NHHF** had three child Medicaid rates that were statistically significantly higher than the national average. **WS** achieved one adult Medicaid rate that was statistically significantly higher than the national average, and the other seven rates were neither statistically significantly higher nor lower than the national average. Last year, none of the **WS** adult rates were statistically significantly higher than the national average. This year, two **WS** child Medicaid rates were statistically significantly higher than the national average, and the additional six rates were neither statistically significantly higher nor lower than the national average. Last year, **WS** also had two child Medicaid rates that were statistically significantly higher than the national average.

New Hampshire requires the MCO to report results from the Healthcare Effectiveness Data and Information Set (HEDIS®).[1-4] **ACNH** was not included in the HEDIS activities this year because members enrolled in **ACNH** did not meet the enrollment and eligibility criteria. Last year, **NHHF** and **WS** each had two measures that fell below the 25th percentile: *Chlamydia Screening in Women (CHL)—Total* and *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* for **NHHF**; and *Chlamydia Screening in Women (CHL)—Total* and *Prenatal and Postpartum Care (PPC)—Postpartum Care* for **WS**. This year, DHHS requested that HSAG also include the results for the two age groups included the *Chlamydia Screening in Women (CHL)—Total* measure (i.e., 16–20 years and 21–24 years). The only measure falling below the 25th percentile for both MCOs was *Chlamydia Screening in Women*

[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

(CHL)—21–24 Years. **NHHF** also fell below the 25th percentile for *Chlamydia Screening in Women (CHL)—Total.*

Concerning the ongoing encounter data quality reports for EDV, all three MCOs met the submission standard regarding X12 encounter data interchange (EDI) compliance edits. All three MCOs correctly populated submitted encounters with member identification numbers for all three encounter types (i.e., 837 professional [837P], 837 Institutional [837I], and pharmacy encounters) except pharmacy encounters from **WS**. However, when the member identification number values were assessed, all three MCOs either met the percent accurate standard or fell slightly below the standard. The three MCOs correctly populated all submitted encounters with billing provider information for all three encounter types. As for the 98.0 percent valid standard for the billing provider information, the three MCOs met the standard except the pharmacy encounters for **WS**. The three MCOs correctly populated all submitted encounters with servicing provider information for 837P/I encounters and met the validity standard for servicing provider information. The percentage of encounters initially submitted to DHHS within 14 calendar days of claim payment dates, however, were below the standard for all three MCOs for all three encounter types.

As previously mentioned, **ACNH** was not included in the CAHPS survey and HEDIS activities this year because members enrolled in this plan did not meet the enrollment and eligibility criteria. Table 1-1 contains a list of the opportunities for improvement for **ACNH** that include the external quality review (EQR) tasks described in this report. **ACNH** completed corrective action plans (CAPs) to remedy the elements not achieving the standard for the compliance review; therefore, targeted improvement activities for **ACNH** should focus on EDV.

Table 1-1—Opportunities for Improvement for ACNH

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Audit	Delegation and Subcontracting	46.9%	100%
	Emergency and Post-Stabilization Care	96.2%	100%
	Care Management/Care Coordination	90.9%	100%
	Behavioral Health	93.1%	100%
	Member Enrollment and Disenrollment	86.1%	100%
	Member Services	80.6%	100%
	Grievances and Appeals	93.6%	100%
	Access	86.3%	100%
	Network Management	91.4%	100%
	Utilization Management (UM)	74.3%	100%
	Quality Management	80.6%	100%
	Substance Use Disorder (SUD)	84.0%	100%
	Fraud, Waste, and Abuse	91.2%	100%
	Financial/Third Party Liability	92.9%	100%
Encounter Data Validation (EDV)	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.9%	100%
	837P: Initial Submission Within 14 Days of Claim Payment	73.0%	100%
	837 Institutional Encounters (837I): Initial Submission Within 14 Days of Claim Payment	76.2%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	86.9%	100%

Additional information about the tasks displayed in Table 1-1 is included in the Summary of Findings and Detailed Findings sections of this report.

Table 1-2 contains a list of the opportunities for improvement for **NHHF** that includes the EQR tasks described in this report. **NHHF** completed CAPs to remedy the elements not achieving the standard for the compliance review. Areas that could be specifically targeted for improvement by **NHHF** include the two HEDIS rates for chlamydia that were below the national Medicaid 25th percentile and the EDV rates that did not achieve the required standard.

Table 1-2—Opportunities for Improvement for NHHF

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Audit	Delegation and Subcontracting	96.9%	100%
	Behavioral Health	98.3%	100%
	Network Management	94.8%	100%
	SUD	89.0%	100%
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average
	Chlamydia Screening in Women (CHL)—Total	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	837P: Validity of Member Identification Number—Percent Valid	99.7%	100%
	837P: Initial Submission Within 14 Days of Claim Payment	86.1%	100%
	837I: Initial Submission Within 14 Days of Claim Payment	97.7%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	48.1%	100%

Additional information about the tasks displayed in Table 1-2 is included in the Summary of Findings and Detailed Findings sections of this report.

Table 1-3 contains a list of the opportunities for improvement for **WS** that includes all EQR tasks described in this report. **WS** completed CAPs to remedy the elements not achieving the standard for the compliance review. Areas that could be specifically targeted for improvement by **WS** include the HEDIS rate for chlamydia screening that was below the national Medicaid 25th percentile and the EDV rates that did not achieve the required standard.

Table 1-3—Opportunities for Improvement for WS

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Audit	Delegation and Subcontracting	91.2%	100%
	Behavioral Health	96.6%	100%
	Network Management	94.9%	100%
	SUD	93.0%	100%
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	Pharmacy Encounters: Validity of Member Identification Number—Percent Present	17.9%	100%
	837P: Validity of Member Identification Number—Percent Valid	99.5%	100%
	837I: Validity of Member Identification Number—Percent Valid	99.2%	100%
	Pharmacy Encounters: Billing Provider Information—Percent Valid	18.2%	98.0%
	837P: Initial Submission Within 14 Days of Claim Payment	99.1%	100%
	837I: Initial Submission Within 14 Days of Claim Payment	98.7%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.9%	100%

Additional information about the tasks displayed in Table 1-3 is included in the Summary of Findings and Detailed Findings sections of this report.

Program Overview

The New Hampshire statewide MCM Program is the primary method of service delivery covering 95 percent[2-1] of the New Hampshire Medicaid population as of December 1, 2019. The following populations are enrolled in the MCM Program.

- Aid to the Needy Blind Recipients;
- Aid to the Permanently and Totally Disabled Recipients;
- American Indians and Alaskan Natives;
- Auto Eligible and Assigned Newborns;
- Breast and Cervical Cancer Program Recipients;
- Children Enrolled in Special Medical Services/Partners in Health;
- Children with Supplemental Security Income;
- Foster Care/Adoption Subsidy Recipients;
- Granite Advantage (Medicaid Expansion Adults);
- Home Care for Children with Severe Disabilities (Katie Beckett);
- Medicaid Children Funded through the Children's Health Insurance Program;
- Medicaid for Employed Adults with Disabilities;
- Medicare Duals;
- Poverty Level Adults (Including Pregnant Women);
- Poverty Level Children; and
- Old Age Assistance Recipients.

The following eligibility groups are exempted from the MCM Program and receive their benefits from the New Hampshire fee-for-service (FFS) program.

- Family Planning Only Benefit Recipients;
- Health Insurance Premium Payment Recipients;
- In and Out Spend-Down Recipients;
- Recipients with Retroactive/Presumptive Eligibility Segments (Excluding Auto Eligible Newborns); and
- Veterans Affairs Benefit Recipients.

[2-1] December 1, 2019, enrollment in the MCM Program. The data source is the EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with New Hampshire MMIS demographics as of August 12, 2020.

The MCM Program covers all New Hampshire Medicaid services with the exception of the following services that are covered by the Medicaid FFS program:

- Dental Benefits;
- Division for Children, Youth and Families Services (i.e. Non-EPSDT [Early and Periodic Screening, Diagnostic, and Treatment] Child Health Support Services, Crisis Intervention, Home Based Therapy, Intensive Home and Community-Based Services, Placement Services, Private Non-Medical Institution for Children);
- Early Supports and Services;
- Glencliff Home Services;
- Home and Community Based Care Waiver Services (i.e. Acquired Brain Disorder Waiver, Choices for Independence Waiver, In Home Support Waiver; Developmental Disabilities Waiver);
- Medicaid to Schools Services; and
- Nursing Facility Services.

New Hampshire has contracted with the following MCOs to provide statewide coverage for the New Hampshire MCM Program in SFY 2020:

- **ACNH** (beginning on September 1, 2019);
- **NHHF**; and
- **WS**.

With the onset of MCM Program in New Hampshire, the Department implemented a comprehensive quality strategy approved by the Centers for Medicare & Medicaid Services (CMS) to evaluate the program. The strategy is updated periodically and includes:

- Monitoring over 200 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 QAPI program.
- Participating in a program evaluation conducted by the EQRO.

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 has contracted with DHHS to perform the EQR activities for the State since 2013.

The SFY 2020 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 summarizes findings on access and quality of care including a description of 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 2020.

Additionally, the report presents and compares the rates of the three New Hampshire Medicaid health plans (i.e., **ACNH**, **NHHF**, and **WS**), and offers nationally recognized comparisons, when appropriate. The report also offers recommendations for improving the quality, timeliness of care, and access to healthcare services provided by each health plan and includes statements from the MCOs concerning their follow-up to the SFY 2019 EQR Technical Report recommendations for improvement. Appendices to this report include a list of abbreviations and acronyms (Appendix A); the methodology for conducting contractual compliance, PIPs, and PMV activities (Appendix B); the designations of *timeliness of care*, *access to care*, and *quality of care* for the HEDIS measures included in the report (Appendix B); the New Hampshire MCM Quality Strategy evaluation (Appendix C); and demographics of the New Hampshire MCM Program (Appendix D).

[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: Oct 6, 2020.

[3-2] 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: Oct 6, 2020.

External Quality Review Activities, Conclusions, and Recommendations

Managed Care Organization (MCO) Contractual Compliance

As required by 42 CFR §438.358(b)(iii),[3-3] HSAG conducted the annual MCO compliance reviews in May and June 2020. Due to the travel restrictions and stay-at-home orders in many states in response to the coronavirus disease 2019 (COVID-19), DHHS, HSAG, and the MCOs agreed to perform this year's compliance reviews virtually. At the request of DHHS, HSAG used two strategies to conduct the SFY 2020 compliance reviews. In keeping with the process established in SFY 2014 when all MCOs were beginning operation in the MCM Program, HSAG reviewed all compliance standards for **ACNH** because this was the first compliance review conducted for that health plan. The cycle of reviewing one-third of the standards established in SFY 2015 continued for the two existing MCOs (i.e., **NHHF** and **WS**). The number of standards reviewed for **ACNH** was 16 and the number of standards reviewed for **NHHF** and **WS** was five.

Findings

Table 3-1 illustrates the overall score for the 2020 Compliance Review for **ACNH**, **NHHF**, and **WS**.

Table 3-1—Summary of the SFY 2020 Compliance Review Scores for ACNH, NHHF, and WS

Overall Rate for the 2020 Compliance Review	ACNH	NHHF	WS
Overall Score*	86.9%	94.3%	94.5%

* HSAG recommends using caution in the comparison of overall scores of **NHHF** and **WS** with **ACNH** due to the varying number of standards reviewed for the new and established health plans: 16 for **ACNH** and five for **NHHF** and **WS**.

In prior years, HSAG generated separate scores for the checklist reviews and file review. The scoring for the SFY 2020 compliance review includes those scores in the overall standard scores listed in Table 3-1. The **ACNH** compliance review included file reviews for subcontracts, grievances, appeals, denials, and credentialing. The **NHHF** and **WS** compliance reviews included file reviews for subcontracts and credentialing.

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCO's performance complied with the requirements. A designation of *Not Applicable (NA)* was used when a requirement was not applicable to the MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[3-4] Any element that did not receive a score of *Met* was included in a CAP document distributed to each MCO. Prior to the

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[3-3]   Ibid.

[3-4]   Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sept 24, 2020.

completion of the CAP process, which was approved by DHHS and HSAG, the MCOs were required to submit information to bring all elements scored *Partially Met* or *Not Met* into compliance with the contract requirements. The elements included in the CAPs for each MCO will be reviewed during the 2021 compliance review to ensure continued compliance with the requirements.

Conclusions and Recommendations for MCO Contractual Compliance

ACNH

ACNH achieved an overall compliance score of 86.9 percent from the review of 16 standards. The score for two standards was 100 percent, and seven standards scored equal to or higher than 90.9 percent but less than 100 percent. Five standards scored equal to or higher than 80.6 percent but less than 90.9 percent, and two standards scored less than 80.6 percent.

The file reviews for four subcontracts revealed one contract that failed to meet any of the nine requirements, and three subcontracts that did not contain one of the nine elements. All items were *Met* in the grievance file review. Two issues were found in the files reviewed for appeals involving the contents of the letters sent to members concerning the appeals. In the 10 denial files reviewed, three notices for urgent requests were not sent within 72 hours, and three non-urgent files did not contain an adverse benefit determination (i.e., the reason for the denial).

Thirty credentialing files did not contain verification of hospital privileges, and one file was not processed in the time period required by the MCM Contract between DHHS and **ACNH**.

NHHF

NHHF achieved an overall compliance score of 94.3 percent from the review of five standards. The score for one standard was 100 percent, and three standards received a score of 94.8 percent or higher but less than 100 percent. One standard received a score of 89.0 percent.

All items were *Met* in the subcontract file review. In the initial credentialing file review, 10 files did not verify the status of hospital privileges. In the recredentialing file review, four files did not contain evidence of verifying the status of hospital privileges, and one file did not contain evidence of an ongoing review of adverse events (i.e., quality issues, complaints, member surveys, utilization, sanctions, etc.).

WS

WS achieved an overall compliance score of 94.5 percent. The score for one standard was 100 percent, and the remaining four standards scored 91.2 percent or higher but less than 100 percent.

One of the four subcontracts reviewed did not include the process to transition services when the agreement expires or terminates, one did not contain program integrity requirements, and one did not include compliance plan requirements. None of the initial credentialing files and none of the

recredentialing files contained evidence of primary source verification of the New Hampshire Medicaid number.

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

For additional information concerning HSAG's methodology for conducting an MCO contractual compliance review, see Appendix B Methodologies for Conducting EQR Activities, page B-1.

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

In SFY 2020, DHHS made the decision to implement HSAG's rapid-cycle PIP approach with its contracted MCOs. During this fiscal year, the MCOs initiated the first two of four required rapid-cycle PIPs; they will initiate two additional PIPs during a subsequent 18-month cycle. The MCOs collaborated with DHHS to select the PIP topics from the DHHS priority measures identified in the New Hampshire MCM Quality Strategy. One PIP topic addressed by all three MCOs in SFY 2020 focused on improving rates for one HEDIS measure: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*). **ACNH** and **NHHF** chose *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* (*IET—Engagement*) as their second PIP topic, and **WS** chose *Continued Engagement of Opioid Abuse or Dependence Treatment.*

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. HSAG presented the rapid-cycle PIP framework components to CMS to demonstrate alignment with the United States (U.S.) Department of Health and Human Services (HHS) CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-5] CMS granted HSAG approval to use this approach in all states interested in a PIP approach intended to improve processes and outcomes of healthcare by way of small-scale testing and continuous quality improvement (QI).

Findings

Table 3-2 through Table 3-6 present a summary of the SFY 2020 validation findings for the MCOs' PIPs. For validation of rapid-cycle PIPs, HSAG developed four modules to guide MCOs in conducting and documenting PIP activities. In SFY 2020, the New Hampshire MCOs progressed through the first two modules: Module 1—PIP Initiation, and Module 2—Intervention Determination. The MCOs will continue working through subsequent modules for the PIPs in the next fiscal year and the final outcomes and PIP validation status for each PIP will be reported in the SFY 2022 EQR Technical Report.

Table 3-2 presents the PIP title and the specific, measurable, attainable, relevant, and time-bound (SMART) Aim statement defined by **ACNH** for each PIP. The SMART Aim statement defines the focus for improvement efforts and sets a quantitative goal for improvement. In SFY 2020, **ACNH** completed Module 1 and Module 2 of the rapid-cycle PIP process.

[3-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): 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-3.pdf. Accessed on: Jan 27, 2020.

Table 3-2—ACNH Performance Improvement Project Topics and SMART Aim Statements

PIP Title	SMART Aim Statement*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, increase the percentage of adult members 18 to 64 years of age residing in Hillsborough County, New Hampshire, who receive diabetic screening while on antipsychotic medications for schizophrenia or bipolar disorder. Diabetic screening is a glucose or hemoglobin A1c (HbA1c) test. Increase from XX% to goal of XX%.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	By June 30, 2021, increase the percentage of adult members 18 years and older having two or more additional alcohol and other drug (AOD) services or medication treatment within 34 days after discharge during the measurement period among adult members 18 years and older discharged from an acute inpatient stay with any diagnosis of substance use disorder (SUD) during the measurement period, from XX% to XX%.

* The SMART Aim baseline and goal percentages will be updated by the MCO once they are available and finalized.

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, **ACNH** chose to focus improvement efforts toward eligible members 18 to 64 years of age, who reside in Hillsborough County. For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, **ACNH** chose to focus improvement efforts toward eligible adult members who initiated SUD treatment during an acute inpatient stay. **ACNH** initiated operations in the New Hampshire MCM Program on September 1, 2019. Due to the recent operations start date, the MCO did not have a full 12 months of historical data needed to establish a baseline rate and goal for the SMART Aim for either PIP. Once complete baseline data are obtained, **ACNH** will resubmit Module 1 and Module 2, with a baseline rate and goal included in the SMART Aim, for each PIP. HSAG will conduct a final review and validation of Module 1 and Module 2 at that time. **ACNH** has received a *Conditional Pass* on Module 1 and Module 2 to allow the MCO to move forward with planning and testing interventions for the PIPs, which will continue during the next fiscal year.

In SFY 2020, **NHHF** completed Module 1 and Module 2 of the rapid-cycle PIP process. Table 3-3 presents the PIP title and SMART Aim statement defined by **NHHF** for each PIP. The SMART Aim statement defines the focus for improvement efforts and sets a quantitative goal for improvement.

Table 3-3—Performance Improvement Project Topics Selected by NHHF

PIP Title	SMART Aim Statement
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, **NHHF** aims to increase the percentage of members 18–64 years of age, who reside in Hillsborough County, New Hampshire and are diagnosed with schizophrenia, schizoaffective or bipolar disorder; dispensed an antipsychotic medication; and are screened for diabetes, utilizing a glucose or HbA1c test, during the measurement period from 80.8% to 90.0%.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	By June 30, 2021, **NHHF** will increase the percentage of engagement of alcohol and other (AOD) treatment among members, ages 13 years or older, who had a new episode of AOD abuse or dependence, who already initiated treatment, who were engaged in ongoing AOD treatment within 34 days of the initiation visit and reside in Rockingham County, New Hampshire, from 13.45% to 20.0%.

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, **NHHF** established a goal to increase the percentage of eligible members in Hillsborough County, New Hampshire, who received a diabetes screening by 9.2 percentage points, from 80.8% to 90.0%. For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, **NHHF** established a goal to increase the percentage of eligible members in Rockingham County, New Hampshire, who initiated AOD treatment and were engaged in ongoing treatment within 34 days of initiation from 13.45 percent to 20.0 percent. **NHHF** has progressed to planning and testing interventions for the PIPs, which will continue during the next fiscal year.

In SFY 2020, **WS** completed Module 1 and Module 2 of the rapid-cycle PIP process. Table 3-4 presents the PIP title and SMART Aim statement defined by **WS** for each PIP.

Table 3-4—Performance Improvement Project Topics Selected by WS

PIP Title	SMART Aim Statement
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, **WS** aims to increase the percentage of members, 18–64 years of age, with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication, assigned to selected PHOs [physician-hospital organizations], and had a diabetes screening (a glucose or HbA1c test) from 78.57% to 92.85%.
Continued Engagement of Opioid Abuse or Dependence Treatment	By June 30, 2021, **WS** aims to increase the percentage of members, 18 years of age or older, newly diagnosed with opioid dependency who engaged in ongoing treatment within 34 days of the initiation visit from 39.1% to 45.1%.

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, **WS** established a goal to increase the percentage of eligible members assigned to selected PHOs who received a diabetes screening by 14.28 percentage points, from 78.57 percent to 92.85 percent. For the *Continued Engagement of Opioid Abuse or Dependence Treatment* PIP, **WS** established a goal to increase the percentage of eligible members 18 years of age or older who initiated opioid treatment and were engaged in ongoing treatment within 34 days of initiation from 39.1 percent to 45.1 percent. **WS** has progressed to planning and testing interventions for the PIPs, which will continue during the next fiscal year.

Conclusions and Recommendations

ACNH

The validation findings suggest that **ACNH** successfully built a PIP team with internal and external partners and developed methodologically sound projects. **ACNH** used QI tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using Plan-Do-Study-Act (PDSA) cycles.

As **ACNH** moves into intervention testing for the next phase of the PIPs, HSAG has the following recommendations:

- When determining interventions to test, **ACNH** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the *quality of care*, *timeliness of care*, and *access to care* for its members.
- When testing interventions, **ACNH** should consider the end date specified in the SMART Aim statement when planning the timing of intervention testing cycles. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement.
- Once **ACNH** has obtained 12 months of data to determine baseline performance, the MCO should identify a quantitative goal for improvement and finalize the SMART Aim statement for each PIP.

NHHF

The validation findings suggest that **NHHF** successfully built a PIP team with internal and external partners and developed methodologically sound projects. **NHHF** used QI tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using PDSA cycles.

As **NHHF** moves into intervention testing for the next phase of the PIPs, HSAG has the following recommendations:

- When determining interventions to test, **NHHF** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the *quality of care*, *timeliness of care*, and *access to care* for its members.
- When testing interventions, **NHHF** should consider the end date specified in the SMART Aim statement when planning the timing of intervention testing cycles. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement.

WS

The validation findings suggest that **WS** successfully built a PIP team with internal and external partners and developed methodologically sound projects. **WS** used QI tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using PDSA cycles.

As **WS** moves into intervention testing for the next phase of the PIPs, HSAG has the following recommendations:

- When determining interventions to test, **WS** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the *quality of care*, *timeliness of care*, and *access to care* for its members.
- When testing interventions, **WS** should consider the end date specified in the SMART Aim statement when planning the timing of intervention testing cycles. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement.

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

For additional information concerning HSAG's methodology for validating PIPs, see Appendix B Methodologies for Conducting EQR Activities, page B-11.

Performance Measure Validation (PMV)

As required by 42 CFR §438.358(b)(1)(ii),[3-6] HSAG completed the validation of MCO performance measures for SFY 2020 following the HHS CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[3-7] The following 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 team for the audit elements reviewed for the 13 state-specific measures validated during the SFY 2020 PMV audit.

Table 3-5—SFY 2020 PMV Findings

	SFY 2020		
	ACNH	**NHHF**	**WS**
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable	Acceptable
Appropriate provider data systems and processing	Acceptable	Acceptable	Acceptable
Appeals data system and process findings	Acceptable	Acceptable	Acceptable
Prior authorization and case management data system and process findings	Acceptable	Acceptable	Acceptable
Performance measure production and reporting findings	Acceptable	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable	Acceptable

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[3-6] 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: Aug 30, 2020.

[3-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sept 24, 2020.

Conclusions and Recommendations

ACNH

As part of the PMV process, HSAG evaluated **ACNH**'s data systems for processing each data type used for reporting DHHS performance measure rates, including claims, membership and enrollment, appeals, prior authorization, and case management. HSAG did not identify any issues with **ACNH**'s data systems or data processing. Additionally, HSAG reviewed and approved the source code used by **ACNH** to produce the measures. During the Webex review, HSAG conducted primary source verification on member enrollment data during the measure drilldowns and found no issues. HSAG ensured the enrollment spans met the specification guidelines for inclusion in the measures. HSAG also benchmarked the reported rates by comparing them to its peers.

At the conclusion of the PMV process, HSAG did not have any concerns, nor did it find any outliers compared to its peers, based on population stratifications. HSAG determined that **ACNH** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **ACNH** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production by **ACNH** for any measure under review this year.

NHHF

As part of the PMV process, HSAG evaluated **NHHF**'s data systems for processing each data type used for reporting DHHS performance measure rates, including claims, membership and enrollment, appeals, prior authorization, and case management. HSAG did not identify any issues with **NHHF**'s data systems or data processing. Additionally, HSAG reviewed and approved the source code used by **NHHF** to produce the measures. During the Webex review, HSAG conducted primary source verification on member enrollment data during the measure drilldowns and found no issues. HSAG ensured the enrollment spans met the specification guidelines for inclusion in the measures. HSAG also benchmarked the reported rates by comparing them to its peers and to the prior year's reported rates.

At the conclusion of the PMV process, HSAG did not have any concerns, nor did it find any outliers compared to its peers, based on population stratifications. HSAG determined that **NHHF** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **NHHF** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production by **NHHF** for any measure under review this year.

WS

As part of the PMV process, HSAG evaluated **WS**'s data systems for processing each data type used for reporting DHHS performance measure rates, including claims, membership and enrollment, appeals, prior authorization, and case management. HSAG did not identify any issues with **WS**'s data systems or data processing. Additionally, HSAG reviewed and approved the source code used by **WS** to produce

the measures. During the Webex review, HSAG conducted primary source verification for each measure under review. The primary source review relied on **WS**'s system demonstrations and individual record verification to validate compliance with the measure's specifications. HSAG also benchmarked the reported rates by comparing them to its peers and to the prior year's reported rates.

At the conclusion of the PMV process, HSAG did not have any concerns, nor did it find any outliers compared to its peers, based on population stratifications. HSAG determined that **WS** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **WS** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production by **WS** for any measure under review this year.

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 **WS** were responsible for contracting with 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 2020, following NCQA's data collection protocol.

The CAHPS survey ask about members' experience with their health plan during the last six months of the measurement period (i.e., July through December 2019). **ACNH** began serving New Hampshire Medicaid members in September 2019. Therefore, **ACNH** was not included in the CAHPS survey activity because members enrolled in this MCO did not meet the enrollment and eligibility criteria.

Findings

This year, one composite measure, *Shared Decision Making*, was eliminated from the CAHPS survey, which changed the total measures displayed in this report from nine to eight. The CAHPS 5.0H Surveys include a set of standardized items including four global ratings and four composite scores.[3-8] The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. 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 experience 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 four composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composites was defined as a response of "Usually" or "Always."

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. If the national average was within the confidence interval, then there was no significant difference, which is denoted with a **dash** (—).

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

[3-8] For this report, the 2020 Adult and Child Medicaid CAHPS results presented for **NHHF** and **WS** are limited to the four CAHPS global ratings and four 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 one individual item measure or five Children with Chronic Conditions [CCC] composite scores/items).

Table 3-6—NHHF and WS Adult Medicaid CAHPS Results

CAHPS Measure	2020 Adult Medicaid Positive Rates	2019 National Average Comparison*	2020 Adult Medicaid Positive Rates	2019 National Average Comparison*
Global Ratings	**NHHF**		**WS**	
Rating of Health Plan	78.7%	—	83.0%	↑
Rating of All Health Care	77.6%	—	78.8%	—
Rating of Personal Doctor	84.7%	—	82.7%	—
Rating of Specialist Seen Most Often	84.0%	—	85.6%	—
Composite Measures	**NHHF**		**WS**	
Getting Needed Care	84.1%	—	83.4%	—
Getting Care Quickly	83.3%	—	84.2%	—
How Well Doctors Communicate	94.1%	—	93.8%	—
Customer Service	91.6%	—	85.2%	—

* The 2019 NCQA national averages are the most current benchmarks available

↑ 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.

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

Table 3-7—NHHF and WS Child Medicaid CAHPS Results

CAHPS Measure	2020 Child Medicaid Positive Rates	2019 National Average Comparison*	2020 Child Medicaid Positive Rates	2019 National Average Comparison*
Global Ratings	**NHHF**		**WS**	
Rating of Health Plan	87.3%	—	88.7%	—
Rating of All Health Care	88.3%	—	90.0%	—
Rating of Personal Doctor	89.5%	—	91.2%	—
Rating of Specialist Seen Most Often	86.3%[+]	—	85.2%[+]	—
Composite Measures	**NHHF**		**WS**	
Getting Needed Care	89.1%	↑	88.4%	—
Getting Care Quickly	94.5%	↑	95.8%	↑
How Well Doctors Communicate	98.0%	↑	96.5%	↑

CAHPS Measure	2020 Child Medicaid Positive Rates	2019 National Average Comparison*	2020 Child Medicaid Positive Rates	2019 National Average Comparison*
Customer Service	**92.6%**	↑	**86.1%**+	—

* The 2019 NCQA national averages are the most current benchmarks available
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ 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.

Conclusions and Recommendations

NHHF

NHHF's adult Medicaid population rates were neither statistically significantly higher nor lower than NCQA's 2019 Medicaid national averages for all measures.

NHHF's child Medicaid population rates were statistically significantly higher than NCQA's 2019 Medicaid national averages for *Getting Needed Care*, *Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service.* The remaining measure rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*, were neither statistically significantly higher nor lower than the national averages.

HSAG recommends that **NHHF** should continue to monitor the measures to ensure that rates do not fall below the national averages.

WS

WS's adult Medicaid population rate for *Rating of Health Plan* was statistically significantly higher than NCQA's 2019 Medicaid national average, while *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* rates were neither statistically significantly higher nor lower than the national averages.

WS's general child Medicaid population rates were statistically significantly higher than NCQA's 2019 Medicaid national averages for *Getting Care Quickly* and *How Well Doctors Communicate*. The remaining measure rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*, were neither statistically significantly higher nor lower than the national averages.

HSAG recommends that **WS** should continue to monitor the measures to ensure that rates do not fall below the national averages.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a standardized set of nationally recognized indicators that are used to measure the 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.[3-9] **NHHF** and **WS** 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).

ACNH operations in New Hampshire began September 1, 2019; therefore, no HEDIS data were available for CY 2019.

Findings

The auditors found **NHHF** and **WS** to be fully compliant with all applicable information system assessment standards. HSAG compared the CY 2019 rates achieved by the MCOs on 44 of 52 measures to percentiles for HEDIS 2019. HSAG displayed the results for each measure in figures that contain the rates achieved by **NHHF** and **WS**, along with the national benchmarks, when applicable. For some rates, comparisons to percentiles were not made (1) due to changes in the technical specifications (*Controlling High Blood Pressure [CBP]*; *Prenatal and Postpartum Care [PPC]—Timeliness of Prenatal Care* and *Postpartum Care*; *Appropriate Testing for Children with Pharyngitis [CWP]*; and *Appropriate Treatment for Children with Upper Respiratory Infection [URI]*); or (2) because lower or higher rates are not indicative of better or worse performance (*Identification of Alcohol and Other Drug Services [IAD]* and *Mental Health Utilization [MPT]*).

To evaluate the performance of **NHHF** and **WS**, 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.

[3-9] National Committee for Quality Assurance. (n.d.). *HEDIS & Quality Measurement*. Available at: http://store.ncqa.org/index.php/performance-measurement.html?___SID=U. Accessed on: Oct 6, 2020.

Table 3-8—Summary of Scores for CY 2019 HEDIS Measures With National Comparative Rates for NHHF

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below 90th Percentile	Met 50th Percentile and Below 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	3	6	3	6	2	**20**
Acute and Chronic Care	1	3	7	0	0	**11**
Behavioral Health	3	6	3	1	0	**13**
All Domains	**7**	**15**	**13**	**7**	**2**	**44**
Percentage	**15.91%**	**34.09%**	**29.55%**	**15.91%**	**4.55%**	**100.0%**

NHHF's rates ranked at or above the 50th percentile for 35 measures (79.55 percent), with seven of these measures (15.91 percent) meeting or exceeding the 90th percentile. The rates for two measures (4.55 percent) fell below the 25th percentile.

Table 3-9—Summary of Scores for CY 2019 HEDIS Measures With National Comparative Rates for WS

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below 90th Percentile	Met 50th Percentile and Below 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	2	4	5	8	1	**20**
Acute and Chronic Care	2	3	3	3	0	**11**
Behavioral Health	4	4	3	2	0	**13**
All Domains	**8**	**11**	**11**	**13**	**1**	**44**
Percentage	**18.18%**	**25.00%**	**25.00%**	**29.55%**	**2.27%**	**100.0%**

WS's rates ranked at or above the 50th percentile for 30 measures (68.18 percent), with eight of these measures (18.18 percent) meeting or exceeding the 90th percentile. The rates for one **WS** measure (2.27 percent) fell below the 25th percentile.

Conclusions and Recommendations

NHHF

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

- Three Prevention measure rates: *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years*, *Well-Child Visits in the First 15 Months of Life (W15)—Six or More Well-Child Visits*, and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*

- One Acute and Chronic Care measure rate: *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)—Systemic Corticosteroid*
- Three Behavioral Health measure rates: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*, and *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Two Prevention measure rates: *Chlamydia Screening in Women (CHL)—21–24 Years* and *Total*

WS

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

- Two Prevention measure rates: *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years* and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Two Acute and Chronic Care measure rates: *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid* and *Bronchodilator*
- Four Behavioral Health measure rates: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*, *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total*, *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*

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

- One Prevention measure rate: *Chlamydia Screening in Women (CHL)—21–24 Years*

Encounter Data Validation (EDV)

During SFY 2020, HSAG conducted the following four EDV activities:

- Continued to use an Encounter Data Quality Reporting System (EDQRS) to evaluate the quality of encounter data files submitted by all three MCOs.
- Began an information systems (IS) review to assess **ACNH**'s IS/processes.
- Began a comparative analysis between DHHS' electronic encounter data and the data extracted from **NHHF**'s and **WS**'s data systems.
- Began to evaluate DHHS' electronic encounter data completeness and accuracy through a comparative analysis between DHHS' electronic encounter data and the medical records for **NHHF** and **WS**.

For the first EDV activity, HSAG continued to use the EDQRS to evaluate the quality of encounter data files submitted by **ACNH**, **NHHF**, and **WS**. The EDQRS was designed to import, store, and review incoming encounter data and generate automated monthly/quarterly reports for DHHS. All MCOs prepare and submit 837P/I and pharmacy files to HSAG 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 From EDQRS

For encounters received from MCOs between September 1, 2019, and June 30, 2020, this section presents the aggregate rates for five standards within Exhibit A of the MCM Contract.[3-10] These standards include:

- Passing X12 EDI compliance edits (Standard 5.1.3.34.2.1.).
- Accuracy and validity of member identification numbers (Standard 5.1.3.34.2.3.).
- Accuracy and validity of billing provider information (Standard 5.1.3.34.2.4.).
- Accuracy and validity of servicing provider information (Standard 5.1.3.34.2.5.).
- Initial encounter data shall be submitted within 14 calendar days of claim payment (Standard 5.1.3.34.3.1).

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 falling below the corresponding standards by more than 10 percentage points. **Black** font indicates that the rate did not meet the required standard, however, the rate *did not* fall below the corresponding standard by more than 10 percentage points.

[3-10] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #2 to the Medicaid Care Management Services Contract.* Available at: https://www.dhhs.nh.gov/ombp/caremgt/documents/mcm-contract-121819.pdf. Accessed on: Oct 6, 2020.

Table 3-10—Aggregate Rates for Encounter Data Submission and Quality Standards

Evaluation Area	Standard	837P (Professional) Encounters			837I (Institutional) Encounters			Pharmacy Encounters		
		ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
X12 EDI Compliance Edits										
X12 EDI Compliance Edits	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	NA
Validity of Member Identification Number*										
Percent Present	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	17.9%
Percent Valid*		99.9%	99.7%	99.5%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%
Validity of Billing Provider Information*										
Percent Present	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	18.2%
Validity of Servicing Provider Information*										
Percent Present	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	NA	NA	NA
Percent Valid*		99.6%	99.8%	99.9%	99.4%	99.6%	99.7%	NA	NA	NA
Timeliness*										
Initial Submission Within 14 Days of Claim Payment	100.0%	73.0%	86.1%	99.1%	76.2%	97.7%	98.7%	86.9%	48.1%	99.9%

* Refer to Table 4-11 through Table 4-15 for more details regarding these items.

The list below shows the findings for each standard:

- X12 EDI Compliance Edits: All three MCOs met the submission standard regarding X12 EDI compliance edits, with 100 percent of all submitted 837P/I encounters successfully translated by HSAG. Of note, this metric was not applicable to pharmacy encounters.

- Member Identification Number: The three MCOs populated all submitted encounters with member identification numbers for all three encounter types except pharmacy encounters from **WS**. However, when these values were assessed, all MCOs either met the percent accurate standard of 100 percent or fell slightly below the standard by no more than 0.8 percentage points.

- Billing Provider Information: The three MCOs populated all submitted encounters with billing provider information for all three encounter types. As for the percent valid standard of 98.0 percent, all MCOs met the standard except the pharmacy encounters for **WS** with a rate of 18.2 percent, which fell far below the standard by 79.8 percentage points.

- Servicing Provider Information: The three MCOs populated all submitted encounters with servicing provider information for 837P/I encounters. As for the percent valid standard of 98.0 percent, all MCOs met that standard.

- Initial Submission Within 14 Days of Claim Payment: The percentage of encounters initially submitted to DHHS within 14 calendar days of claim payment dates were below the standard of 100 percent for all three MCOs for all three encounter types. While the rates for **WS** were at least 98.7 percent for all three encounter types, the rates for **ACNH** were below the standard by at least 13.1 percentage points. **NHHF** submitted more than 97.7 percent of its initial 837I encounters within 14 days of claim payment, though the percentages for its 837P and pharmacy encounters were 86.1 percent and 48.1 percent, respectively, which were below the standard of 100 percent.

Conclusions and Recommendations from EDQRS

ACNH

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

- X12 EDI compliance edits
- Data accuracy related to member identification numbers for 837I and pharmacy encounters
- Data accuracy related to billing providers for all three encounter types
- Data accuracy related to servicing providers for 837P/I encounters

HSAG recommends that **ACNH** focus on improving the following rates:

- Data accuracy related to member identification numbers for 837P encounters
- Initial submissions to DHHS within 14 days of the claim payment date for all three encounter types

NHHF

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

- X12 EDI compliance edits
- Data accuracy related to member identification numbers for 837I and pharmacy encounters
- Data accuracy related to billing providers for all three encounter types
- Data accuracy related to servicing providers for 837P/I encounters

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

- Data accuracy related to member identification numbers for 837P encounters
- Initial submissions to DHHS within 14 days of the claim payment date for all three encounter types

WS

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

- X12 EDI compliance edits
- Data accuracy related to billing providers for 837P/I encounters
- Data accuracy related to servicing providers for 837P/I encounters

HSAG recommends that **WS** focus on improving the following rates:

- Data accuracy related to member identification numbers for 837P/I encounters, as well as data completeness (i.e., percent present) related to member identification numbers for pharmacy encounters
- Data accuracy related to billing providers for pharmacy encounters
- Initial submissions to DHHS within 14 days of the claim payment date for all three encounter types

Other EDV Activities

HSAG is currently conducting the following three EDV activities:

- IS Review for **ACNH**: The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from **ACNH** to DHHS is understood. To date, HSAG has employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- Comparative Analysis for **NHHF** and **WS**: The goal of the comparative analysis is to evaluate the extent to which encounters submitted to DHHS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' data systems. In this activity, HSAG developed a data requirements document requesting claims/encounter data from DHHS, **NHHF**, and **WS** based on the same data extraction parameters (i.e., encounters with dates of service between July 1, 2018, and June 30, 2019, with MCO adjustment/paid dates on or before November 30, 2019, and submitted to DHHS on or before December 31, 2019) and then followed up with a technical assistance conference call for any questions. Once HSAG received data files from DHHS, **NHHF**, and **WS**, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. Based on the preliminary file review results, HSAG followed up with DHHS, **NHHF**, and **WS** for clarifications and resubmissions. Currently, HSAG is conducting the comparative analyses and calculating rates for the study indicators.

- Medical Record Review for **NHHF** and **WS**: This activity is evaluating encounter data completeness and accuracy through a review of medical records for physician services rendered between July 1, 2018, and June 30, 2019. This study will answer the following question:

– *Are the dates of service, diagnosis codes, procedure codes, and modifiers found on the professional encounters complete and accurate when compared to information contained within the medical records?*

To answer the study question, HSAG has identified the eligible population and generated samples from data extracted from the DHHS data warehouse. In addition, the MCOs are procuring medical records from providers. Currently, HSAG is reviewing the medical records against DHHS' encounter data and will then move forward with calculating study indicators.

In summary, to conclude the study, HSAG is finalizing a single aggregate report that will be completed in December 2020, and the report will contain key findings for DHHS, **ACNH**, **NHHF**, and **WS**, as well as conclusions and recommendations. The results from the three EDV activities will be included in the SFY 2021 technical report.

For additional information concerning EDV, see Section 4 Detailed Findings, page 4-85.

Other External Quality Review (EQR) Activities

Semi-Structured Qualitative Interviews

Fall Semi-Structured Interviews

Thirty women who had recently given birth participated in the SFY 2020 fall study. Half of the participants were members of **NHHF**, and half of the participants were members of **WS**. Horn Research conducted the telephone interviews with women who lived across New Hampshire between November 5, 2019, and December 6, 2019.

Findings

Participants indicated that the most positive experiences included having their medical bills paid, the incentives and rewards available to them, and interactions with both customer service and case management. Twenty-six of the 30 participants did not have any challenging experiences to share about their interactions with their MCO, although some mentioned challenges including coverage and billing issues, difficulties with the Medicaid recertification process, and not receiving promised incentives. Overall, participants knew who to call for assistance when needed and said that their interactions with their MCO had been positive and helpful.

Participants reported receiving early prenatal care and expressed satisfaction with the range of choices available to them for providers and birthing centers. All participants said they had accessed postpartum care. All but a few members indicated that they had been screened for tobacco and substance use during and after pregnancy. Sixteen women were not familiar with the programs offered by their MCO for pregnant women (i.e., *Sunny Start* and *Smart Start for Your Baby*); however, the participants did receive some of the services offered through those programs. Thirteen women received educational information about pregnancy, birth, and postpartum care from the MCO, and all but five participants said they had received some kind of incentive from their MCO.

Conclusions and Recommendations

Overall, participants expressed satisfaction with the care they received from their providers and the support they received from their MCO both during and after their pregnancy. Recommendations included improving awareness of the programs for pregnant women offered by their MCO and the benefits available during and after pregnancy. Information gained during the interviews indicated that first time moms were most likely to need, want, and value the case management support and educational information during pregnancy than women who had previously given birth. Focusing outreach and information to first time moms may have the effect of optimizing resources while ensuring support for the highest need families.

Spring Semi-Structured Qualitative Study

The SFY 2020 spring study with the parents or guardians of 30 Medicaid members who were 11 or 12 years of age at the time of sampling. Horn Research conducted the telephone interviews between April 16, 2020, and May 14, 2020, and members from all three MCOs were included in the study.

Findings

Participants were asked to describe their understanding of their child's health plan, positive and challenging encounters they had experienced with their MCO, their understanding of their MCO's complaint process, and their utilization of the MCO's case management services. They were also asked to describe their experience with educational materials they may have received from their MCO.

Eighteen participants said they understood their child's health insurance plan, and 12 participants indicated that they did not understand their child's health insurance plan. Those who did not understand their child's health insurance plan believed that knowledge was unnecessary because their child's health needs had been covered. Positive attributes of the MCOs included the coverage provided by the plan, the provider network, the ease of use, and the MCO's customer service. When asked about negative experiences with their MCO, most participants said they had not experienced any challenges.

Twenty-five participants said they were not aware of their MCO's complaint process; however, the participants did think they could contact their MCO's customer service department if they had a complaint. When asked about case management services, most participants said their child did not receive those services; however, four participants indicated their child received those services at school or at a community-based organization. The 14 participants who said they received educational information from their MCO noted that the information was not helpful and was too general in nature.

Of the 12 participants whose children took medication regularly, only four had experienced challenges (i.e., pharmacies not accepting their insurance and pre-authorization for insulin). Overall, participants described positive relationships with their child's primary care provider (PCP) but noted a long wait time to schedule appointments. Of those who had seen a specialist in the last six months, participants indicated satisfaction with the communication between specialists and the PCP.

Participants were asked to describe their experience with the evaluation of their child's mental and emotional health by the PCP. Ten participants indicated that the PCP did an extensive evaluation, and seven participants said their PCP used a screening tool but did not think it was effective. Five participants said the PCP casually checked with their child to see how he/she was doing. Four participants noted that their PCP did not evaluation their child's emotional health during the previous visit, and an additional four said they did not know whether the provider had included a mental health evaluation in their last visit.

Conclusions and Recommendations

Overall, participants expressed satisfaction with the care they received from their providers and the support they received from their MCO. Based on the information gathered from interview participants,

three recommendations emerged from the discussions: (1) Increase the number of mental health providers in their local communities; (2) Continue to provide communication on the importance, value, and safety of vaccines, especially human papillomavirus (HPV) and the flu vaccine; and (3) Consider providing funding for sports fees and equipment to support and encourage physical activity.

Secret Shopper Survey

During February and March 2020,[3-11] HSAG completed a secret shopper telephone survey among PCPs contracted with a Medicaid MCO. A "secret shopper" is a person employed to pose as a patient to evaluate the validity of available provider information (e.g., accurate MCO affiliation information). The secret shopper telephone survey allows for objective data collection from healthcare providers while minimizing potential bias introduced by knowing the identity of the surveyor. The goal of the survey was to evaluate New Hampshire's MCM network to address the following survey objectives:

- Determine whether providers accept members enrolled with a Medicaid MCO
- Determine whether providers are accurately identified in the MCOs' provider data as PCPs
- Determine whether providers accept new patients
- Determine appointment availability for new Medicaid members requesting routine well checks or nonurgent problem-focused ("sick") visits

ACNH, NHHF, and WS submitted provider data to HSAG, reflecting providers who were actively enrolled in the New Hampshire Medicaid program as of December 16, 2019. For comparison to the Medicaid MCOs, HSAG also assessed appointment availability for individuals with commercial health insurance, using the Anthem State Employee Plan (Anthem) offered in New Hampshire by Anthem BlueCross BlueShield.

HSAG's interviewers used a DHHS-approved survey script to complete survey calls to all sampled provider locations. HSAG attempted to contact 1,592 sampled provider locations (i.e., "cases"), with an overall response rate of 67.5 percent among the health plans.

Results

Of the responsive cases, 85.6 percent accepted the health plan requested by the caller (i.e., the Medicaid MCO or Anthem). Among the cases in which the provider accepted patients with the health plan, 84.3 percent confirmed that the requested provider was a PCP, and 54.3 percent responded that the provider location was accepting new patients, with similar results across all health plans. However,

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[3-11] HSAG began survey calls on February 10, 2020, and completed all calls by March 13, 2020, prior to the federal emergency declaration regarding the COVID-19 pandemic and subsequent impacts to PCPs' scheduling of routine well checks and nonurgent sick visits.

among the cases accepting the health plan, confirmed as a PCP, and accepting new patients, only 6.9 percent offered an appointment date to the caller. Table 3-11 displays a summary of the survey case outcomes, by visit type and health plan.

Table 3-11—Summary of Survey Case Outcomes, by Visit Type and Health Plan

Health Plan	Total Survey Cases	Cases Reached	Providers Accepting MCO	Providers Identified as a PCP	Accepting New Patients[1]	Offered An Appointment Date[2]
Routine Well-Check Visit						
ACNH	197	144	101	74	40	2
NHHF	199	130	110	96	55	3
WS	203	139	126	101	53	4
MCO Total	**599**	**413**	**337**	**271**	**148**	**9**
Anthem[3]	194	120	108	99	49	0
Nonurgent Sick Visit[4]						
ACNH	198	125	96	74	42	4
NHHF	201	137	120	106	56	5
WS	205	149	133	109	62	3
MCO Total	**604**	**411**	**349**	**289**	**160**	**12**
Anthem[3]	195	130	125	116	64	8

[1] Sampled cases included PCP-type providers from each MCO and were not limited to providers that were accepting new patients.

[2] Based on the survey findings, most providers required a pre-registration process prior to offering an appointment date.

[3] HSAG used the same Medicaid MCO provider lists to identify provider locations not sampled for the Medicaid MCOs to ask about providers' acceptance of the Anthem commercial insurance plan.

[4] The survey script for nonurgent sick visits was limited to a specific clinical condition (i.e., a persistent earache without fever) and did not address additional clinical scenarios that may have resulted in more timely appointments or greater availability of services (e.g., a patient with underlying health conditions).

Recommendations

Based on the survey findings, the following findings/recommendations were provided to DHHS and the MCOs:

- DHHS to provide **ACNH**, **NHHF**, and **WS** with the list of provider deficiencies (e.g., provider records with invalid telephone numbers) identified during the EQR activity. **ACNH**, **NHHF**, and **WS** to verify the telephone numbers listed in their provider data to ensure the accuracy of the information in the provider file.

- All cases received in the provider data files from the MCOs indicated that the information contained only the names of PCPs. The survey results, however, indicated that some of the providers were not

PCPs. DHHS should consider conducting an independent provider directory review to verify that the MCOs' publicly available provider data contain accurate information for their members.

- Survey responses include several barriers to obtaining appointment availability, including offices requiring pre-registration, Medicaid eligibility verification, the MCO's assignment of the member with the PCP, and/or medical record review prior to offering an appointment date. DHHS and the MCOs should consider conducting a review of the provider offices' requirements to ensure these barriers are not unduly burdening the members' ability to access primary care.

- Differences in appointment wait times by MCO suggest that providers are not contracted with all Medicaid MCOs. DHHS could consider comparing provider networks to determine the extent to which each MCO is contracted with available providers.

Provider Satisfaction Survey

When HSAG created the original timeline for the SFY 2020 Provider Satisfaction Survey in August 2019, the mailing of provider surveys was to begin in July 2020. However, due to the travel restrictions and stay-at-home orders in many states in response to the COVID-19 pandemic, DHHS and HSAG agreed to delay the administration of the survey until later in 2020. As a result of this delay, the provider satisfaction survey findings will be included in the SFY 2021 technical report.

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.[3-12]

- *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."[3-13] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. 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).[3-14]

[3-12] 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: Oct 25, 2019.

[3-13] NCQA. *2017 Standards and Guidelines for the Accreditation of Health Plans*. Washington, DC: The NCQA; 2017: UM5.

[3-14] 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: Aug 30, 2020.

AmeriHealth Caritas New Hampshire

Compliance

ACNH achieved an overall score of 86.9 percent in the SFY 2020 compliance review. Of the 16 standards reviewed, **ACNH** scored 100 percent on two standards, representing total compliance with requirements; 90.9 percent or higher but less than 100 percent on seven standards, representing areas of relative strength; 80.6 percent or higher but less than 90.9 percent on five standards, representing areas with multiple opportunities for improvement; and less than 80.0 percent on the remaining two standards, representing the greatest opportunities for improvement. Delegation and Subcontracting, the lowest scoring standard, represents the greatest opportunity for improvement. Of the 525 elements reviewed, **ACNH** *Met* the requirements for 421 elements, representing total compliance with federal and State requirements for *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **ACNH** in the elements found to be *Partially Met* or *Not Met* in this year's compliance review. A review of those elements reveals that they could affect *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries. After finalization of the SFY 2020 Compliance Review Report in September 2020, **ACNH** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be *Partially Met* or *Not Met* during the compliance review. **ACNH** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2020 compliance review. HSAG will include a review of the SFY 2020 Compliance Review CAP items during the SFY 2021 compliance audit.

PIPs

ACNH collaborated with DHHS and the other MCOs to select the topics for the two PIPs initiated in SFY 2020. The PIP topics focused on improving rates for two HEDIS measures: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (*IET*). The two HEDIS measures are related to the domains of *quality of care* and *access to care*. The selection of these topics suggests that the MCO has opportunities for improvement in these domains. For the PIP focused on improving the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who are being treated for schizophrenia or bipolar disorder by ensuring these members receive appropriate screening for diabetes. For the PIP topic focused on improving the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (*IET*) HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who have initiated treatment for alcohol or other drug abuse or dependence by ensuring these members are engaged in ongoing treatment.

During SFY 2020, **ACNH** demonstrated the following strengths as the MCO initiated PIPs to address the topics described above:

- Established a multidisciplinary team to support each PIP.
- Developed a sound methodology for measuring and evaluating progress toward improvement.
- Used robust QI tools, such as process mapping, failure modes and effect analysis (FMEA), and a key driver diagram, to develop interventions to address identified opportunities for improvement.

PMV

HSAG's PMV activities found all 13 performance measures representing *quality of care*, *timeliness of care*, and *access to care* acceptable for reporting, and the auditors recommended that **ACNH**:

- Continue to communicate regularly with the measure-producing staff to ensure any changes to measures are captured and reported accurately.
- Conduct internal audits of all measures through sampling and trend rates over time. Several measures did not have sufficient history to produce any results.

CAHPS

ACNH operations in New Hampshire began September 1, 2019. No CAHPS results were available for CY 2019 because none of the **ACNH** members met the enrollment and eligibility criteria for this year's survey.

HEDIS

ACNH operations in New Hampshire began September 1, 2019. No HEDIS results were available for CY 2019 because none of the **ACNH** members met the enrollment and eligibility criteria for this year's study.

Encounter Data Validation

ACNH met the standard for X12 EDI compliance edits, data accuracy related to the member identification numbers for 837I and pharmacy encounters, data accuracy related to billing provider information for all three encounter types, and data accuracy related to servicing provider information for 837P/I encounters. **ACNH** should continue improving its data accuracy for the member identification numbers for 837P encounters and timely initial data submissions to DHHS so that **ACNH** can submit initial encounters to DHHS within 14 days of claim payment. **ACNH** may work with DHHS on example cases with inaccurate member identification numbers to determine the root cause. Also, appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the *timeliness of care* issues. Determining *access to care* and health outcomes that represent *quality of care* could be difficult if **ACNH** does not submit accurate and timely encounter data to DHHS.

New Hampshire Healthy Families

Compliance

NHHF continued showing strength in complying with federal and State standards by achieving an overall score of 94.3 percent in the SFY 2020 compliance review. Of the five standards reviewed, **NHHF** scored 100 percent on one standard, representing total compliance with the requirements. Three standards scored 94.8 percent or higher but less than 100 percent, representing areas of relative strength. One remaining standard, SUD, was the lowest scoring standard, representing the greatest opportunity for improvement. Of the 209 elements reviewed, **NHHF** *Met* the requirements for 190 elements, representing strengths in compliance with federal and State requirements for *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **NHHF** in the elements found to be *Partially Met* or *Not Met* in this year's compliance review. A review of those elements reveals that they could affect *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries. After finalization of the SFY 2020 Compliance Review Report in September 2020, **NHHF** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be *Partially Met* or *Not Met* during the compliance review. **NHHF** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2020 compliance review. HSAG will include a review of the SFY 2020 Compliance Review CAP items during the SFY 2021 compliance audit.

PIPs

NHHF collaborated with DHHS and the other MCOs to select the topics for the two PIPs initiated in SFY 2020. The PIP topics focused on improving rates for two HEDIS measures: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (*IET*). The two HEDIS measures are related to the domains of *quality of care* and *access to care*. The selection of these topics suggests that the MCO has opportunities for improvement in these domains. For the PIP focused on improving the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who are being treated for schizophrenia or bipolar disorder by ensuring these members receive appropriate screening for diabetes. For the PIP topic focused on improving the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (*IET*) HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who have initiated treatment for alcohol or other drug abuse or dependence by ensuring these members are engaged in ongoing treatment.

During SFY 2020, **NHHF** demonstrated the following strengths as the MCO initiated PIPs to address the topics described above:

- Established a multidisciplinary team to support each PIP.

- Analyzed baseline performance data and set a quantitative goal for improvement.
- Developed a sound methodology for measuring and evaluating progress toward improvement.
- Used robust QI tools, such as process mapping, FMEA, and a key driver diagram, to develop interventions to address identified opportunities for improvement.

PMV

HSAG's PMV activities found all 13 performance measures representing *quality of care*, *timeliness of care*, and *access to care* acceptable for reporting, and the auditors recommended that **NHHF**:

- Continue to communicate regularly with the measure-producing staff to ensure any changes to measures are captured and reported accurately.

CAHPS

There were no 2020 measure rates for **NHHF**'s adult Medicaid population that were statistically significantly higher than the 2019 NCQA adult Medicaid national averages; however, there were four 2020 measure rates for the child Medicaid population that were statistically significantly higher than the 2019 NCQA child Medicaid national averages. These measures represent responses related to *quality of care*, *timeliness of care*, and *access to care* (i.e., *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*). Eight 2020 adult measure rates and the remaining four child measure rates for **NHHF**, representing the *quality of care*, *timeliness of care*, and *access to care* domains, were neither statistically significantly higher nor lower than the 2019 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 *quality of care* and *timeliness of care*. **NHHF** could encourage providers to explore an open access scheduling model, which can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: (1) it reduces delays in patient care; (2) it increases continuity of care; and (3) it decreases wait times and the number of no-shows, resulting in cost savings. An evaluation of current MCO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. MCOs should further promote the use of existing after-hours customer service to improve customer service results. Also, asking members to complete a short survey at the end of each call could assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Additionally, **NHHF** could enhance on-demand advice services, such as telemedicine options, to provide members with more timely access to care and information about their health. Allowing members to access their health information through Internet access could lead to shorter duration office visits, more phone consultations, and reduced emotional distress. This aims to address the demand for immediate information and to reinforce the relationship between MCOs and their members.

HEDIS

NHHF demonstrated strength for measures related to *quality of care*, exceeding the 50th percentile for 29 of the 37 (78.38 percent) measures related to *quality*. The following measures related to *quality of care* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits**
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
- *Adolescent Well-Care Visits (AWC)*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing* and *HbA1c Poor Control (>9.0%)*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total* and *Initiation of AOD Treatment—Total*

NHHF has opportunities for improvement related to *quality of care*, with **NHHF**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile—Total*
- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Cervical Cancer Screening (CCS)*
- *Chlamydia Screening in Women (CHL)—16–20 Years*, *21–24 Years*,† and *Total*†
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*

NHHF demonstrated strength in measures related to *timeliness of care*, exceeding the 50th percentile for nine of the 10 (90.00 percent) measures related to *timeliness of care*. The following measures related to *timeliness* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**

- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and 30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total and Initiation of AOD Treatment—Total*

NHHF has opportunities for improvement related to *timeliness of care*, with **NHHF**'s performance falling below the 50th percentile for the following measures:

- *Diabetes Screening for People With Diabetes and Schizophrenia (SMD)*

NHHF demonstrated strength in measures related to *access to care*, exceeding the 50th percentile for 11 of the 13 (84.62 percent) measures related to *access*. The following measures related to *access* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years,* and 12–19 Years*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and 30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total and Initiation of AOD Treatment—Total*

NHHF has opportunities for improvement related to *access to care*, with **NHHF**'s performance falling below the 50th percentile for the following measures:

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*
- *Diabetes Screening for People With Diabetes and Schizophrenia (SMD)*

Encounter Data Validation

NHHF met the standard for X12 EDI compliance edits, data accuracy related to the member identification numbers for 837I and pharmacy encounters, data accuracy related to billing provider information for all three encounter types, and data accuracy related to servicing provider information for 837P/I encounters. **NHHF** should continue improving its data accuracy for the member identification numbers for 837P encounters and timely initial data submissions to DHHS so that **NHHF** can submit initial encounters to DHHS within 14 days of claim payment. **NHHF** may work with DHHS on example cases with inaccurate member identification numbers to determine the root cause. Also, appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the *timeliness of care* issues. Determining *access to care* and health outcomes that represent *quality of care* could be difficult if **NHHF** does not submit accurate and timely encounter data to DHHS.

Well Sense Health Plan

Compliance

WS continued showing strength in complying with federal and State standards by achieving an overall score of 94.5 percent in the SFY 2020 compliance review. Of the five standards reviewed, **WS** scored 100 percent on one standard and 91.2 percent or higher on the remaining four standards. Delegation and Subcontracting, the lowest scoring standard, represents the greatest opportunity for improvement. Of the 211 elements reviewed, **WS** *Met* the requirements for 192 elements, representing strengths in compliance with federal and State requirements for *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **WS** in the elements found to be *Partially Met* or *Not Met* in this year's compliance review. A review of those elements reveals that they could affect *quality of care*, *timeliness of care*, and *access to care* for the New Hampshire Medicaid beneficiaries. After finalization of the SFY 2020 Compliance Review Report in September 2020, **WS** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be *Partially Met* or *Not Met* during the compliance review. **WS** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2020 compliance review. HSAG will include a review of the SFY 2020 Compliance Review CAP items during the SFY 2021 compliance audit.

PIPs

WS collaborated with DHHS and the other MCOs to select one topic for a PIP initiated in SFY 2020. The PIP topic focused on improving rates for the HEDIS measure, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*). For the second PIP topic, **WS** chose *Continued Engagement of Opioid Abuse or Dependence Treatment*. The two HEDIS measures are related to the domains of *quality of care* and *access to care*. The selection of these topics suggests that the MCO has opportunities for improvement in these domains. For the PIP focused on improving the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who are being treated for schizophrenia or bipolar disorder by ensuring these members receive appropriate screening for diabetes. For the PIP topic focused on improving the *Continued Engagement of Opioid Abuse or Dependence Treatment* HEDIS measure, there is an opportunity to improve *quality of care* and *access to care* for members who have initiated treatment for opioid drug abuse or dependence by ensuring these members are engaged in ongoing treatment.

During SFY 2020, **WS** demonstrated the following strengths as the MCO initiated PIPs to address the topics described above:

- Established a multidisciplinary team to support each PIP.
- Analyzed baseline performance data and set a quantitative goal for improvement.

- Developed a sound methodology for measuring and evaluating progress toward improvement.
- Used robust QI tools, such as process mapping, FMEA, and a key driver diagram, to develop interventions to address identified opportunities for improvement.

PMV

HSAG's PMV activities found all 13 performance measures representing *quality of care*, *timeliness of care*, and *access to care* acceptable for reporting, and the auditors recommended that **WS**:

- Continue to communicate regularly with the measure-producing staff to ensure any changes to measures are captured and reported accurately.

CAHPS

One measure rate for **WS**'s adult Medicaid population and three measure rates for the child Medicaid population in 2020 were statistically significantly higher than the 2019 NCQA adult and child Medicaid national averages. These measures represent responses related to *quality of care* and *timeliness of care* (i.e., *Rating of Health Plan*, *Getting Care Quickly*, and *How Well Doctors Communicate)*. The remaining seven 2019 adult measure rates and five 2019 child measure rates for **WS**, representing the *quality of care*, *timeliness of care*, and *access to care* domains, were neither statistically significantly higher nor lower than the 2019 NCQA adult and child Medicaid national averages.

To improve CAHPS rates for quality of care, **WS** could consider exploring service recovery methods. This type of intervention is used to identify and resolve dissatisfaction in customer or clinical service. Service recovery actions can range from simply listening to the upset patient to providing solutions or making amends for problems that patient reported. In order to properly handle customer complaints, **WS** could implement the following protocols: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

WS could consider requesting physician practices to allow open access scheduling to improve CAHPS rates related to *timeliness of care* measures. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling enables practices to eliminate delays in patient care without adding resources while improving access to care. Better access to care often yields improved satisfaction rates in access to care, and higher levels of patient and provider satisfaction by enhancing continuity of care through allowing patients to see their personal physician. Additionally, 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.

To improve access to care rates, **WS** could also conduct an evaluation of current MCO call center hours and practices to determine if the hours and resources meet members' needs. MCOs should further promote the use of existing after-hours customer service to improve customer service results. Additionally, implementing or enhancing on-demand advice services, such as telemedicine options, provide members with more timely access to care and information about their health.

HEDIS

WS demonstrated strength for measures related to *quality of care*, exceeding the 50th percentile for 24 of 37 (64.86 percent) measures related to *quality of care*. The following measures related to *quality of care* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

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

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

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and Systemic Corticosteroid**

- *Use of Imaging Studies for Low Back Pain (LBP)*

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

- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and 30-Day Follow-Up—Total*

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**

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

- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*

- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total* and Initiation of AOD Treatment—Total*

WS has opportunities for improvement related to *quality of care*, with **WS**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

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

- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*

- *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,† and Total*

- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%)*

- *Asthma Medication Ratio (AMR)—Total*

- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*

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

WS demonstrated strength in measures related to *timeliness of care*, exceeding the 50th percentile for eight of the 10 (80.00 percent) measures related to *timeliness*. The following measures related to *timeliness* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator** and *Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total** and *Initiation of AOD Treatment—Total*

WS has opportunities for improvement related to *timeliness of care*, with **WS**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*

WS demonstrated strength in measures related to *access to care*, exceeding the 50th percentile for 10 of the 13 (76.92 percent) measures related to *access*. The following measures related to *access* met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years,** and *12–19 Years*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total** and *Initiation of AOD Treatment—Total*

WS has opportunities for improvement related to *access to care*, with **WS**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*

Encounter Data Validation

WS met the standard for X12 EDI compliance edits and data accuracy related to billing and servicing provider information for 837P/I encounters. **WS** should continue improving its data accuracy related to the member identification numbers for 837P/I encounters, data completeness (i.e., percent present rate in Table 3-10) related to the member identification numbers for pharmacy encounters, data accuracy related to billing provider information for pharmacy encounters, as well as timely initial data submissions to DHHS so that **WS** can meet the corresponding standards. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. **WS** 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 data submission may correct the *timeliness of care* issues. Determining *access to care* and health outcomes that represent *quality of care* could be difficult if **WS** does not submit accurate and timely encounter data to DHHS.

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

MCO Contractual Compliance

HSAG used two strategies to conduct the SFY 2020 compliance reviews. Since **ACNH** entered the New Hampshire MCM Program in September 2019, the SFY 2020 compliance review for that MCO included all 16 standards included in the complete compliance tool. This process aligns with the philosophy used in December 2013 when the MCM Program began operating in New Hampshire. In SFY 2014, the first compliance review for the MCOs in New Hampshire, HSAG reviewed all standards for all MCOs. In SFY 2015, HSAG began reviewing one-third of the standards each year. In SFY 2020, the existing MCOs (i.e., **NHHF** and **WS**) continued with the established review cycle of one-third of the standards in the compliance tool, and their review included five standards.

Due to the travel restrictions and stay-at-home orders in many states in response to COVID-19, DHHS, HSAG, and the MCOs agreed to perform this year's review virtually through the use of Webex, which supported an end-to-end encryption program. The use of Webex allowed HSAG and the MCOs to display documents and databases discussed during the review. The compliance review process with HSAG included pre-site, virtual review, and post-site activities.

Results of the SFY 2020 Compliance Review

Table 4-1 includes the findings from the SFY 2020 compliance reviews for **ACNH**, **NHHF**, and **WS**. In prior years, HSAG generated separate scores for the checklist reviews and the file reviews. The scoring for the SFY 2020 compliance review, however, includes those scores in the overall standard scores listed below.

Table 4-1—Comparison of MCO Scores for the SFY 2020 Compliance Review

Standard	Standard Name	ACNH	NHHF	WS
I.	Delegation and Subcontracting	46.9%	96.9%	91.2%
II.	Emergency and Post-Stabilization Care	96.2%	NA	NA
III.	Care Management/Care Coordination	90.9%	NA	NA
IV.	Wellness and Prevention	100%	NA	NA
V.	Behavioral Health	93.1%	98.3%	96.6%
VI.	Member Enrollment and Disenrollment	86.1%	NA	NA
VII.	Member Services	80.6%	NA	NA
VIII.	Cultural and Accessibility Considerations	100%	NA	NA

Standard	Standard Name	ACNH	NHHF	WS
IX.	Grievances and Appeals	93.6%	NA	NA
X.	Access	86.3%	NA	NA
XI.	Network Management	91.4%	94.8%	94.9%
XII.	Utilization Management	74.3%	NA	NA
XIII.	Quality Management	80.6%	NA	NA
XIV.	Substance Use Disorder	84.0%	89.0%	93.0%
XV.	Fraud, Waste, and Abuse	91.2%	NA	NA
XVI.	Financial/Third Party Liability	92.9%	100%	100%
Overall Score*		**86.9%**	**94.3%**	**94.5%**

* HSAG recommends using caution in the comparison of overall scores of **NHHF** and **WS** with **ACNH** due to the varying number of standards reviewed for the new and established health plans: 16 for **ACNH** and five for **NHHF** and **WS**.

Of the five standards included in the SFY 2020 compliance review for **NHHF** and **WS**, **NHHF** achieved 100 percent compliance for one standard, less than 100 percent but greater than 90 percent on three standards, and less than 90 percent but greater than 80 percent on the SUD standard. **WS** achieved 100 percent compliance for one standard, less than 100 percent but greater than 90 percent on the remaining four standards.

Of the 16 standards included in the SFY 2020 compliance review for **ACNH**, the MCO achieved 100 percent compliance on two standards, less than 100 percent but greater than 90 percent on seven standards, less than 90 percent but greater than 80 percent five standards, and less than 80 percent on two standards.

Conclusions and Recommendations for the Compliance Review

ACNH

Since **ACNH** began in the New Hampshire MCM Program in September 2019, the 2020 compliance review was the first compliance review conducted by HSAG for that MCO. **ACNH** achieved complete compliance for the requirements included in the Wellness and Prevention and Cultural and Accessibility Considerations standards by scoring 100 percent. **ACNH** received a score of *90.9 percent or higher but less than 100 percent* on the following seven standards, representing areas of relative strength:

- Emergency and Post-Stabilization Care
- Care Management/Care Coordination
- Behavioral Health
- Grievances and Appeals
- Network Management
- Fraud, Waste, and Abuse

- Financial/Third Party Liability

ACNH received a score of *80.6 percent or higher but less than 90.9 percent* on five standards, representing areas having multiple opportunities for improvement:

- Member Enrollment and Disenrollment
- Member Services
- Access
- Quality Management
- SUD

ACNH received a score of less than *80.6 percent* on two standards, representing the greatest opportunities for improvement:

- Delegation and Subcontracting
- UM

Subcontracts File Reviews

ACNH submitted four subcontracts for the file review, and HSAG evaluated nine elements in each of the four documents. One contract received a *Not Met* score for all nine items, and three subcontracts received a *Partially Met* score on one item.

Grievances File Reviews

All items were *Met* in the **ACNH** grievance file reviews.

Appeals File Reviews

HSAG reviewed 10 **ACNH** appeal files and determined that one acknowledgement letter was not sent as required, and one file did not contain a resolution letter.

Denials File Reviews

In the 10 **ACNH** denial files reviewed, three notices for urgent requests were not sent within 72 hours, and three nonurgent files did not contain an adverse benefit determination (i.e., the reason for the denial).

Credentialing File Reviews

Thirty **ACNH** initial credentialing files reviewed did not contain verification of hospital privileges, and one file did not contain validation of timely processing of the application (i.e., within 30 days of receipt of complete application for PCPs).

NHHF

NHHF achieved an overall score of 94.3 percent. **NHHF** demonstrated complete compliance with the requirements included in the Financial/Third Party Liability standard by scoring 100 percent. **NHHF** received a score of *94.8 percent or higher but less than 100 percent* on three standards, representing areas of relative strength:

- Delegation and Subcontracting
- Behavioral Health
- Network Management

NHHF received *89.0 percent* on the SUD standard, representing the greatest opportunity for improvement.

Subcontracts File Reviews

All items were *Met* in the **NHHF** Delegation and Subcontracts file reviews.

Credentialing File Reviews

Initial Credentialing

One element, the requirement to obtain primary source verification concerning the status of hospital privileges for all **NHHF** practitioners who have admitting privileges to a hospital, was found to be non-compliant in 10 of the 19 files reviewed.

Recredentialing

Four **NHHF** recredentialing files of the 19 reviewed did not contain information to verify the status of hospital privileges for those practitioners. Recredentialing files also must contain evidence of conducting an ongoing review of adverse events (e.g., quality issues, complaints, member surveys, utilization, sanctions, etc.), and one **NHHF** recredentialing file of the 30 reviewed failed to contain the required evidence.

WS

WS achieved an overall score of 94.5 percent. Of the five standard areas reviewed, **WS** achieved *100 percent compliance* on one standard, Financial/Third Party Liability, demonstrating adherence to all requirements. **WS** received a score of *93.0 percent or higher compliance* on three standards, representing relative strength:

- Behavioral Health
- SUD
- Network Management

Delegation and Subcontracting, the lowest scoring standard (i.e., 91.2 percent), represents the greatest opportunity for improvement for **WS**.

Subcontracts File Reviews

Of the 10 items evaluated during the **WS** delegation and subcontracts file reviews, the following areas represent opportunities for improvement:

- The process to transition services when the agreement expires or terminates.
- Program integrity requirements to include policies and procedures for referrals to the DHHS Program Integrity Unit and the Medicaid Fraud Control Unit (MFCU) on credible allegations of fraud and for payment suspension where there is a credible allegation of fraud.
- The subcontractor must have a compliance plan that meets the requirements of 42 CFR §438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements.

Credentialing File Reviews

Initial Credentialing

One element, the requirement to ensure primary source verification of the New Hampshire Medicaid number for all **WS** providers in the New Hampshire Medicaid network, was found to be non-compliant in 30 files reviewed.

Recredentialing

Thirty **WS** recredentialing files also did not contain primary source verification of the New Hampshire Medicaid number. Completing primary source verification of the New Hampshire Medicaid number represents an area of improvement for **WS**.

Corrective Action Plan (CAP)

Any element that did not receive a score of *Met* was included in a CAP document distributed to each MCO. The MCOs were required to submit information to bring any elements scored *Partially Met* or *Not Met* into compliance with the contract requirements. Criteria that were used in evaluating the sufficiency of the CAP included:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

The CAPs that did not meet the above criteria required resubmission by the organization until the documents, activities, and interventions were approved by DHHS and HSAG. The elements included in the CAPs for each MCO will be reviewed during the 2021 compliance review to ensure continued compliance with the requirements.

Trending

Table 4-2 displays the compliance scores achieved by **NHHF** and **WS** during the seven years that HSAG conducted compliance reviews for the MCM Program. Since **ACNH** began operating in New Hampshire in September 2019, there are no compliance review scores prior to SFY 2020.

Table 4-2—MCO Compliance Scores from 2014–2020

Fiscal Year	Standards Reviewed	Elements Reviewed	ACNH	NHHF	WS
2014	14	294	NA	95.1%	93.4%
2015	14	82	NA	99.5%	99.5%
2016	13	130	NA	92.7%	88.8%
2017	14	110	NA	97.3%	98.6%
2018	14	128	NA	98.0%	98.8%
2019	12	105	NA	95.7%	96.2%
2020*	**ACNH**: 16 **NHHF**: 5 **WS**: 5	**ACNH**: 525 **NHHF**: 209 **WS**: 211	86.9%	94.3%	94.5%

* HSAG recommends using caution in the comparison of overall scores of **NHHF** and **WS** with **ACNH** due to the varying number of standards reviewed for the new and established health plans: 16 for **ACNH** and five for **NHHF** and **WS**.

In SFY 2014, HSAG reviewed all the elements in every standard included in the compliance tool. During years 2015–2019, DHHS required the compliance review to include some elements from multiple standards. In 2020, DHHS required the review of all 16 standards for **ACNH** and five standards for **NHHF** and **WS** during the annual compliance reviews. In future years, HSAG will continue to ensure that each standard is reviewed at least once every three years to comply with 42 CFR §438.358(b)(iii).[4-1] Appendix B contains a crosswalk of the CMS-required elements in an EQR compliance review and the corresponding year that HSAG reviews the standards containing those requirements in New Hampshire.

[4-1] 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: Oct 6, 2020.

The lowest and highest scores for the compliance reviews over the past seven years for **NHHF** ranged from 92.7 percent to 99.5 percent. The lowest and highest scores for the compliance reviews over the past seven years for **WS** ranged from 88.8 percent to 99.5 percent. This was the first year that **ACNH** participated in the New Hampshire compliance review, and the MCO achieved a score of 86.9 percent.

PIPs

In SFY 2020, DHHS made the decision to implement HSAG's rapid-cycle PIP approach with its contracted MCOs. During this fiscal year, the MCOs initiated the first two of four required rapid-cycle PIPs; they will initiate two additional PIPs during a subsequent 18-month cycle.

HSAG's rapid-cycle PIP approach directs MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the HHS CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-2] HSAG presented the crosswalk and rapid-cycle PIP framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that, given the pace of QI science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed and granted HSAG approval to use this approach in all requesting states.

The rapid-cycle PIP approach is intended to improve processes and outcomes of healthcare by way of continuous QI. The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of the approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. A complete explanation of the rapid-cycle PIP methodology is included in Appendix B.

During SFY 2020, the MCOs completed the first two modules of the rapid-cycle PIP process. HSAG validated the module submission forms submitted by the MCOs for each PIP. As part of the validation process, HSAG provided feedback and technical assistance for any unmet validation criteria and the MCOs resubmitted each module until all validation criteria were met. The final overall PIP validation status is not assigned until the health plan has completed and submitted all four modules for validation. Rapid-cycle PIPs run on an approximate 18-month schedule and the current PIPs will continue into the next fiscal year. Validation findings for the final two modules of the PIPs, and the final validation status for each PIP, will be reported in the SFY 2022 annual EQR technical report.

[4-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): 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-3.pdf. Accessed on: Jan 27, 2020.

In SFY 2020, **ACNH** completed Module 1 and Module 2 of the rapid-cycle PIP process. Table 4-3 presents the PIP title and SMART Aim statement defined by **ACNH** for each PIP.

Table 4-3—Performance Improvement Project Topics Selected by ACNH

PIP Title	SMART Aim Statement*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, increase the percentage of adult members 18 to 64 years of age residing in Hillsborough County, New Hampshire, who receive diabetic screening while on antipsychotic medications for schizophrenia or bipolar disorder. Diabetic screening is a glucose or HbA1c test. Increase from XX% to goal of XX%.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment— Engagement Total (IET— Engagement)	By June 30, 2021, increase the percentage of adult members 18 years and older having two or more additional AOD services or medication treatment within 34 days after discharge during the measurement period among adult members 18 years and older discharged from an acute inpatient stay with any diagnosis of SUD during the measurement period, from XX% to XX%.

* The SMART Aim baseline and goal percentages will be updated by the MCO once they are available and finalized.

The SMART Aim statement **ACNH** developed for each PIP defines the focus for the project. **ACNH** will complete each SMART Aim statement with baseline and goal percentages once the MCO has obtained 12 months of data to calculate baseline results for the SMART Aim measure. HSAG will assess each PIP for meeting the SMART Aim goal when **ACNH** reports the final results at the end of the project.

In SFY 2020, **NHHF** completed Module 1 and Module 2 of the rapid-cycle PIP process. Table 4-4 presents the PIP title and SMART Aim statement defined by **NHHF** for each PIP.

Table 4-4—Performance Improvement Project Topics Selected by NHHF

PIP Title	SMART Aim Statement
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, **NHHF** aims to increase the percentage of members 18–64 years of age, who reside in Hillsborough County, New Hampshire, are diagnosed with schizophrenia, schizoaffective or bipolar disorder, and dispensed an antipsychotic medication and are screened for diabetes, utilizing a glucose or HbA1c test, during the measurement period from 80.8% to 90.0%.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment— Engagement Total (IET— Engagement)	By June 30, 2021, **NHHF** will increase the percentage of engagement of AOD treatment among members, ages thirteen years or older, who had a new episode of AOD abuse or dependence, who already initiated treatment, who were engaged in ongoing AOD treatment within 34 days of the initiation visit and reside in Rockingham County, New Hampshire, from 13.45% to 20.0%.

The SMART Aim statement **NHHF** developed for each PIP defines the focus for the project and the quantitative goal for improvement. HSAG will assess each PIP for meeting the SMART Aim goal when **NHHF** reports the final results at the end of the project.

In SFY 2020, **WS** completed Module 1 and Module 2 of the rapid-cycle PIP process. Table 4-5 presents the PIP title and SMART Aim statement defined by **WS** for each PIP.

Table 4-5—Performance Improvement Project Topics Selected by WS

PIP Title	SMART Aim Statement
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	By June 30, 2021, **WS** aims to increase the percentage of members, 18–64 years of age, with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication, assigned to selected PHOs, and had a diabetes screening (a glucose or HbA1c test) from 78.57% to 92.85%.
Continued Engagement of Opioid Abuse or Dependence Treatment	By June 30, 2021, **WS** aims to increase the percentage of members, 18 years of age or older, newly diagnosed with opioid dependency who engaged in ongoing treatment within 34 days of the initiation visit from 39.1% to 45.1%.

The SMART Aim statement **WS** developed for each PIP defines the focus for the project and the quantitative goal for improvement. HSAG will assess each PIP for meeting the SMART Aim goal when **WS** reports the final results at the end of the project.

Validation Results

Table 4-6 summarizes PIP performance across the MCOs in SFY 2020. During this validation cycle, the MCOs initiated new rapid-cycle PIPs focusing on topics selected by DHHS. The PIPs run on an 18-month schedule and will continue into the next fiscal year. During SFY 2020, the primary PIP activities included the MCOs receiving training and technical assistance concerning the rapid-cycle PIP process and developing the foundation of the projects in the first two modules of the process. Table 4-6 summarizes how far through the four modules of the rapid-cycle PIP process each MCO progressed. As noted in the "Validation Status" column in the table, no PIPs progressed to being evaluated on outcomes or receiving a final validation status.

Table 4-6—SFY 2020 PIP Validation Results Comparison by MCO for Topics Selected by ACNH, NHHF, and WS

MCO	PIP Topics	Module Status	Validation Status
ACNH	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Completed Module 1 and Module 2**	NA*
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	Completed Module 1 and Module 2**	NA*
NHHF	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Completed Module 1 and Module 2	NA*
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	Completed Module 1 and Module 2	NA*
WS	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Completed Module 1 and Module 2	NA*
	Continued Engagement of Opioid Abuse or Dependence Treatment	Completed Module 1 and Module 2	NA*

*   NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the SFY 2020 validation cycle.

** **ACNH** received a *Conditional Pass* Module 1 and Module 2 for both PIPs because, at the initiation of the PIP, the MCO did not yet have 12 months of historical data to establish a baseline and goal for the PIPs. The MCO will resubmit Module 1 and Module 2 for validation of each PIP, once 12 months of data are available to calculate the SMART Aim goal and baseline rates. The *Conditional Pass* allowed the MCO to progress to Module 3 while collecting 12 months of baseline data.

During SFY 2020, two of the MCOs, **NHHF** and **WS**, passed Module 1 and Module 2, achieving all validation criteria for the first two modules for four of the six PIPs listed in Table 4-6. **ACNH** received a *Conditional Pass* for Module 1 and Module 2 for the two remaining PIPs. Since **ACNH** began operations in the New Hampshire MCM Program shortly before the initiation of the PIPs, the MCO lacked historical data to fully address some validation criteria. The *Conditional Pass* assigned to the two PIPs allowed the MCO to continue progressing through subsequent PIP modules while collecting data to fully address remaining validation criteria for Module 1 and Module 2. **ACNH** will resubmit Module 1 and Module 2 once complete baseline data have been collected, and HSAG will conduct a final validation of those modules for both PIPs. The SFY 2020 validation findings for all six PIPs suggested that all MCOs designed methodologically sound projects addressing the DHHS-defined rapid-cycle PIP topics. In the next fiscal year, the MCOs will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. HSAG will report the final validation status for each PIP in the SFY 2022 annual EQR technical report.

PIP-Specific Outcomes

ACNH

As noted in Table 4-6, **ACNH** completed Module 1 and Module 2 for both PIPs during SFY 2020. The objective of Module 1—*PIP Initiation* is for the MCO to ask and answer the first two fundamental questions of the Model for Improvement: "What are we trying to accomplish?" and "How will we know

that a change is an improvement?" In Module 1, the MCO is establishing the foundation for the PIP. The primary outcome of this module is the SMART Aim statement, which defines the measure to be improved and the goal for improvement. The SMART Aim statements for the **ACNH** PIPs are summarized in Table 4-3.

The objective of Module 2—*Intervention Determination* is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In Module 2, **ACNH** used process mapping and a FMEA to identify process gaps and failures to be addressed by interventions. Table 4-7 summarizes the primary outcomes of Module 2 for both **ACNH** PIPs.

Table 4-7—Module 2—*Intervention Determination* Outcomes for ACNH PIPs

PIP Topics	Failure Modes	Key Drivers	Potential Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Prescribing provider is not the PCP and is unaware that the PCP has not done the metabolic monitoring. • Prescriber is unaware that metabolic monitoring is a clinical guideline. • Member does not keep the appointment.	• Exchange of clinical information between prescribing providers. • Member's knowledge of medication and potential side effects for engagement and disease management. • Provider's awareness of the clinical practice guideline for metabolic testing.	• Outreach to the provider regarding the importance of the exchange of clinical information. • Outreach to members to help remove any barriers to scheduling and attending appointment(s) and lab testing. • Outreach to providers and provide education regarding clinical guidelines for metabolic testing when the member is taking antipsychotic medication.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	• Member is not given an appointment date and time for a subsequent SUD service appointment. • Hospital discharge planner does not contact the MCO transition of care coordinator with timely discharge information. • Member is having social determinants of health	• Consistent, collaborative dialogue between the hospital discharge planner and the MCO transition of care coordinator. • Appropriate SUD services to meet the member's needs. • SDOH barrier recognition. • Member's recognition of SDOH.	• Improve the transition of care process and develop a network management plan. • Develop a case management procedure from transition of care through post-discharge outreach. • Develop alternate ways to collect SDOH information.

PIP Topics	Failure Modes	Key Drivers	Potential Interventions
	(SDOH) difficulties (e.g., homelessness, lack of transportation, taking care of family, lack of positive social support for recovery) with getting to a community-based SUD provider.		• Develop case management's ability to engage the member through motivation and choice (change architecture).

ACNH has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, the MCO will be testing an intervention focused on prescribing provider outreach to facilitate scheduling and completion of metabolic screening for eligible members. For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, **ACNH** will be testing an intervention focused on timely communication with hospital discharge planners by the **ACNH** transition of care coordinator to facilitate scheduling follow-up appointments for eligible members prior to discharge. Details of the intervention testing plan will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until SFY 2022; therefore, final outcomes for these PIPs will be included in the SFY 2022 annual EQR technical report.

NHHF

As noted in Table 4-6, **NHHF** completed Module 1 and Module 2 for both PIPs during SFY 2020. The objective of Module 1—*PIP Initiation* is for the MCO to ask and answer the first two fundamental questions of the Model for Improvement: "What are we trying to accomplish?" and "How will we know that a change is an improvement?" In Module 1, the MCO is establishing the foundation for the PIP. The primary outcome of this module is the SMART Aim statement, which defines the measure to be improved and the goal for improvement. The SMART Aim statements for the **NHHF** PIPs are summarized in Table 4-4.

The objective of Module 2—*Intervention Determination* is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In Module 2, **NHHF** used process mapping and a FMEA to identify process gaps and failures to be addressed by interventions. Table 4-8 summarizes the primary outcomes of Module 2 for both **NHHF** PIPs.

Table 4-8—Module 2—Intervention Determination Outcomes for NHHF PIPs

PIP Topics	Failure Modes	Key Drivers	Potential Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Lab test is not ordered. • Member does not have a follow-up appointment, or the appointment is not scheduled. • Member is not aware of the importance of the test. • Member does not show up for a test appointment. • Member does not have transportation.	• Provider's compliance with the lab order. • Convenient access to testing. • Member's compliance with the follow-up appointment with the prescriber. • Member's compliance with obtaining the lab order and completing the lab test.	• Develop a best practice to remind the provider at time of prescription to order tests. • Implement a reminder system for the member regarding provider follow-up. • Improve care coordination to members to help them receive appropriate care. • Arrange transportation services.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	• Member did not attend the appointment and was dissatisfied or perceived ineffective results of treatment/recovery. • Member's housing situation may be unstable (the member may have to move, is homeless, or lacks resources to access or reschedule the appointment). • Limited access to individual care needs; specific treatment is not available. • No transportation to get to the appointment. • Member does not receive initiation treatment or only attends one visit.	• Transitions of care coordination. • Transportation. • Health literacy. • SDOH. • Reduced mental health comorbidities or complex underlying conditions.	• Collaborate with the local county hospital (emergency department or inpatient) to increase follow-up outreach by care management at the MCO level. • Outreach to members to educate awareness of current benefit(s) including transportation. • Educate members on the importance of follow-up care. • Identify the SDOH within the county and implement a care management program that addresses the member's needs. • Outreach to the member in a person-centered approach using an integrated care team.

NHHF has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, the MCO will be testing an intervention focused on telephone outreach to remind prescribing providers to schedule screening for eligible members. For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, **NHHF** will be testing an intervention focused on provider outreach and education to promote timely submission of the Notification of Alcohol and Other Drug (AOD) Diagnosis and/or Referral Form. Details of the intervention testing plan will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until SFY 2022; therefore, final outcomes for these PIPs will be included in the SFY 2022 annual EQR technical report.

WS

As noted in Table 4-6, **WS** completed Module 1 and Module 2 for both PIPs during SFY 2020. The objective of Module 1—*PIP Initiation* is for the MCO to ask and answer the first two fundamental questions of the Model for Improvement: "What are we trying to accomplish?" and "How will we know that a change is an improvement?" In Module 1, the MCO is establishing the foundation for the PIP. The primary outcome of this module is the SMART Aim statement, which defines the measure to be improved and the goal for improvement. The SMART Aim statements for the **WS** PIPs are summarized in Table 4-5.

The objective of Module 2—*Intervention Determination* is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In Module 2, **WS** used process mapping and a FMEA to identify process gaps and failures to be addressed by interventions. Table 4-9 summarizes the primary outcomes of Module 2 for both **WS** PIPs.

Table 4-9—Module 2—Intervention Determination Outcomes for WS PIPs

PIP Topics	Failure Modes	Key Drivers	Potential Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Provider lacks reporting regarding antipsychotic prescriptions being dispensed by a pharmacy to the patient (member) by the ordering practitioner. • Provider lacks knowledge of the need to perform routine diabetes screening tests for patients (members) who are dispensed antipsychotic medications. • PCP may not be aware of medication(s) and	• Provider lacks reporting regarding antipsychotic prescriptions being dispensed by a pharmacy to their member by ordering practitioner. • PCP's awareness of medication(s) and treatment(s) prescribed by other practitioner(s). • Provider awareness regarding the need to perform routine diabetes screening tests	• Promote utilization of MCO care gap reports and provider education to identify members in need of an annual diabetic screening. • Educate and promote best practices for release of information from behavioral health providers to primary care providers for treatment and continuity of care

PIP Topics	Failure Modes	Key Drivers	Potential Interventions
	treatment(s) prescribed by the behavioral health practitioner as a result of failure to obtain/provide a release of information from the patient (member). • Member is not aware of the importance of annual diabetes screening as a result of being on antipsychotic medications. • Health system's electronic medical record (EMR) may not prompt the provider to order an annual diabetes screening test.	for members who are dispensed antipsychotic medications. • Health system's EMR prompting the provider to order an annual diabetes screening test. • Member's awareness regarding the importance of annual diabetes screening as a result of being on antipsychotic medications.	• Promote the integration of PCPs into behavioral health settings. • Promote the use of EMR programming options to prompt diabetes screening for members with an antipsychotic listed in their medications list. • Develop member-facing educational materials.
Continued Engagement of Opioid Abuse or Dependence Treatment	• Shortage of SUD provider in the network/state necessary to treat the volume of members. • Geographic proximity to treatment services. • Provider does not have the experience treating members with substance use and/or is unaware of the available treatment options in the community. • Member does not feel informed about the treatment process. • Member is not motivated to participate in ongoing treatment. • Fear of stigma and/or lack of confidentiality associated with SUD.	• Accessibility of SUD treatment services. • SUD provider capacity and availability to treat high-volume of members. • Provider knowledge and comfort level surrounding substance use care. • Member awareness and understanding of available SUD treatment options and resources. • Member motivation in participating in ongoing treatment. • Reduced fear of stigma and discomfort to assessing substance use services.	• Promote utilization of MDLIVE telehealth service and other telehealth services. • Promote nonemergency transportation benefit and friends and family reimbursement incentive. • Distribute provider-facing SUD education packet. • Develop member-facing SUD education materials.

WS has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, the MCO will be testing an intervention focused on provider education

concerning the use of care gap reports to identify and outreach members due for diabetes screening. For the *Continued Engagement of Opioid Abuse or Dependence Treatment* PIP, **WS** will be testing two interventions. One intervention will focus on provider education on SUD care resources and the second intervention will focus on provider outreach regarding telehealth options for SUD care. Details of the intervention testing plans will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until SFY 2022; therefore, final outcomes for these PIPs will be included in the SFY 2022 annual EQR technical report.

Conclusions and Recommendations

ACNH

The validation findings suggest that **ACNH** was successful at building the PIP team and developing methodologically sound projects. **ACNH** used QI tools to identify opportunities for improvement within its current processes, which led to the determination of interventions to test as the MCO moves forward with the PIP process.

As **ACNH** moves into intervention testing, HSAG has the following recommendations:

- When testing interventions, **ACNH** should make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- **ACNH** should clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- **ACNH** should regularly update the key driver diagram for the PIPs to incorporate knowledge gained and lessons learned as the MCO progresses through the steps for determining and testing interventions.
- Once **ACNH** has obtained 12 months of data to calculate baseline performance, the MCO should set a quantitative goal for improvement and finalize the SMART Aim statement for each PIP.

NHHF

The validation findings suggest that **NHHF** was successful at building the PIP team and developing methodologically sound projects. **NHHF** used QI tools to identify opportunities for improvement within its current processes, which led to the determination of interventions to test as the MCO moves forward with the PIP process.

As **NHHF** moves into intervention testing, HSAG has the following recommendations:

- When testing interventions, **NHHF** should make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.

- **NHHF** should clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.

WS

The validation findings suggest that **WS** was successful at building the PIP team and developing methodologically sound projects. **WS** used QI tools to identify opportunities for improvement within its current processes, which led to the determination of interventions to test as the MCO moves forward with the PIP process.

As **WS** moves into intervention testing, HSAG has the following recommendations:

- When testing interventions, **WS** should make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- **WS** should clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- **WS** should regularly update the key driver diagram for the PIPs to incorporate knowledge gained and lessons learned as the MCO progresses through the steps for determining and testing interventions.

PMV

The following section of the report describes the results of HSAG's SFY 2020 EQR activities specific to validation of performance measures. This section provides conclusions as to the strengths and areas of opportunity related to the *quality of care*, *timeliness of care*, and *access to care* provided by the New Hampshire Medicaid MCOs. During SFY 2020, each MCO submitted rates for 13 state-specific measures that were validated during PMV. Recommendations are offered to each MCO to facilitate continued QI in the Medicaid program. The measures reviewed in SFY 2020 and a complete description of the audit methodology used to conduct the review of performance measures are included in Appendix B.

Table 4-10—SFY 2020 PMV Findings

Audit Element	ACNH	NHHF	WS
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable	Acceptable

Audit Element	ACNH	NHHF	WS
Appropriate provider data systems and processing	Acceptable	Acceptable	Acceptable
Appeals data system and process findings	Acceptable	Acceptable	Acceptable
Prior authorization and case management data system and process findings	Acceptable	Acceptable	Acceptable
Performance measure production and reporting findings	Acceptable	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable	Acceptable

Conclusions and Recommendations for Improvement

ACNH

ACNH used a variety of methods for producing the measures under review and had staff members who were dedicated to quality reporting. **ACNH** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations and had sufficient policies and procedures in place to ensure reporting accuracy. **ACNH** demonstrated its knowledge of the measures and provided system demonstrations without issue during the Webex meeting. HSAG had no concerns with the measure production for any measure under review this year.

HSAG recommends that **ACNH** communicate regularly with the measure-producing staff members to ensure any changes to measures are captured and reported accurately.

HSAG recommends that **ACNH** conduct internal audits of all measures through sampling and trend rates over time. Several measures did not have sufficient history to produce any results.

NHHF

NHHF used a variety of methods for producing the measure under review and had staff members who were dedicated to quality reporting. **NHHF** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **NHHF** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production for any measure under review this year.

NHHF completed all measures without issue during the reporting period. There were no adjustments or data reconsiderations that needed correction.

HSAG continues to recommend that **NHHF** communicate regularly with the measure-producing staff members to ensure any changes to measures are captured and reported accurately.

WS

WS used a variety of methods for producing the measure under review. The measures underwent source code review by HSAG to ensure eligible populations, numerators, and denominators were accounted for accurately. HSAG had no concerns with the measure production for any measure under review this year.

HSAG continues to recommend that **WS** communicate regularly with the measure-producing staff members to ensure any changes to measures are captured and reported accurately.

CAHPS

This year **NHHF** and **WS** administered the CAHPS survey. **ACNH** began operations in New Hampshire on September 1, 2019. No CAHPS results were available for CY 2019 for **ACNH** because none of the members met the enrollment and eligibility criteria.

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with healthcare. 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 **WS** were responsible for obtaining a CAHPS vendor to conduct CAHPS surveys of its adult and child Medicaid populations. Symphony Performance Health Analytics (SPHA), an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2020 CAHPS surveys for **NHHF** and **WS**.

Technical Methods of Data Collection

For both **NHHF** and **WS**, 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 **WS** used a mixed-mode methodology for data collection for the adult and child Medicaid populations.[4-3] Adult members and parents or caretakers of child members completed the surveys in 2020, following NCQA's data collection protocol.

The CAHPS 5.0H Surveys include a set of standardized items (40 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.0H Child Medicaid Health Plan Survey with CCC measurement set) that assess patient perspectives on care. This year, one composite measure, *Shared Decision Making*, was eliminated from the CAHPS survey which changed the number of total measures displayed in this report from nine to eight. The survey questions were categorized into eight

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[4-3] For the adult and child Medicaid populations, **NHHF** used a mixed-mode (i.e., mail, telephone, and Internet protocol) survey methodology pre-approved by NCQA. **WS** also used a mixed-mode (i.e., mail, telephone, and Internet protocol) survey methodology pre-approved by NCQA.

measures of satisfaction. These measures included four global ratings and four composite scores.[4-4] The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures 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 experience 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 (i.e., positive response). For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composites was defined as a response of "Usually/Always." The percentage of positive responses is referred to as a global proportion for the composite measures. The positive rates presented in this report for **NHHF** and **WS** 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 2019 NCQA CAHPS adult and general child Medicaid national averages, where applicable.[4-5]

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

A total of 2,228 **NHHF** adult Medicaid members were surveyed in 2020, of which 382 completed surveys were returned. After ineligible members were excluded, the response rate was 17.4 percent. In 2020, the **NHHF** adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey, which was 19.6 percent. Figure 4-1 and Figure 4-2 show the 2020 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA

[4-4] For this report, the 2020 Child Medicaid CAHPS results presented for **NHHF** and **WS** are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

[4-5] National data were obtained from the 2019 Quality Compass. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2019 national averages for the global ratings and composite measures, respectively, for **NHHF**'s adult Medicaid population.

NHHF

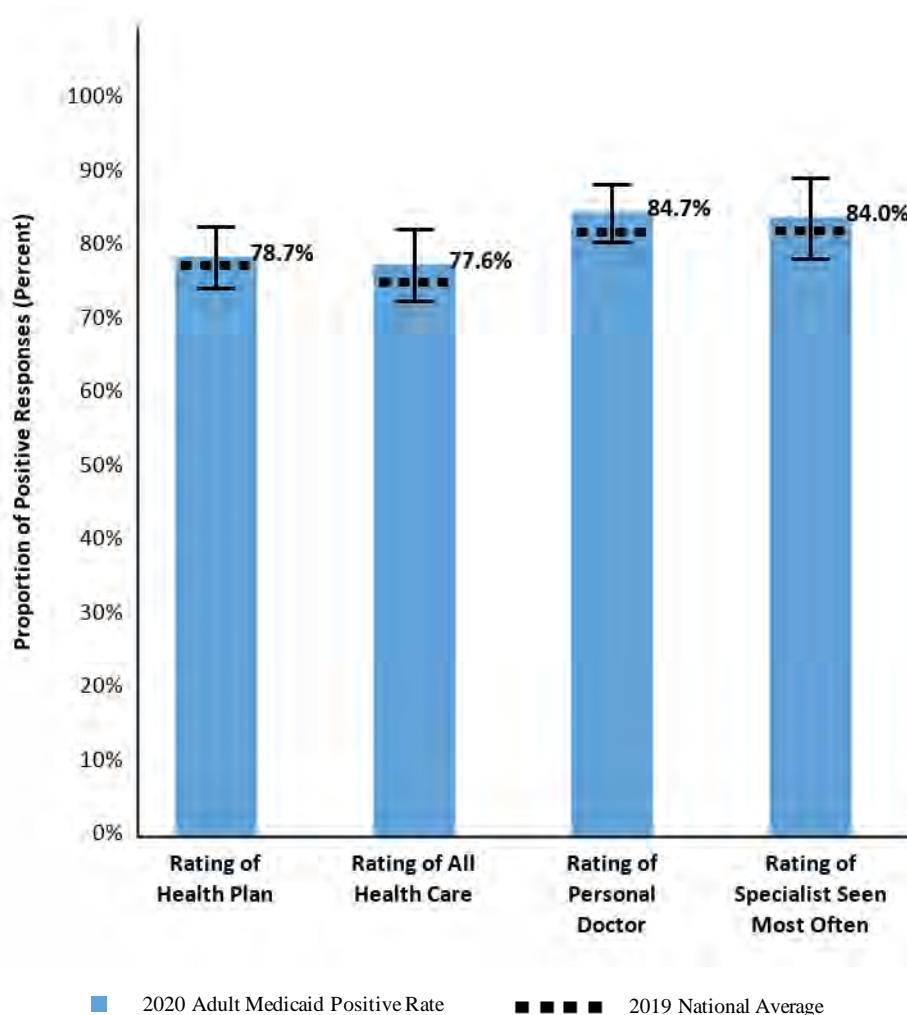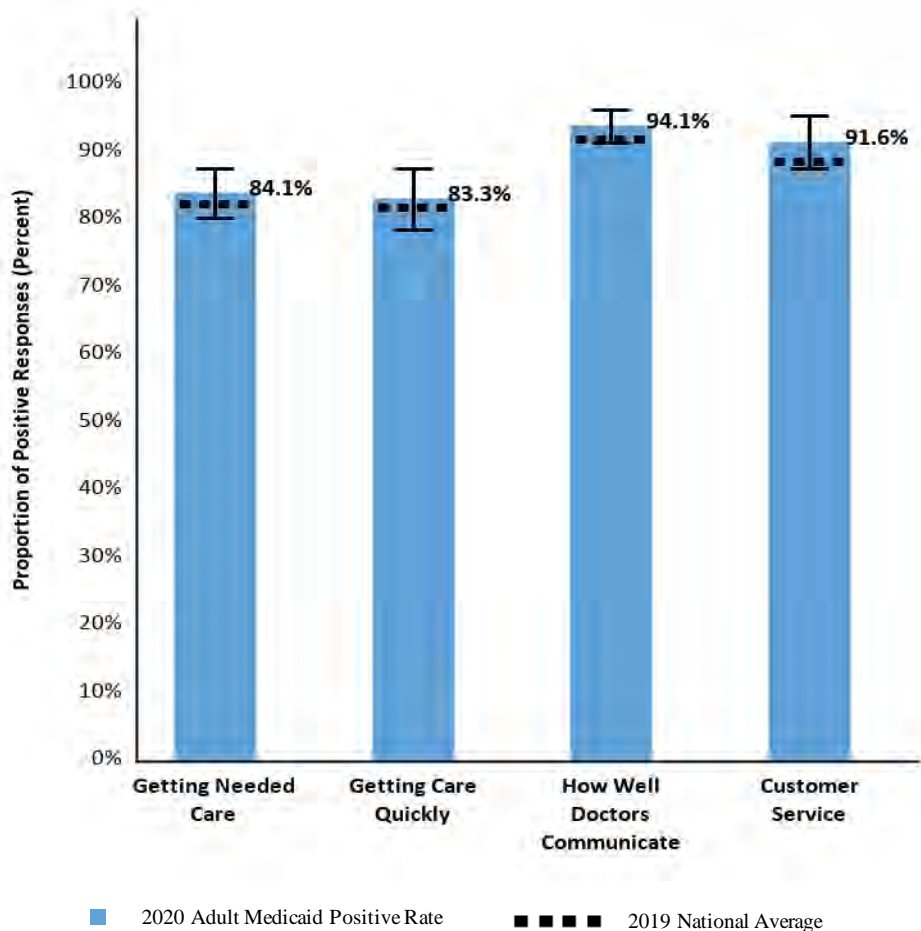**Figure 4-1—NHHF Adult Medicaid CAHPS Results: Global Ratings**

Legend: 2020 Adult Medicaid Positive Rate · 2019 National Average

Values shown: Rating of Health Plan 78.7%, Rating of All Health Care 77.6%, Rating of Personal Doctor 84.7%, Rating of Specialist Seen Most Often 84.0%

Figure 4-2—NHHF Adult Medicaid CAHPS Results: Composite Measures

For **NHHF**'s adult Medicaid population, all rates were higher than NCQA's 2019 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

A total of 2,640 **NHHF** general child Medicaid members were surveyed in 2020, of which 410 completed surveys were returned on behalf of these members. After ineligible members were excluded, the response rate was 15.6 percent. In 2020, the **NHHF** general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set, which was 18.4 percent.[4-6] Figure 4-3 and Figure 4-4 show the 2020 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2019 national averages for the global ratings and composite measures, respectively, for **NHHF**'s general child Medicaid population.[4-7]

Figure 4-3—NHHF Child Medicaid CAHPS Results: Global Ratings

| 2020 Child Medicaid Positive Rate | 2019 National Average |
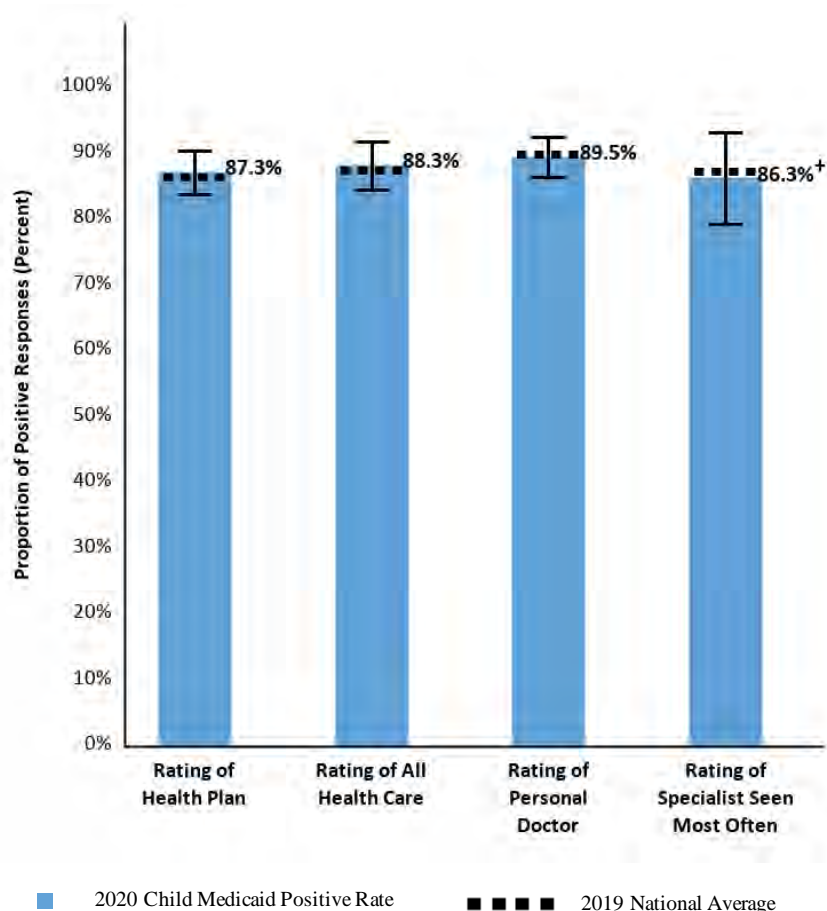
4-6   The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid beneficiaries in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

4-7   The 2020 child Medicaid CAHPS results presented in Figure 4-3 and Figure 4-4 for **NHHF** are based on results of the general child population only.

Figure 4-4—NHHF Child Medicaid CAHPS Results: Composite Measures
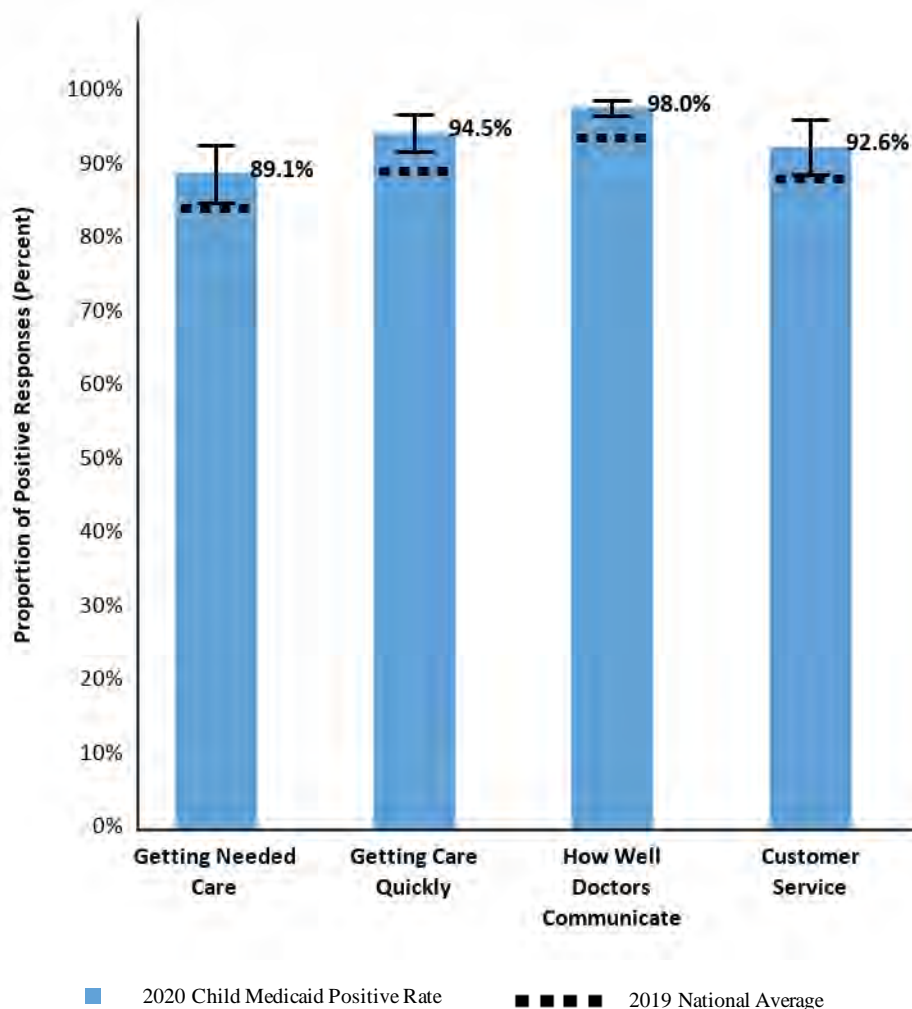
For **NHHF**'s general child Medicaid population, all rates were higher than NCQA's 2019 Medicaid national averages, except for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. Four rates, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, were statistically significantly higher than NCQA's 2019 Medicaid national average, while the remaining four rates were neither statistically significantly higher nor lower than the national averages.

WS

A total of 2,295 **WS** adult Medicaid members were surveyed in 2020, of which 352 completed surveys were returned. After ineligible members were excluded, the response rate was 15.5 percent. In 2020, the **WS** adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey, which was 19.6 percent. Figure 4-5 and Figure 4-6 show the 2020 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2019 national averages for the global ratings and composite measures, respectively, for **WS**'s adult Medicaid population.

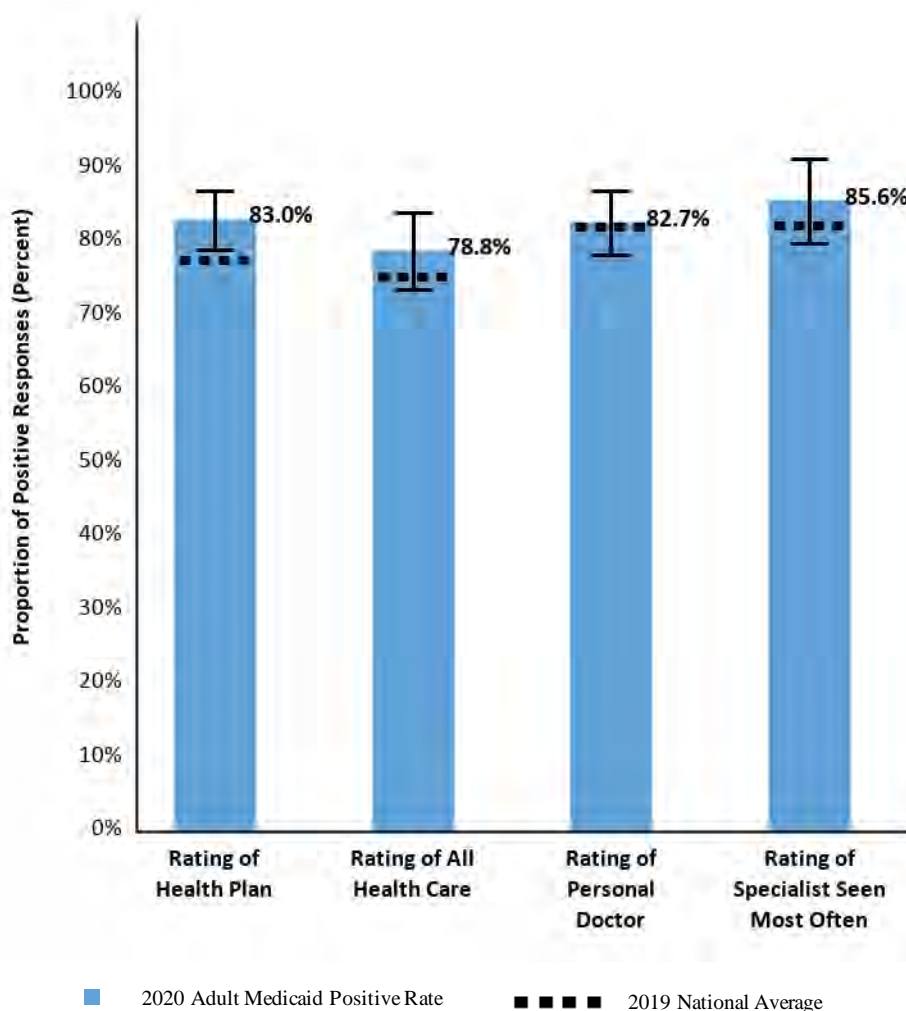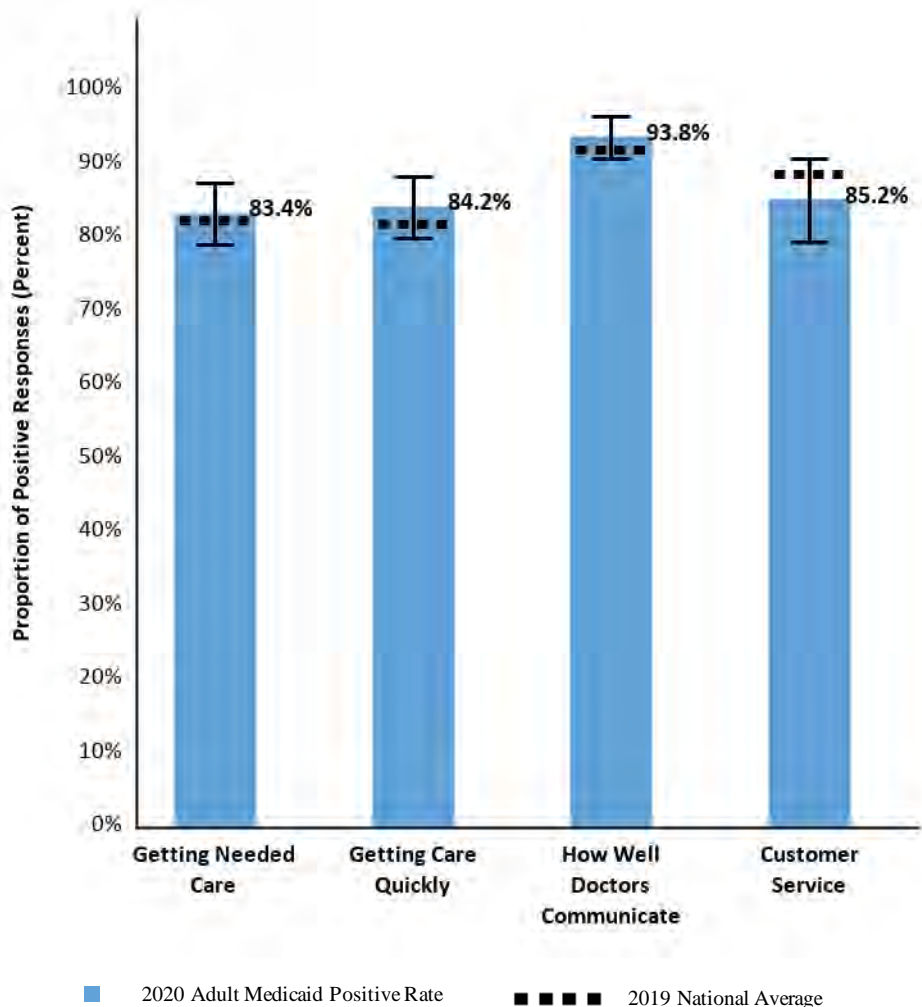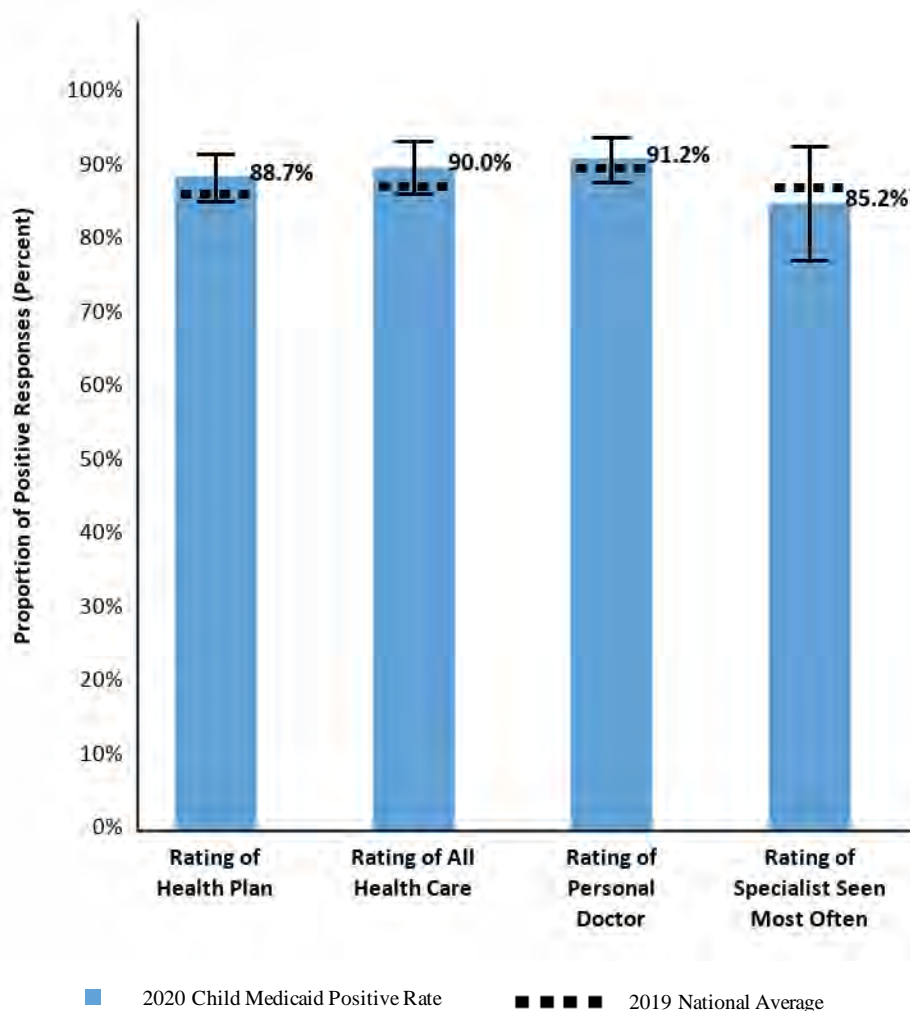**Figure 4-5—WS Adult Medicaid CAHPS Results: Global Ratings**

Figure 4-6—WS Adult Medicaid CAHPS Results: Composite Measures

For **WS**'s adult Medicaid population, all rates were higher than NCQA's 2019 Medicaid national averages, except for *Customer Service.* One rating, *Rating of Health Plan*, was statistically significantly higher than NCQA's 2019 Medicaid national average. The remaining seven rates were neither statistically significantly higher nor lower than the national averages.

A total of 2,475 **WS** general child Medicaid members were surveyed in 2020, of which 373 completed surveys were returned on behalf of these members. After ineligible members were excluded, the response rate was 15.2 percent. In 2020, the **WS** general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set, which was 18.4 percent.[4-8] Figure 4-7 and Figure 4-8 show the 2020 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2019 national averages for the global ratings and composite measures, respectively, for **WS**'s general child Medicaid population.[4-9]

Figure 4-7—WS Child Medicaid CAHPS Results: Global Ratings

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

[4-9]   The 2020 child Medicaid CAHPS results presented in Figure 4-7 and Figure 4-8 for **WS** are based on results of the general child population only.

Figure 4-8—WS Child Medicaid CAHPS Results: Composite Measures
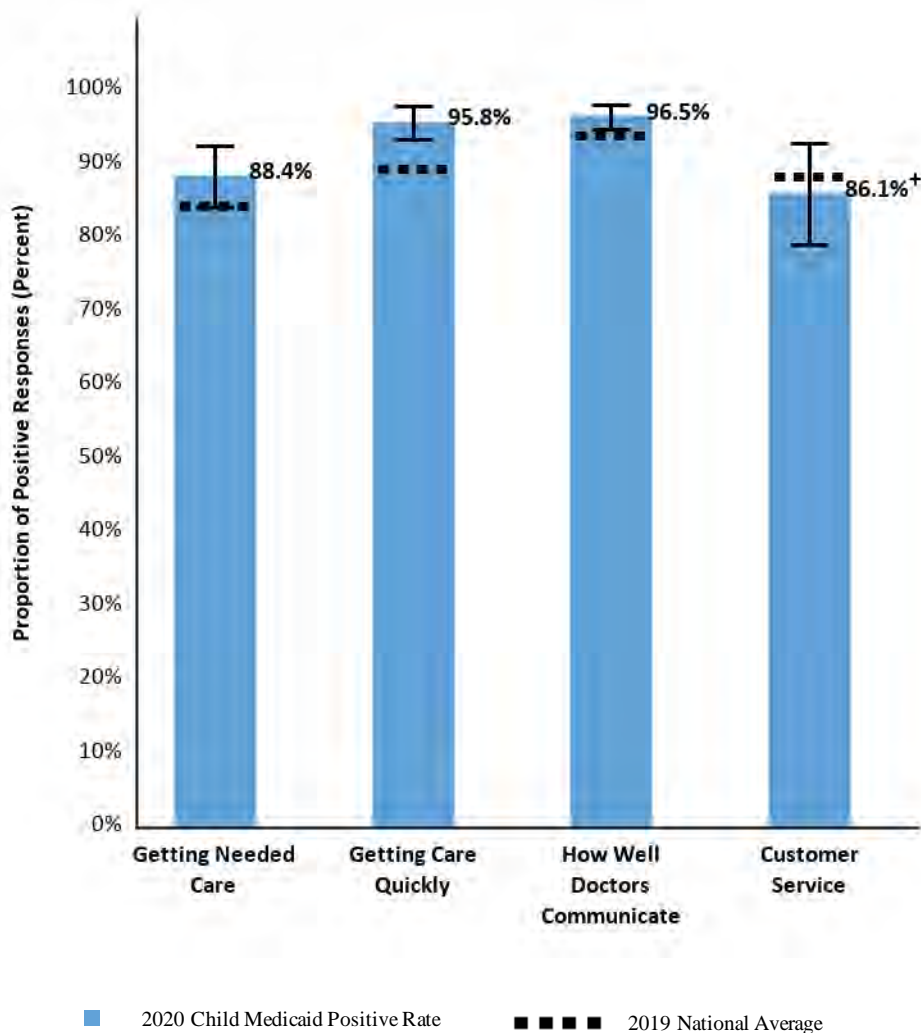
For **WS**'s general child Medicaid population, all rates were higher than NCQA's 2019 Medicaid national average, except for *Rating of Specialist Seen Most Often* and *Customer Service*. Two rates, *Getting Care Quickly* and *How Well Doctors Communicate*, were statistically significantly higher than NCQA's 2019 Medicaid national averages, while the remaining seven rates were neither statistically significantly higher nor lower than the national averages.

Conclusions and Recommendations for Improvement

NHHF

HSAG compared the adult and child Medicaid populations' 2020 CAHPS survey results to the 2019 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2019 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2019 NCQA Medicaid national averages, HSAG recommends that **NHHF** focus QI efforts on the *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* for the child population as these rates fell below the national average.

The rates for *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 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. **NHHF** should consider obtaining feedback from patients on their recent office visit, such as a follow-up call or email, to gather more information concerning areas for improvement.

WS

HSAG performed a comparison of the adult and child Medicaid populations' 2020 CAHPS survey results to the 2019 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2020 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2019 NCQA Medicaid national averages, HSAG recommends that **WS** focus its QI efforts on the *Customer Service* measure, as this rate fell below the national average for both the adult and child populations, as well as *Rating of Specialist Seen Most Often* for the child population.

To improve CAHPS rates, **WS** could consider involving MCO staff members at every level to assist in improving *Rating of Specialist Seen Most Often* and *Customer Service* rates. To improve the rate for *Rating of Specialist Seen Most Often*, **WS** could include reminders about the importance of improving communication 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 could 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 and manage their conditions. **WS** should ensure providers share their patients' summaries of

their medical record and/or health assessments with them and talk to them about their health issues. **WS** should consider obtaining feedback from patients on their recent office visit, such as a follow-up call or email, to gather more information concerning areas for improvement.

The rates for *Customer Service* could be improved by conducting an evaluation of current MCO call center hours and practices to determine if the hours and resources meet members' needs. **WS** could further promote the use of existing after-hours customer service to improve customer service results. The MCO's Member Advisory Board could be used to better understand what constitutes high quality services from the perspective of its members. **WS** could appoint work groups from call center staff members to develop service standards that clearly inform staff members what is expected of them during their interactions with members.

HEDIS

This year **NHHF** and **WS** administered the HEDIS survey. **ACNH** operations in New Hampshire began September 1, 2019. No HEDIS results were available for CY 2019 because none of the members in **ACNH** met the enrollment and eligibility criteria.

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

This standard assesses whether:

- Industry standard codes are used, and all characters are captured.
- Principal codes are identified, and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields. Measure Results was moved relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.
- Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure the accurate entry and processing 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, 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.

- Data approved for Electronic Clinical Data System reporting met reporting requirements.
- NCQA-certified Electronic Clinical Quality Measure (eCQM) data met reporting requirements.

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

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.
- Data transfers to HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting is suitable for measures and enable required programming efforts.
- Report production is managed effectively, and operators perform appropriately.
- The organization regularly monitors vendor performance against expected performance standards.

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

This standard assesses whether:

- Data transfers to HEDIS repository from transaction files are accurate.
- 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 and **WS** were found to be fully compliant with all applicable IS assessment standards. The HEDIS audits confirmed that the MCOs had the systems, processes, and data control procedures necessary to ensure that all data relevant to HEDIS measure calculation were stored, maintained, translated, and analyzed appropriately. The MCOs demonstrated the accuracy and completeness of their primary databases, which contained claims and encounters, membership and enrollment, and provider credentialing data. The MCOs also demonstrated the ability to appropriately store data used for HEDIS reporting.

HEDIS Measures Results

HSAG organized, aggregated, and analyzed the validated performance measure data to draw conclusions about **NHHF**'s and **WS**'s performance in providing quality, accessible, and timely care to its members. The following performance measure results reflect all three domains of care—quality of care, timeliness

of care, and access to care. Each figure contains HEDIS 2020 (CY 2019) performance measure rates for **NHHF** (i.e., the bar shaded dark blue) and **WS** (i.e., the bar shaded light blue), along with national benchmarks (i.e., the bar shaded light red, orange, yellow, and green), when applicable. The national benchmarks stacked bar is shaded to indicate percentiles (i.e., light red represents the 25th percentile, orange represents the 50th percentile, yellow represents the 75th percentile, and green represents the 90th percentile). National benchmarks are based on NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018. Additionally, due to specification changes in HEDIS 2020 (CY 2019), comparisons to percentiles are not appropriate for some measures as indicated on the following figures. NCQA also retired one measure previously included in this report, *Annual Monitoring for Patients on Persistent Medications (MPM)—Total*.

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 2019. **NHHF**'s and **WS**'s *AAP—Total* measure results are shown in Figure 4-9.
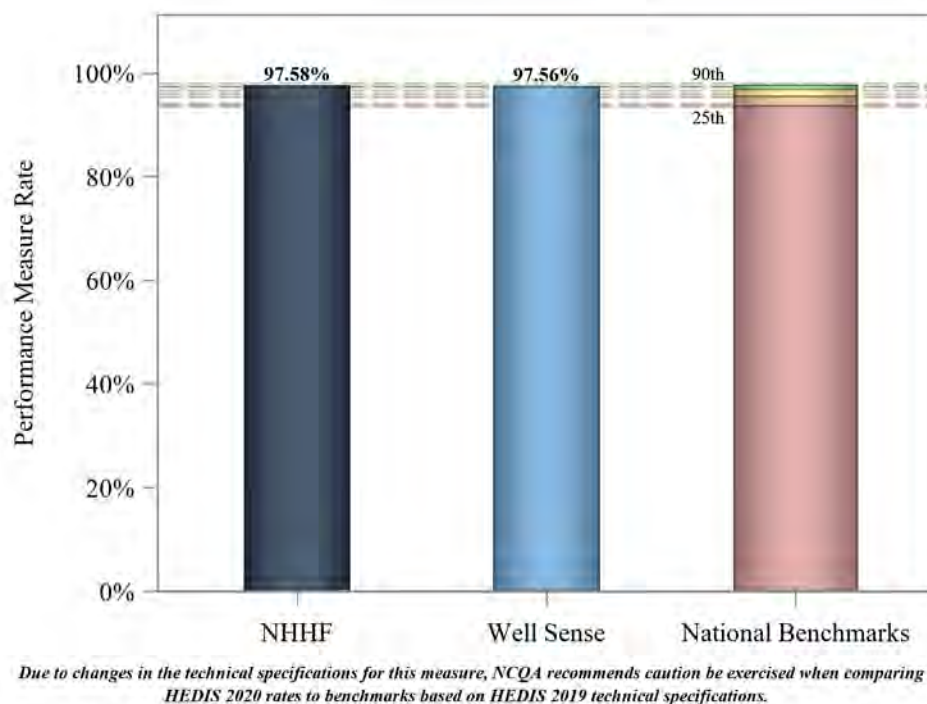
Figure 4-9—CY 2019 *AAP—Total* Measure Results
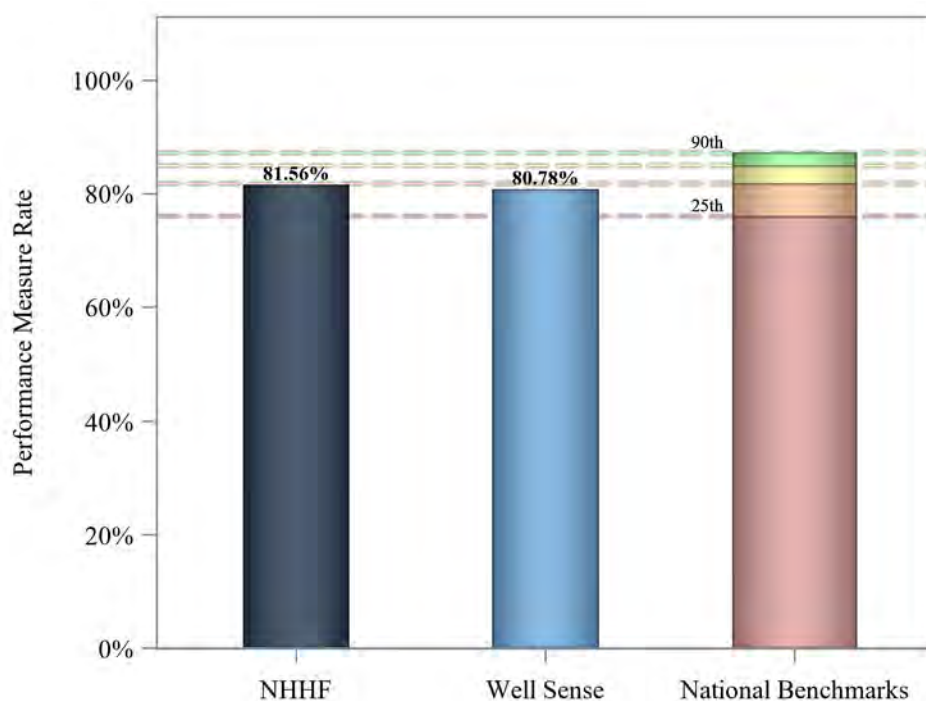
NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

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 2019. **NHHF**'s and **WS**'s *CAP—12–24 Months* measure results are shown in Figure 4-10.

Figure 4-10—CY 2019 *CAP—12–24 Months* Measure Results

Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.
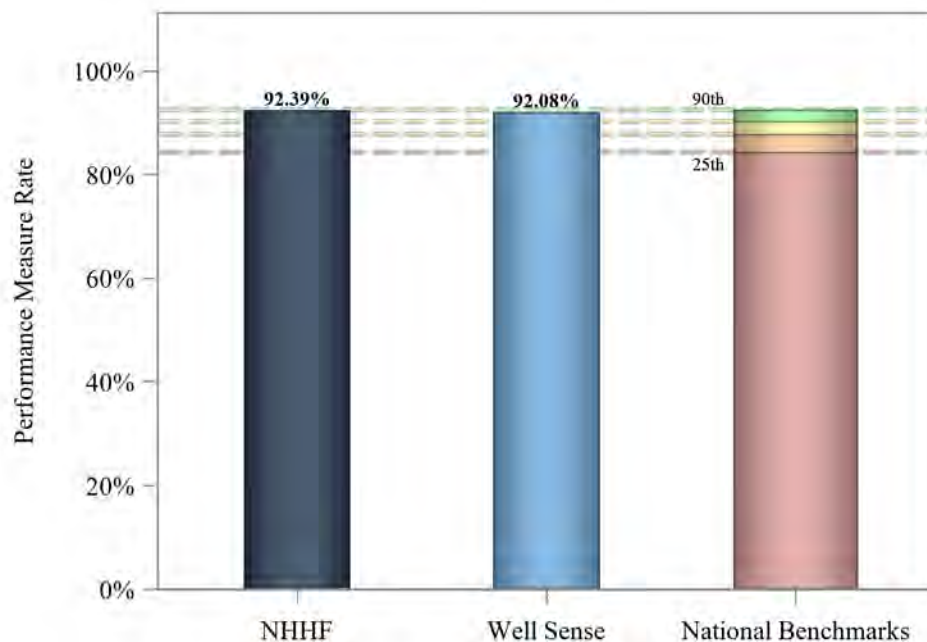
NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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 2019. **NHHF**'s and **WS**'s *CAP—25 Months–6 Years* measure results are shown in Figure 4-11.

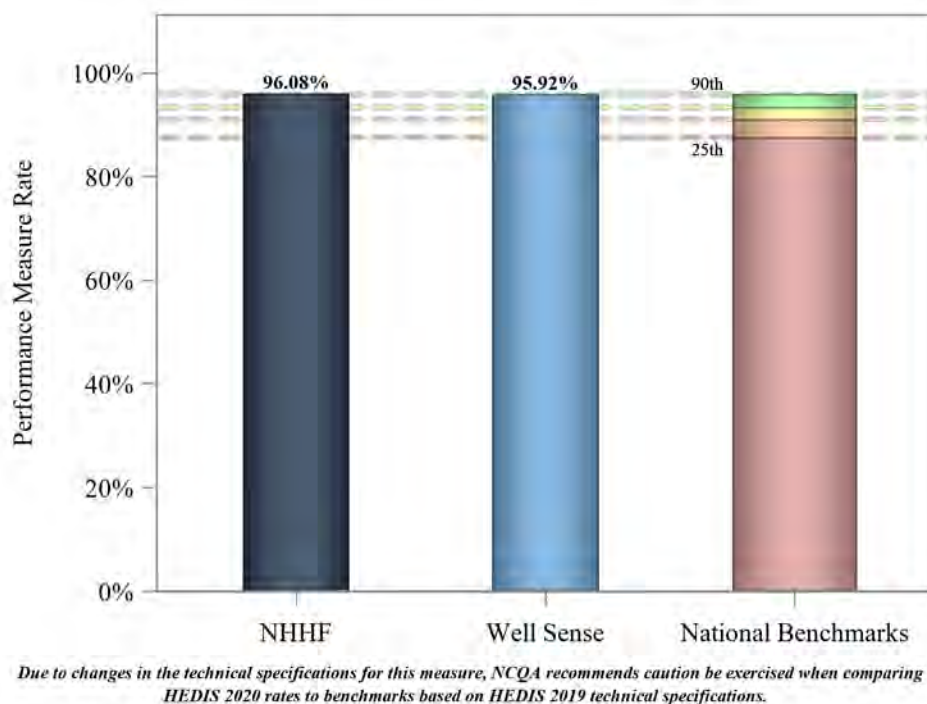**Figure 4-11—CY 2019 *CAP—25 Months–6 Years* Measure Results**

Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.

NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 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 2018 or 2019. **NHHF**'s and **WS**'s *CAP—7–11 Years* measure results are shown in Figure 4-12.

Figure 4-12—CY 2019 *CAP—7–11 Years* Measure Results

Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.
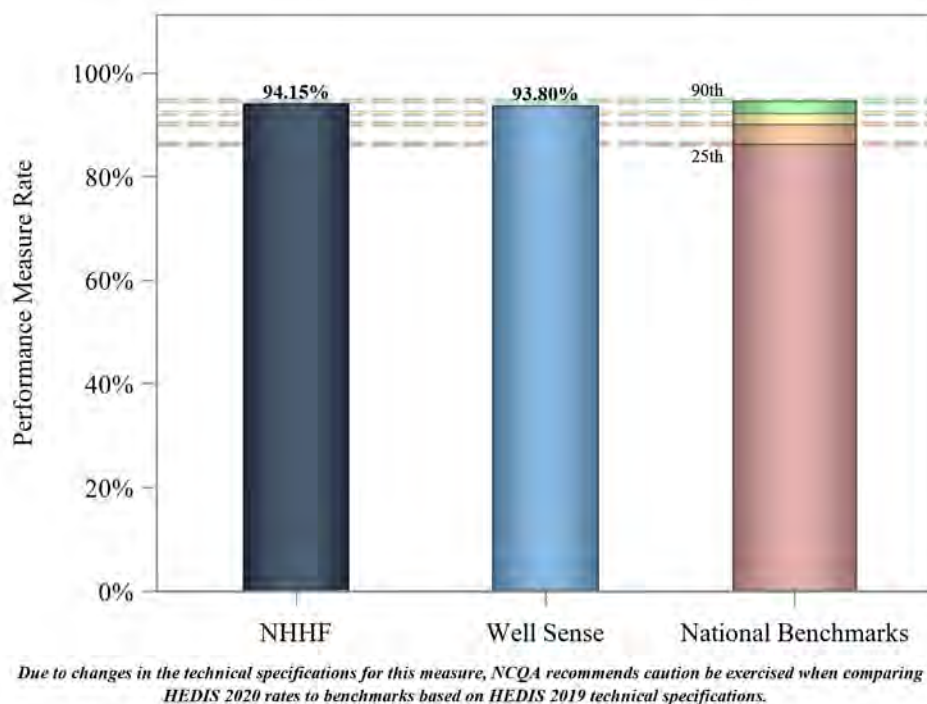
NHHF's and **WS**'s reported rates ranked at or above the 90th percentile.

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 2018 or 2019. **NHHF**'s and **WS**'s *CAP—12–19 Years* measure results are shown in Figure 4-13.

Figure 4-13—CY 2019 *CAP—12–19 Years* Measure Results

Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.
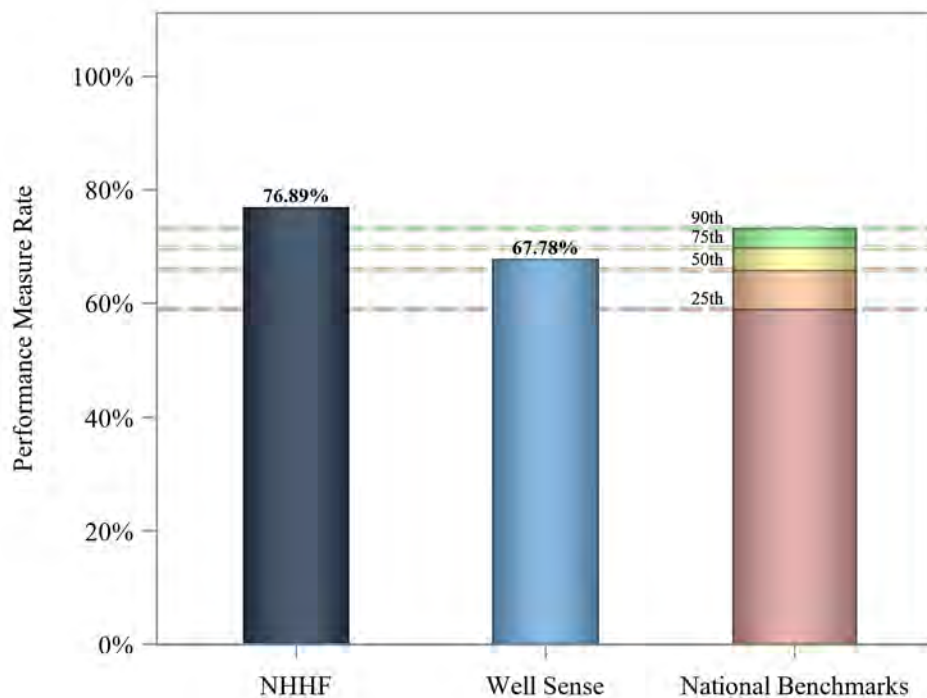
NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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 2019 and who received six or more well-child visits with a PCP during their first 15 months of life. **NHHF**'s and **WS**'s *W15—Six or More Visits* measure results are shown in Figure 4-14.

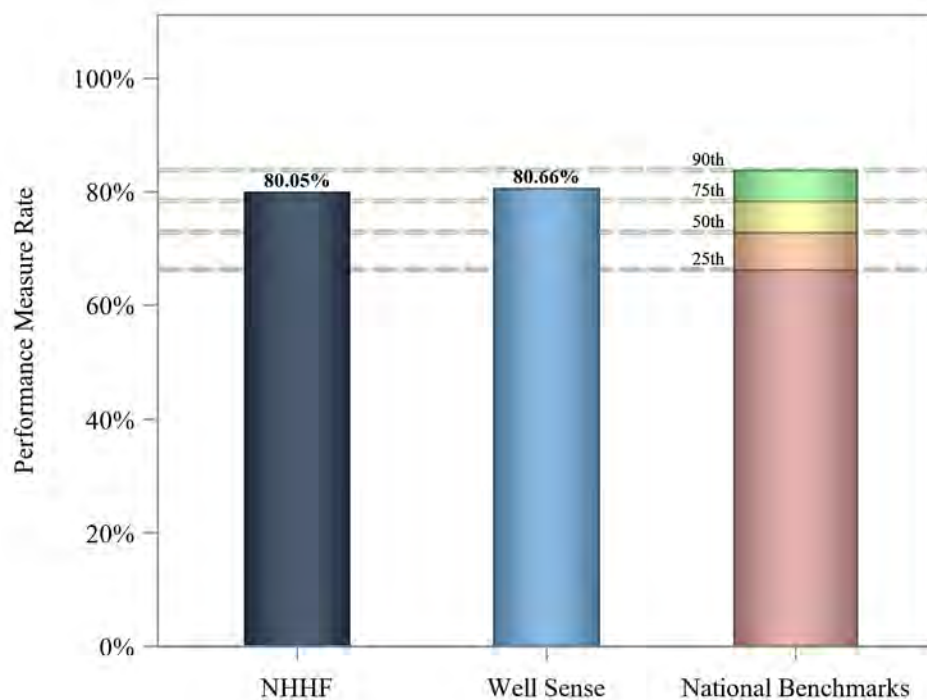**Figure 4-14—CY 2019 *W15—Six or More Visits* Measure Results**

NHHF's reported rate ranked at or above the 90th percentile, and **WS**'s reported rate ranked at or above the 50th percentile but below the 75th 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 2019. **NHHF**'s and **WS**'s *W34* measure results are shown in Figure 4-15.

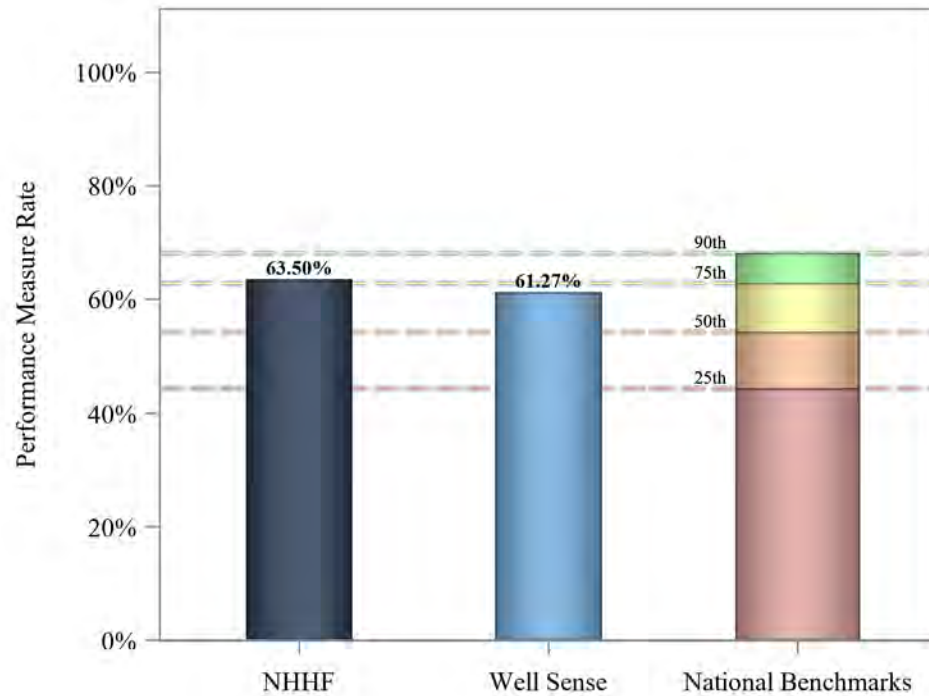**Figure 4-15—CY 2019 *W34* Measure Results**

NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

Adolescent Well-Care Visits (AWC)

AWC measures the percentage of members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) practitioner during 2019. **NHHF**'s and **WS**'s *AWC* measure results are shown in Figure 4-16.
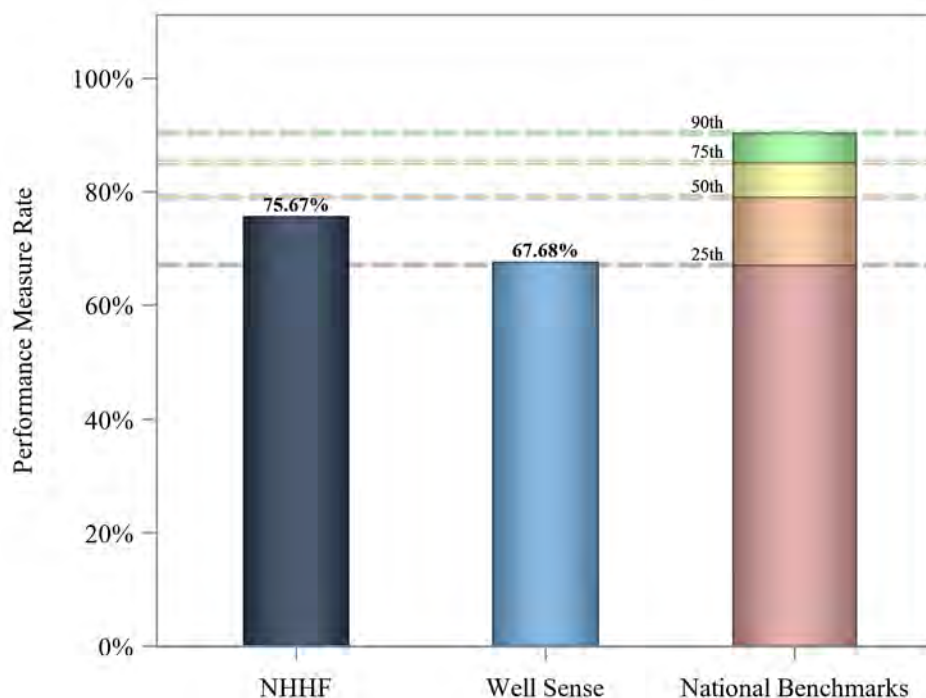
Figure 4-16—CY 2019 *AWC* Measure Results

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate ranked at or above the 50th percentile but below the 75th 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—Total 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 2019. **NHHF**'s and **WS**'s *WCC—BMI Percentile Documentation—Total* measure results are shown in Figure 4-17.

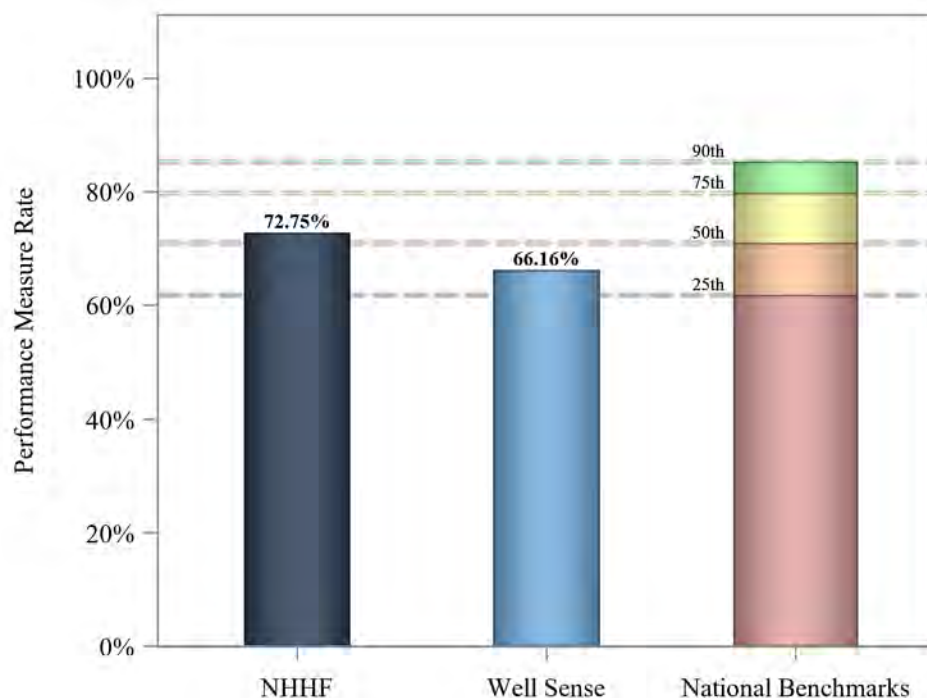**Figure 4-17—CY 2019 *WCC—BMI Percentile Documentation* Measure Results**

NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

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

WCC—Counseling for Nutrition—Total 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 2019. **NHHF**'s and **WS**'s *WCC—Counseling for Nutrition—Total* measure results are shown in Figure 4-18.

Figure 4-18—CY 2019 *WCC—Counseling for Nutrition—Total* Measure Results

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

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

WCC—Counseling for Physical Activity—Total 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 2019. **NHHF**'s and **WS**'s *WCC—Counseling for Physical Activity—Total* measure results are shown in Figure 4-19.

Figure 4-19—CY 2019 *WCC—Counseling for Physical Activity—Total* Measure Results
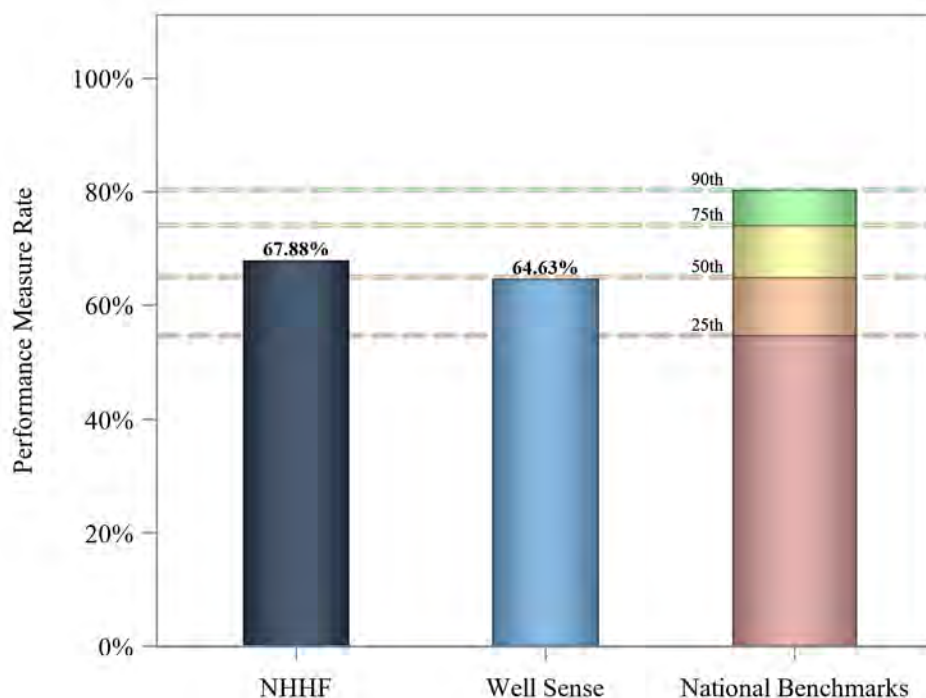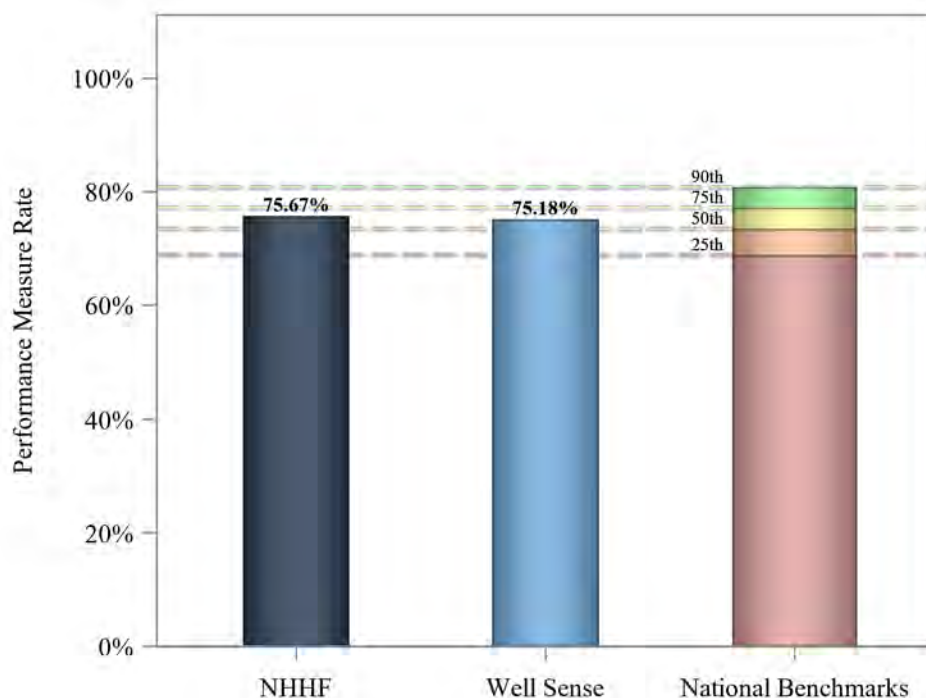

NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)

CIS—Combination 2 measures the percentage of children who turned 2 years of age during 2019 and who received four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenzae type B (HiB); three hepatitis B (HepB); and one chicken pox (VZV) vaccines by their second birthday. **NHHF**'s and **WS**'s *CIS—Combination 2* measure results are shown in Figure 4-20.

Figure 4-20—CY 2019 *CIS—Combination 2* Measure Results

NHHF's and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

Childhood Immunization Status (CIS)—Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)

CIS—Combination 10 measures the percentage of children who turned 2 years of age during 2019 and who received four DTaP; three IPV; one MMR; three HiB; three HepB; one VZV; four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. **NHHF**'s and **WS**'s *CIS—Combination 10* measure results are shown in Figure 4-21.

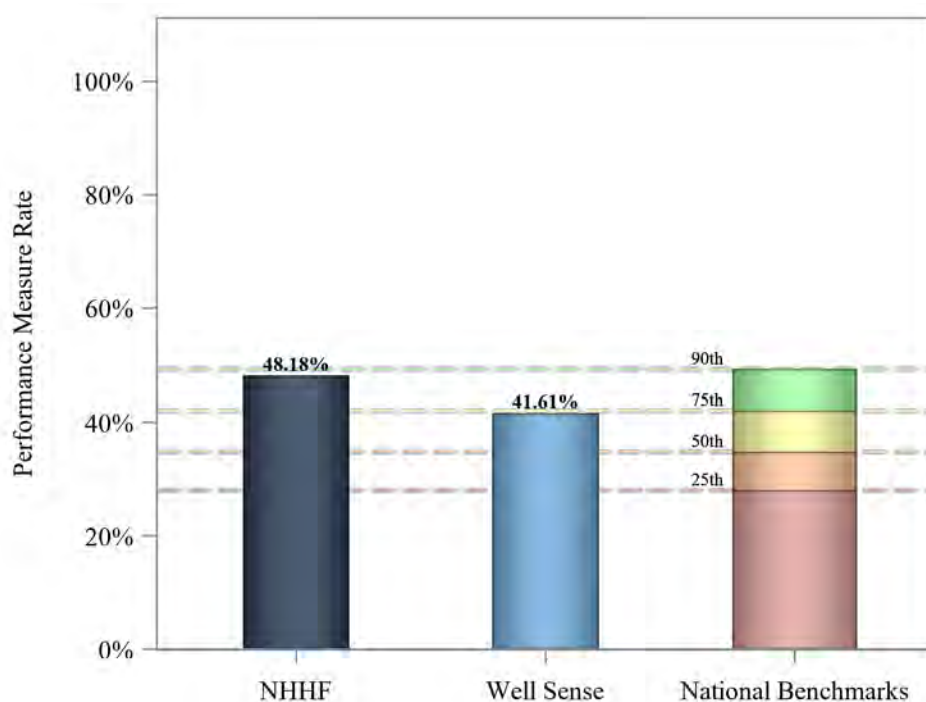**Figure 4-21—CY 2019 *CIS—Combination 10* Measure Results**

NHHF's reported rates ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

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

IMA—Combination 1 measures the percentage of adolescents 13 years of age during 2019 who received one meningococcal conjugate vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. **NHHF**'s and **WS**'s *IMA—Combination 1* measure results are shown in Figure 4-22.

Figure 4-22—CY 2019 *IMA—Combination 1 (Meningococcal, Tdap)* Measure Results

NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Immunization of Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)

IMA—Combination 2 measures the percentage of adolescents 13 years of age during 2019 who received one dose of meningococcal vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and at least two HPV vaccines by their 13th birthday. **NHHF**'s and **WS**'s *IMA—Combination 2* measure results are shown in Figure 4-23.
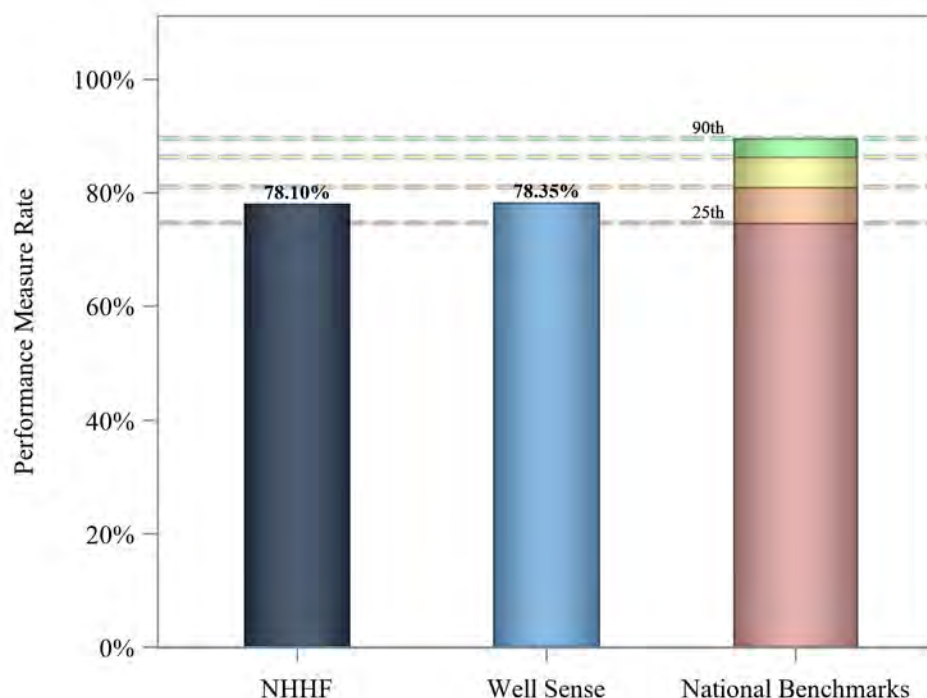
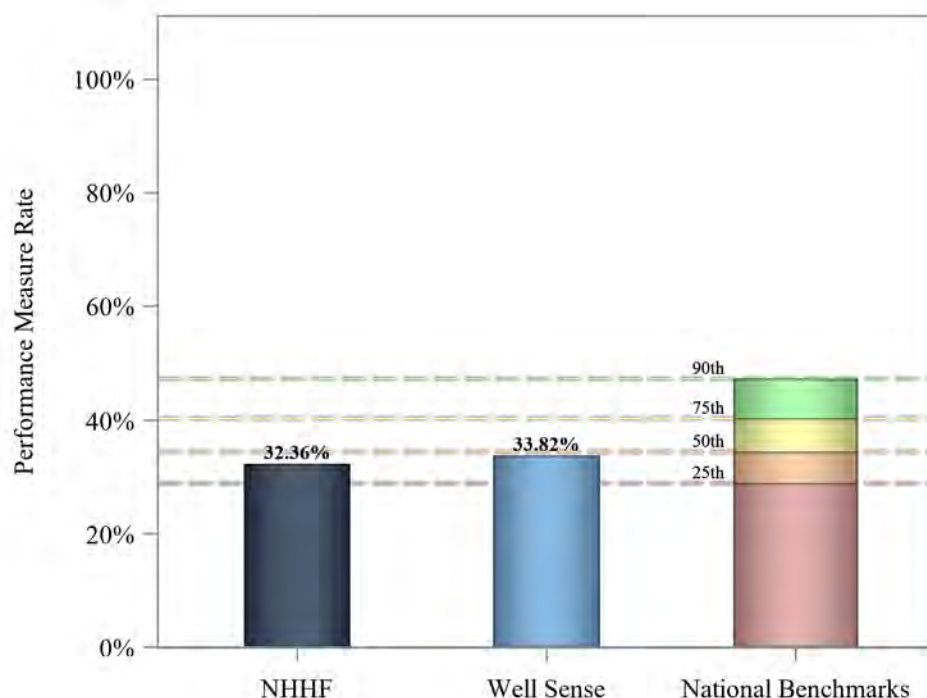**Figure 4-23—CY 2019 *IMA—Combination 2 (Meningococcal, Tdap, HPV)* Measure Results**

NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th 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 2019. **NHHF**'s and **WS**'s *CCS* measure results are shown in Figure 4-24.

Figure 4-24—CY 2019 *CCS* Measure Results
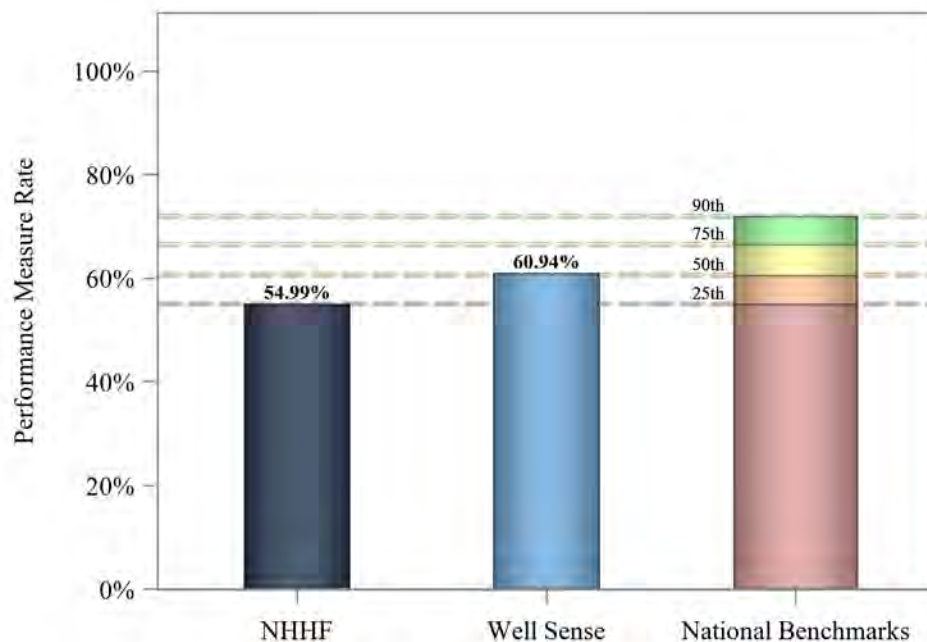
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.

NHHF's reported rate ranked at or above the 25th percentile but below the 50th percentile, and **WS**'s reported rate ranked at or above the 50th percentile but below the 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 2019. **NHHF**'s and **WS**'s *NCS* measure results are shown in Figure 4-25. Note, lower rates for this measure indicate better performance. HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures. For example, the 25th percentile (a lower rate) was reversed to become the 90th percentile, indicating better performance.

Figure 4-25—CY 2019 *NCS* Measure Results
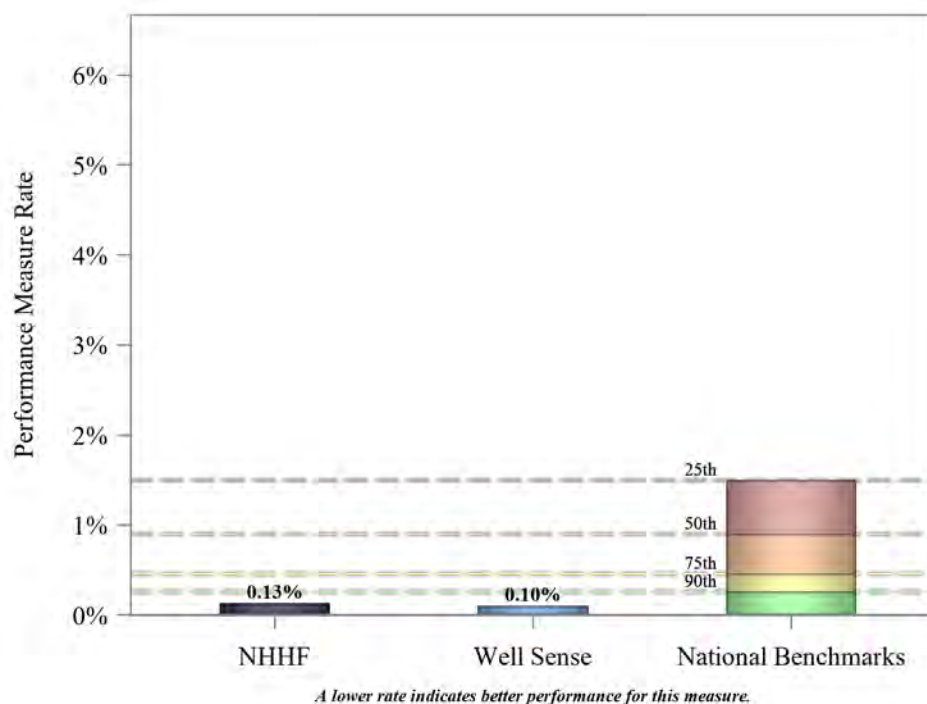
A lower rate indicates better performance for this measure.

NHHF's and **WS**'s reported rates exceeded the 90th percentile.

Chlamydia Screening in Women (CHL)—16–20 Years

CHL—16–20 Years measures the percentage of women 16 to 20 years of age identified as sexually active who had at least one test for chlamydia during 2019. **NHHF**'s and **WS**'s *CHL—16–20 Years* measure results are shown in Figure 4-26.

Figure 4-26—CY 2019 *CHL—16–20 Years* Measure Results
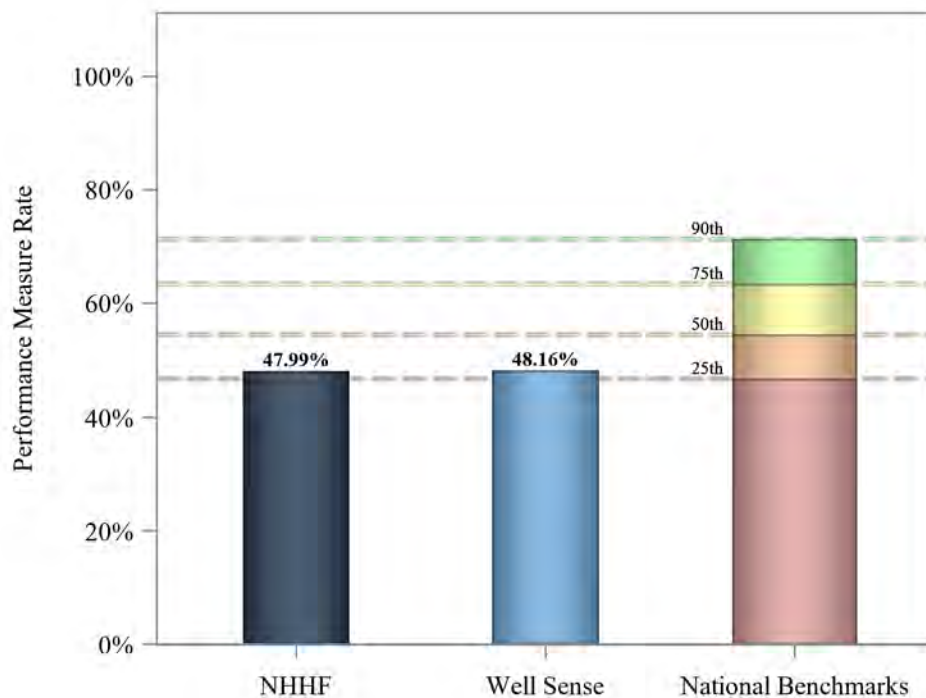
NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Chlamydia Screening in Women (CHL)—21–24 Years

CHL—21–24 Years measures the percentage of women 21 to 24 years of age identified as sexually active who had at least one test for chlamydia during 2019. **NHHF**'s and **WS**'s *CHL—21–24 Years* measure results are shown in Figure 4-27.

Figure 4-27—CY 2019 *CHL—21–24 Years* Measure Results
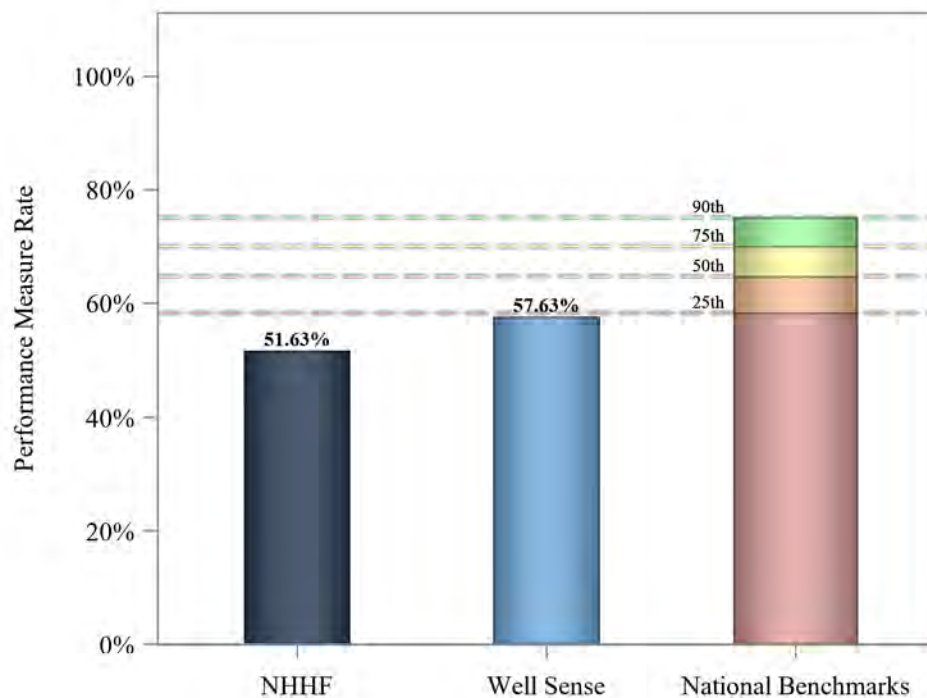
NHHF's and **WS**'s reported rates ranked below the 25th percentile.

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 2019. **NHHF**'s and **WS**'s *CHL—Total* measure results are shown in Figure 4-28.

Figure 4-28—CY 2019 *CHL—Total* Measure Results
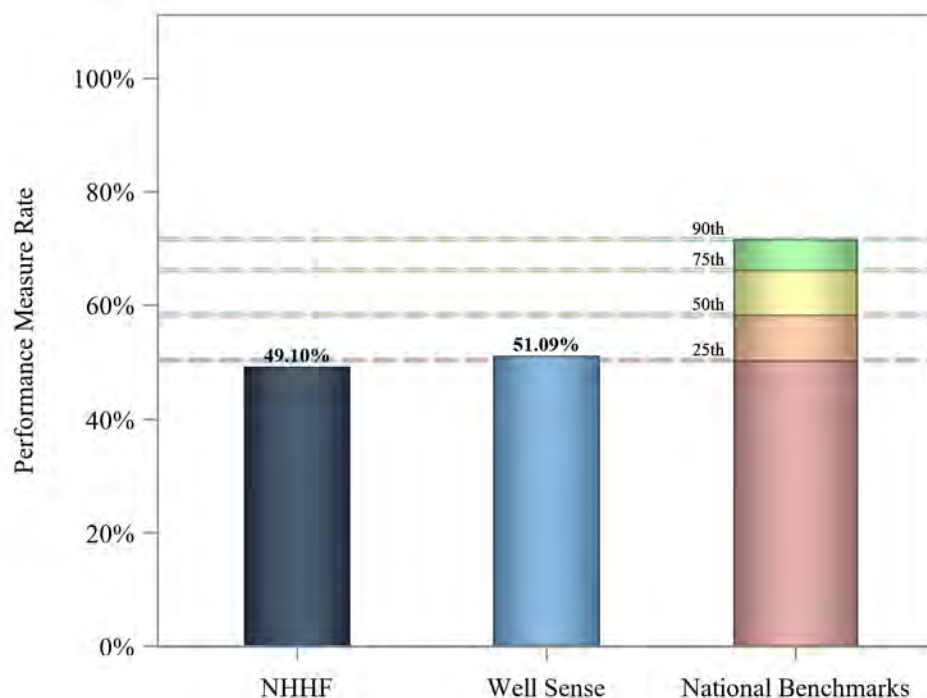
NHHF's reported rate ranked at or below the 25th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

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 MCO in the first trimester or within 42 days of enrollment in the MCO. **NHHF**'s and **WS**'s *PPC—Timeliness of Prenatal Care* measure results are shown in Figure 4-29.

Figure 4-29—CY 2019 *PPC—Timeliness of Prenatal Care* Measure Results
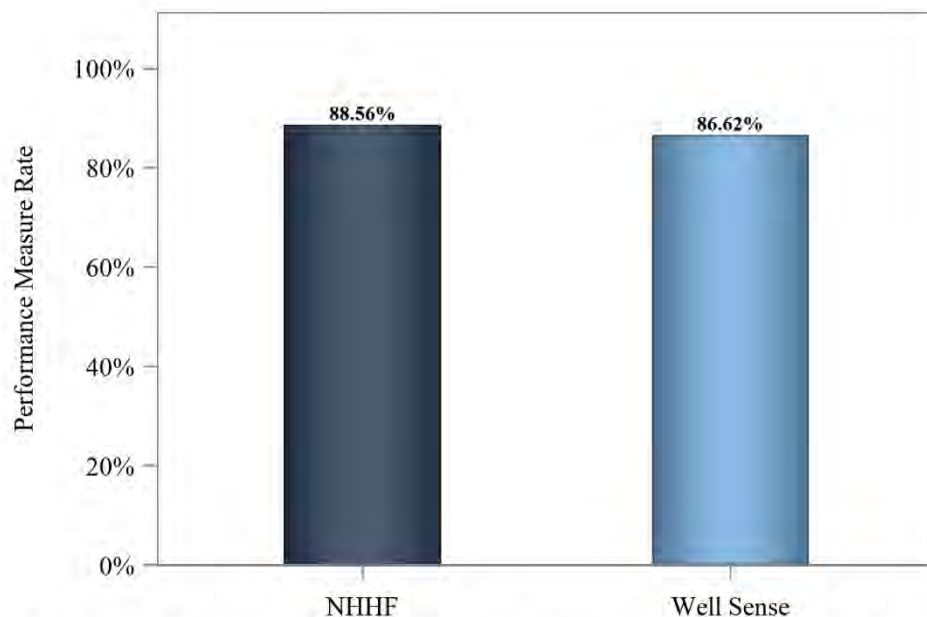
Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, comparisons to benchmarks based on HEDIS 2019 technical specifications are not appropriate.

NHHF's reported rate was less than 2 percentage points higher than **WS**'s reported rate.

Prenatal and Postpartum Care (PPC)—Postpartum Care

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

Figure 4-30—CY 2019 *PPC—Postpartum Care* Measure Results

Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, comparisons to benchmarks based on HEDIS 2019 technical specifications are not appropriate.

NHHF's reported rate was more than 5 percentage points higher than **WS**'s reported rate.

Acute and Chronic Care

Appropriate Testing for Children with Pharyngitis (CWP)

CWP measures the percentage of children 3 to 18 years of age who were diagnosed with pharyngitis during 2019, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. **NHHF**'s and **WS**'s *CWP* measure results are shown in Figure 4-31.

Figure 4-31—CY 2019 *CWP* Measure Results

Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, comparisons to benchmarks based on HEDIS 2019 technical specifications are not appropriate.
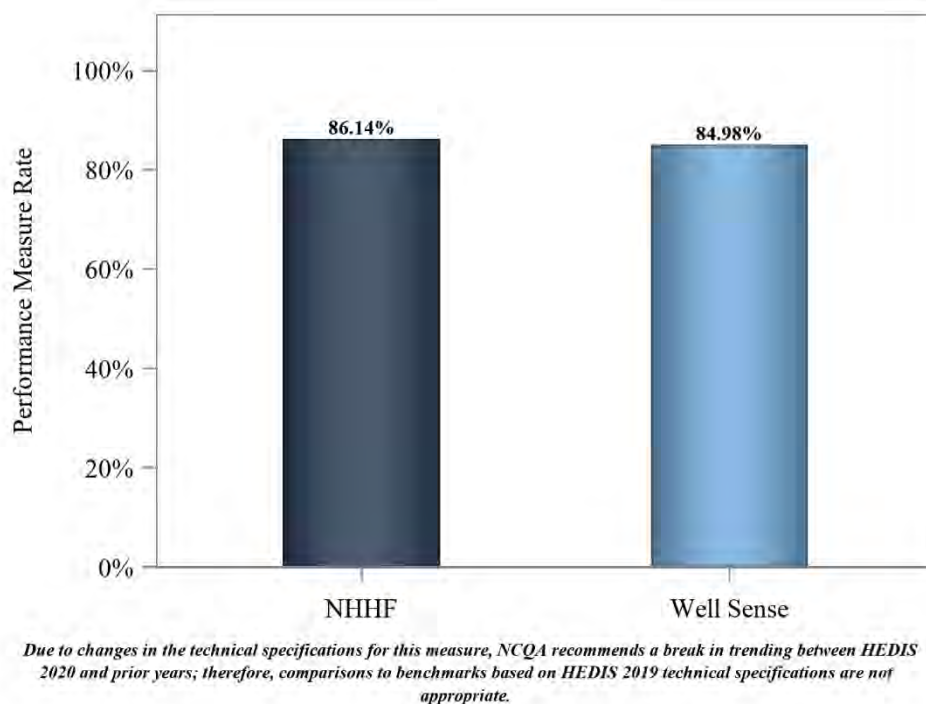
NHHF's reported rate was less than 2 percentage points higher than **WS**'s reported rate.

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 during 2019 and were not dispensed an antibiotic prescription. **NHHF**'s and **WS**'s *URI* measure results are shown in Figure 4-32.

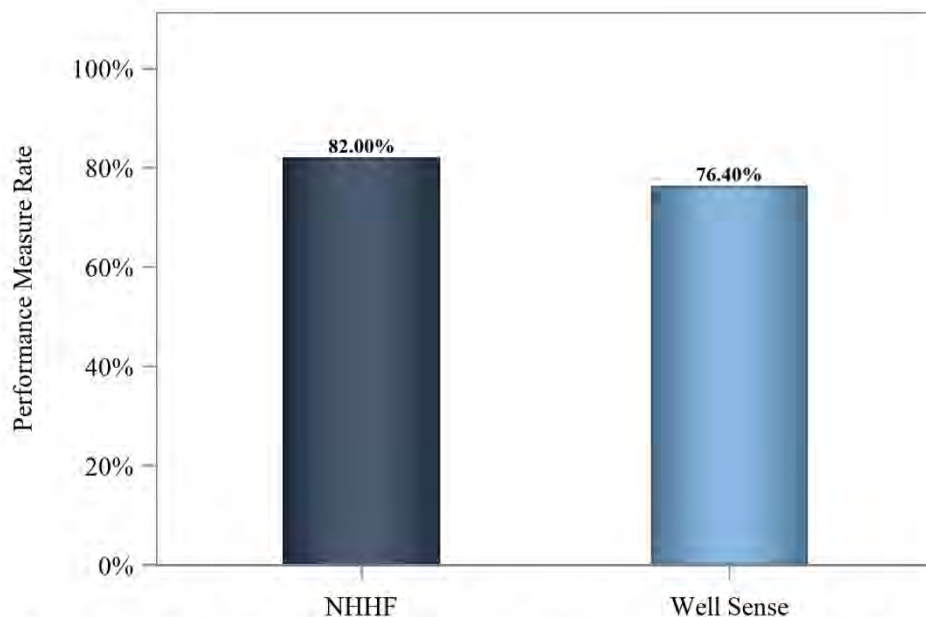**Figure 4-32—CY 2019 *URI* Measure Results**

Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, comparisons to benchmarks based on HEDIS 2019 technical specifications are not appropriate.
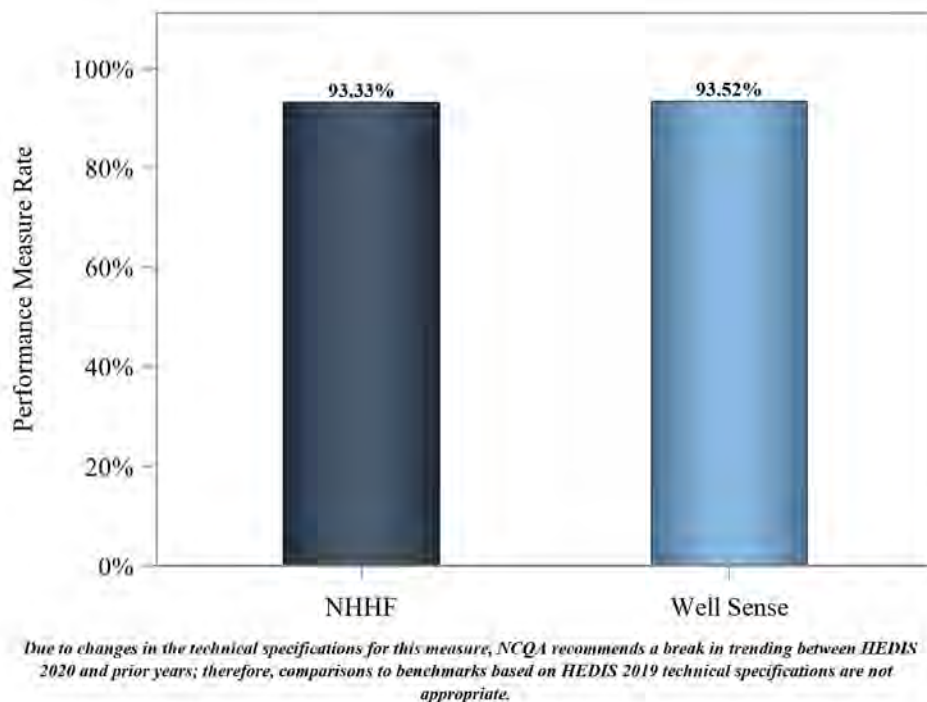
NHHF's reported rate was less than 1 percentage point lower than **WS**'s reported rate.

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 were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event during 2019. **NHHF**'s and **WS**'s *PCE—Systemic Corticosteroid* measure results are shown in Figure 4-33.

Figure 4-33—CY 2019 *PCE—Systemic Corticosteroid* Measure Results
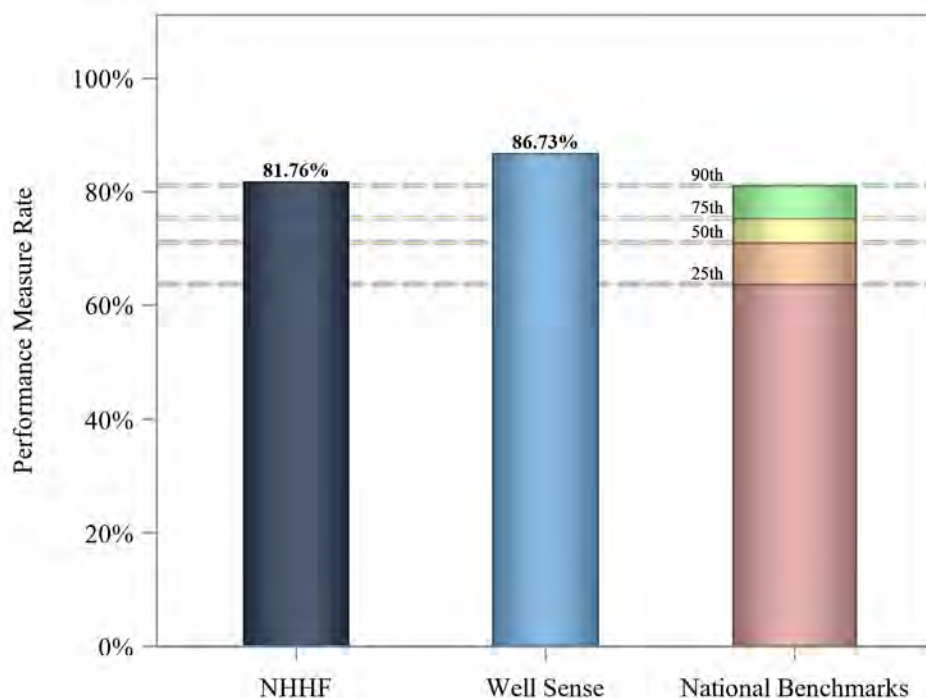
NHHF's and **WS**'s reported rates exceeded the 90th percentile.

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 were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event during 2019. **NHHF**'s and **WS**'s *PCE—Bronchodilator* measure results are shown in Figure 4-34.

Figure 4-34—CY 2019 *PCE—Bronchodilator* Measure Results
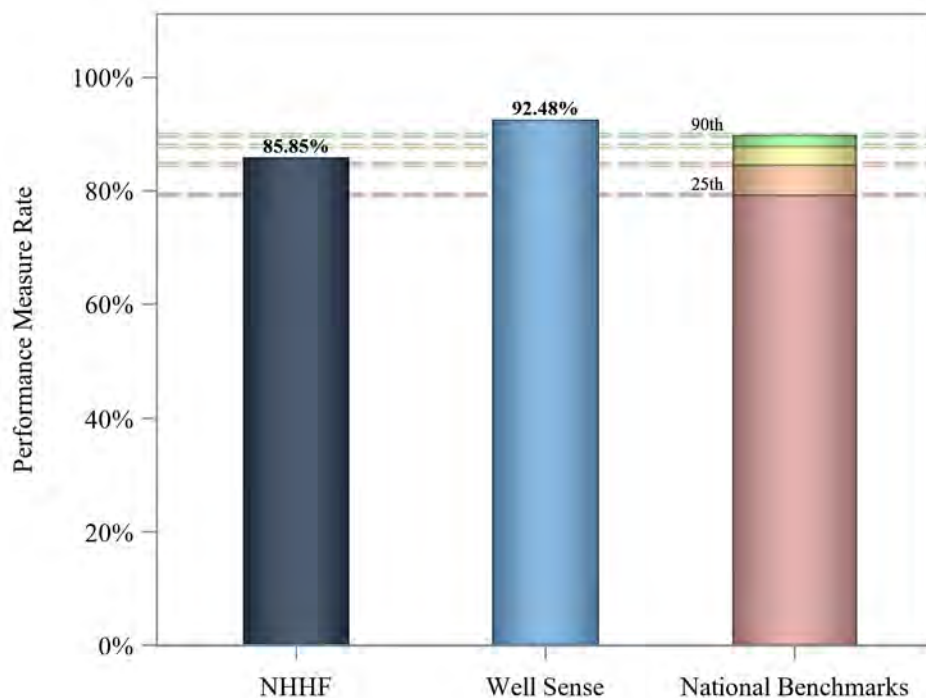
NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate exceeded the 90th percentile.

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 2019. **NHHF**'s and **WS**'s *CDC—HbA1c Testing* measure results are shown in Figure 4-35.

Figure 4-35—CY 2019 *CDC—HbA1c Testing* Measure Results

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate ranked at or above the 50th percentile but below the 75th 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 most recent HbA1c test showed poor control, with levels greater than 9.0 percent during 2019. **NHHF**'s and **WS**'s *CDC—HbA1c Poor Control (>9.0%)* measure results are shown in Figure 4-36. Note, lower rates for this measure indicate better performance. HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures. For example, the 25th percentile (a lower rate) was reversed to become the 90th percentile, indicating better performance.

Figure 4-36—CY 2019 *CDC—HbA1c Poor Control (>9.0%)* Measure Results

A lower rate indicates better performance for this measure.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th 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 most recent HbA1c test revealed levels less than 8.0 percent during 2019. **NHHF**'s and **WS**'s *CDC––HbA1c Control (<8.0%)* measure results are shown in Figure 4-37.

Figure 4-37—CY 2019 *CDC—HbA1c Control (<8.0%)* Measure Results
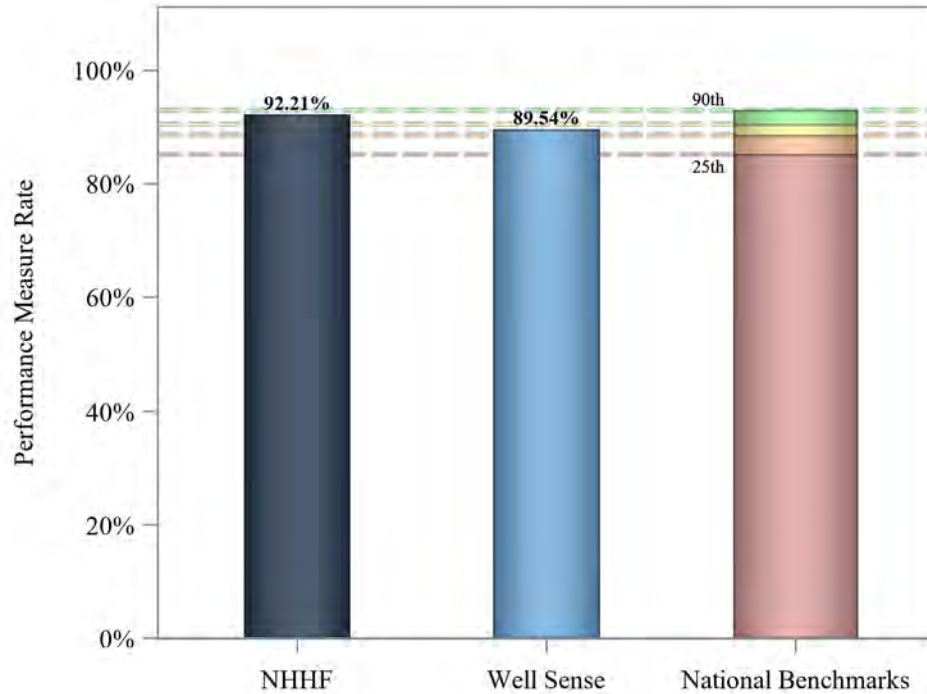

NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

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 2019. **NHHF**'s and **WS**'s *CBP* measure results are shown in Figure 4-38.

Figure 4-38—CY 2019 *CBP* Measure Results

NHHF's and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th 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 2019. **NHHF**'s and **WS**'s *LBP* measure results are shown in Figure 4-39.

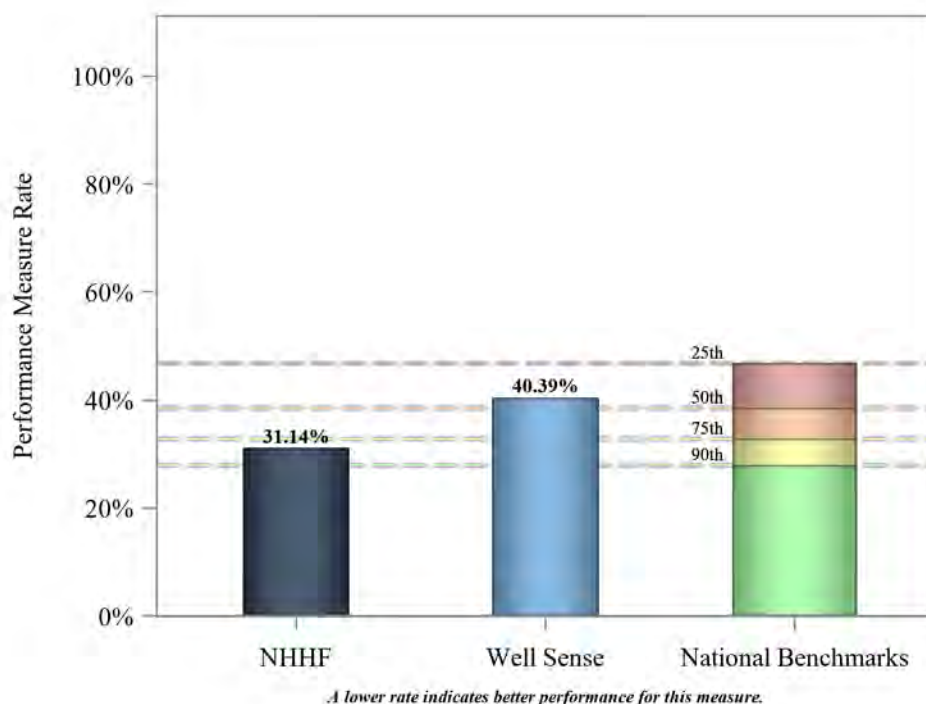**Figure 4-39—CY 2019 *LBP* Measure Results**
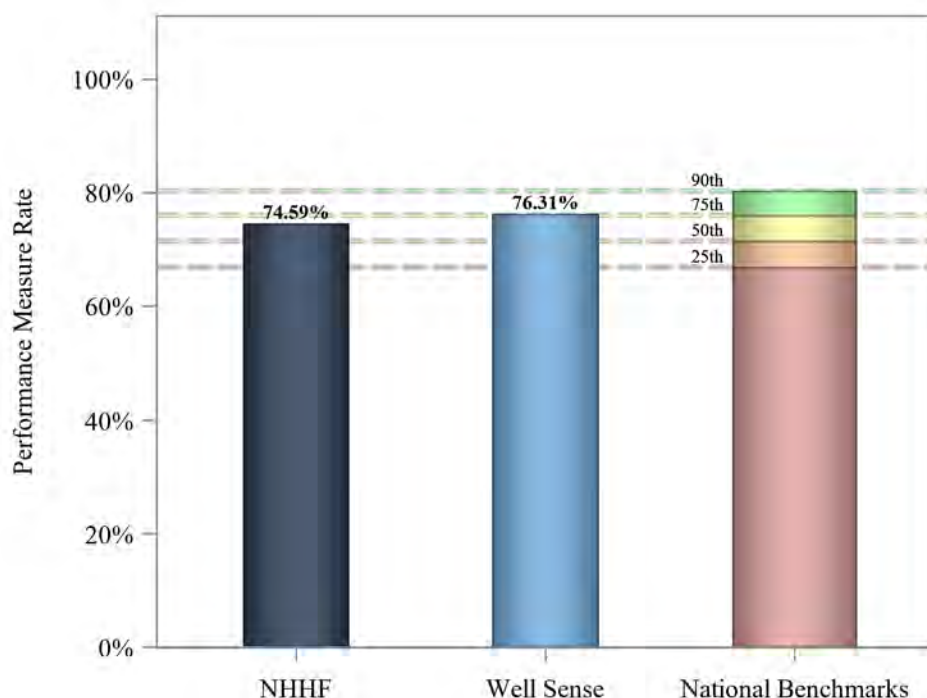
NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

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 2019. **NHHF**'s and **WS**'s *AMR—Total* measure results are shown in Figure 4-40.

Figure 4-40—CY 2019 *AMR—Total* Measure Results
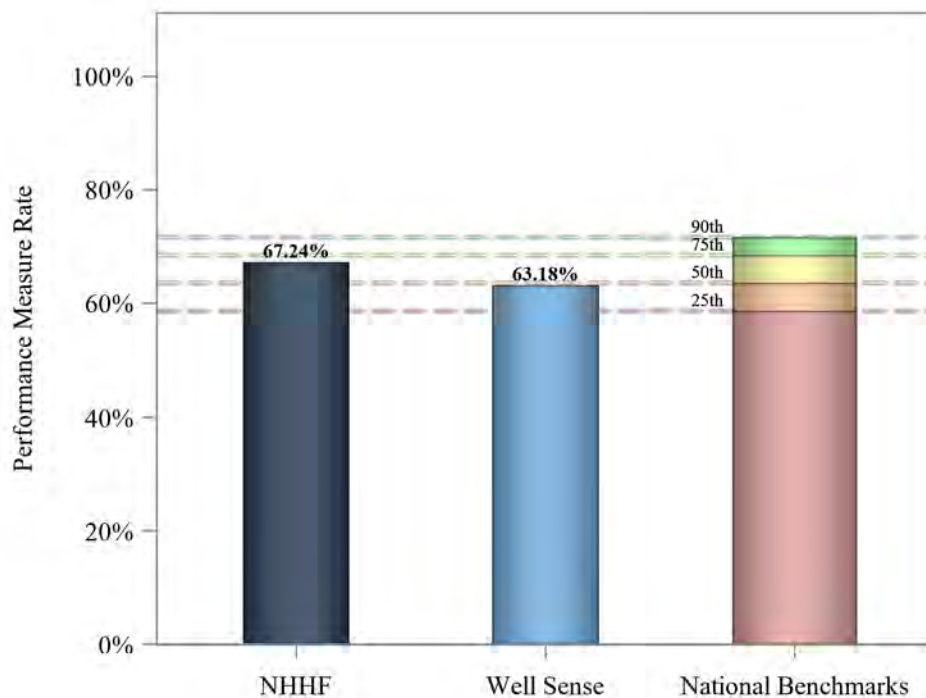
NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

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 were dispensed appropriate medications and remained on an asthma controller medication for at least 75 percent of the time during the treatment period in 2019. **NHHF**'s and **WS**'s *MMA—Medication Compliance 75%—Total* measure results are shown in Figure 4-41.

Figure 4-41—CY 2019 *MMA—Medication Compliance 75%—Total* Measure Results
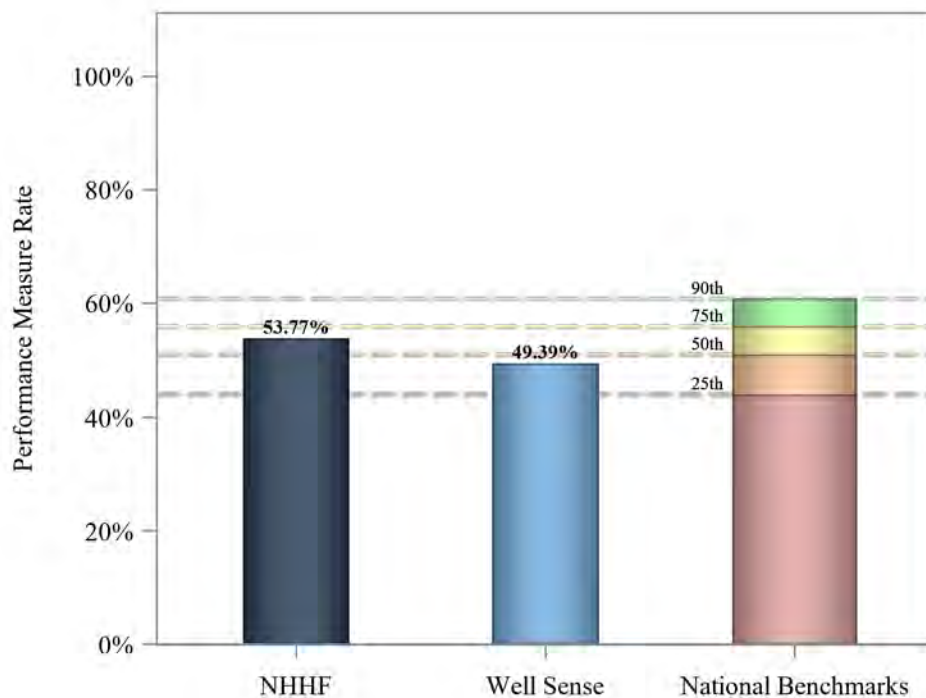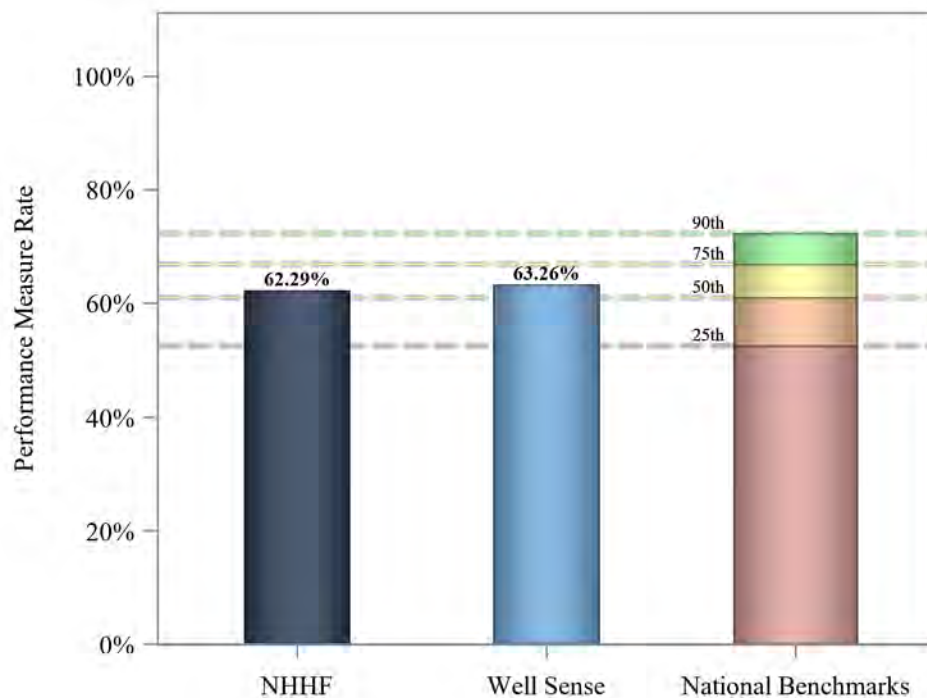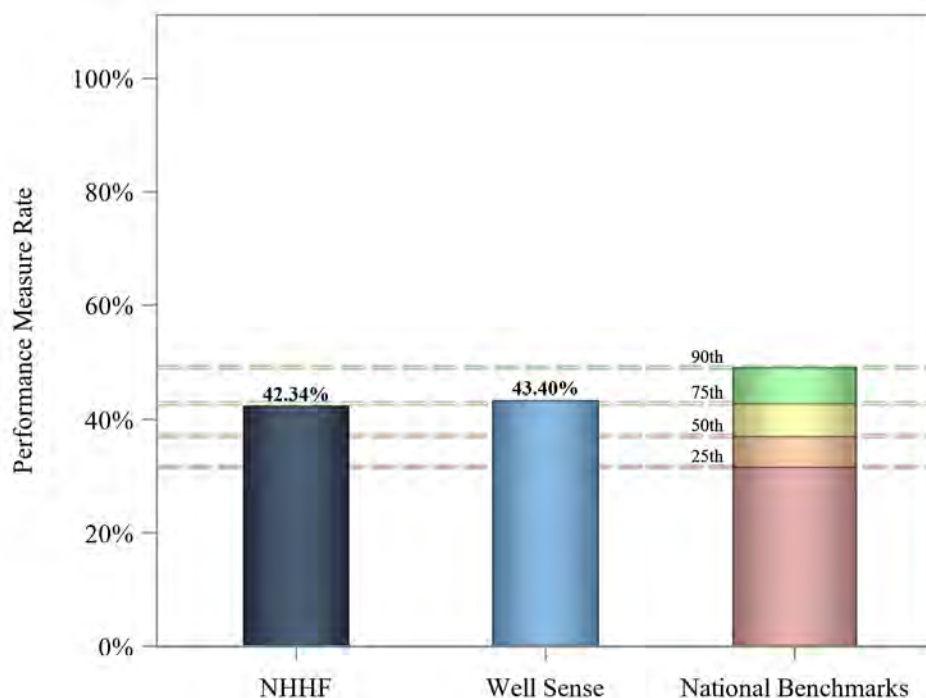

NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

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

AMB—ED Visits measures the utilization of ED visits among the member population during 2019. **NHHF**'s and **WS**'s *AMB—ED Visits* measure results are shown in Figure 4-42. Note, a lower rate may indicate better performance for this measure. HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures. For example, the 10th percentile (a lower rate) was reversed to become the 90th percentile, indicating better performance.

Figure 4-42—CY 2019 *AMB—ED Visits* Measure Results
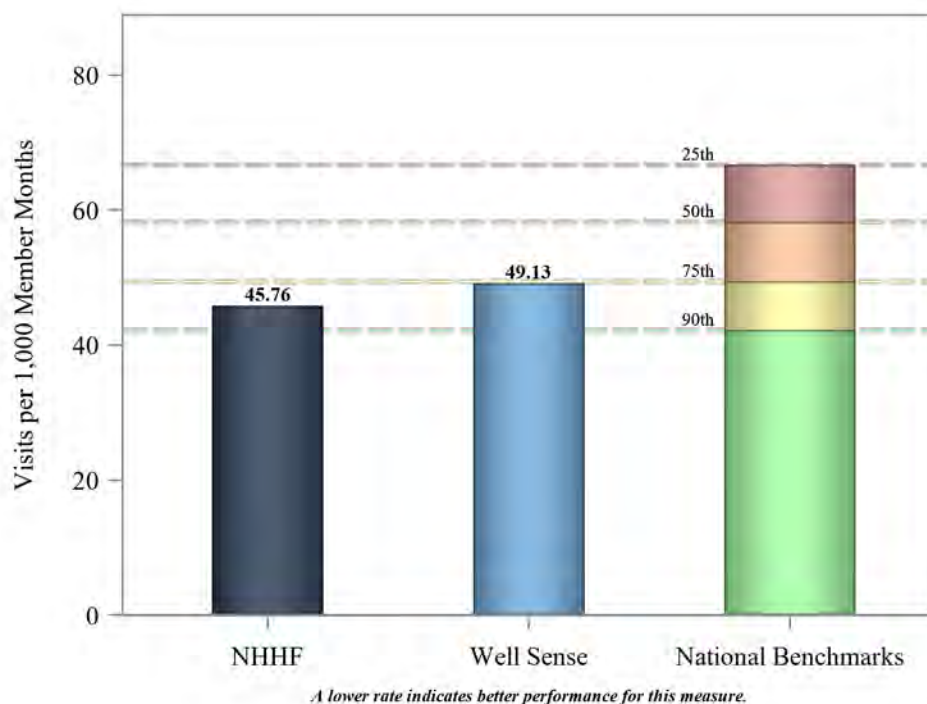
A lower rate indicates better performance for this measure.

NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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 2019. **NHHF**'s and **WS**'s *ABX—Percentage of Antibiotics of Concern for All Antibiotics Prescriptions* measure results are shown in Figure 4-43. Note, a lower rate indicates better performance for this measure. HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures.

Figure 4-43—CY 2019 *ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* Measure Results

A lower rate indicates better performance for this measure.
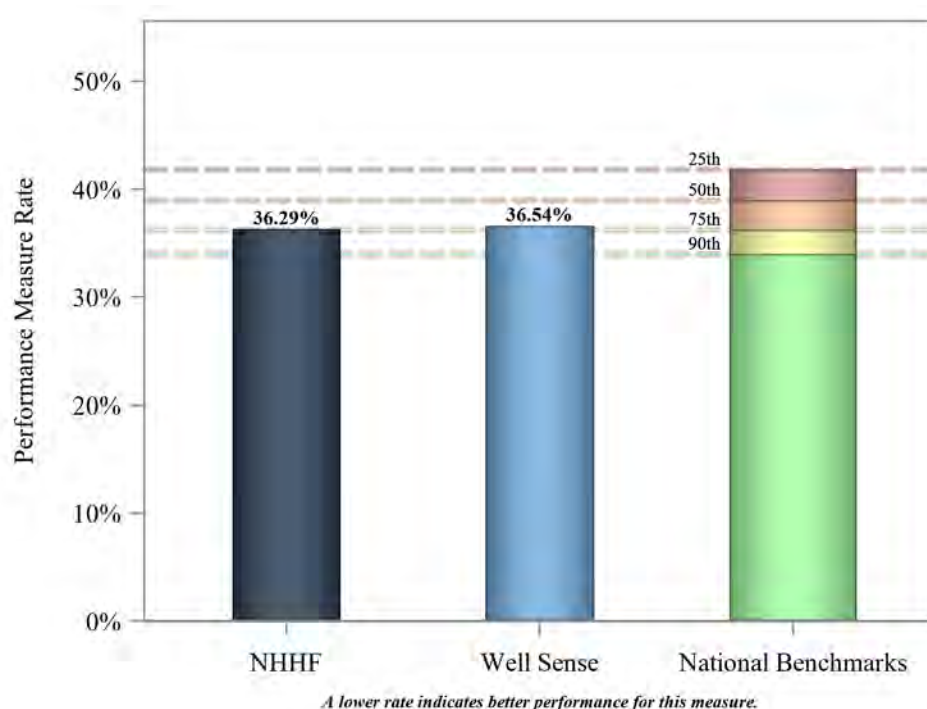
NHHF's and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

Behavior Health

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

FUH—7-Day Follow-Up—Total measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 7 days of discharge during 2019. **NHHF**'s and **WS**'s *FUH—7-Day Follow-Up—Total* measure results are shown in Figure 4-44.

Figure 4-44—CY 2019 *FUH—7-Day Follow-Up—Total* Measure Results
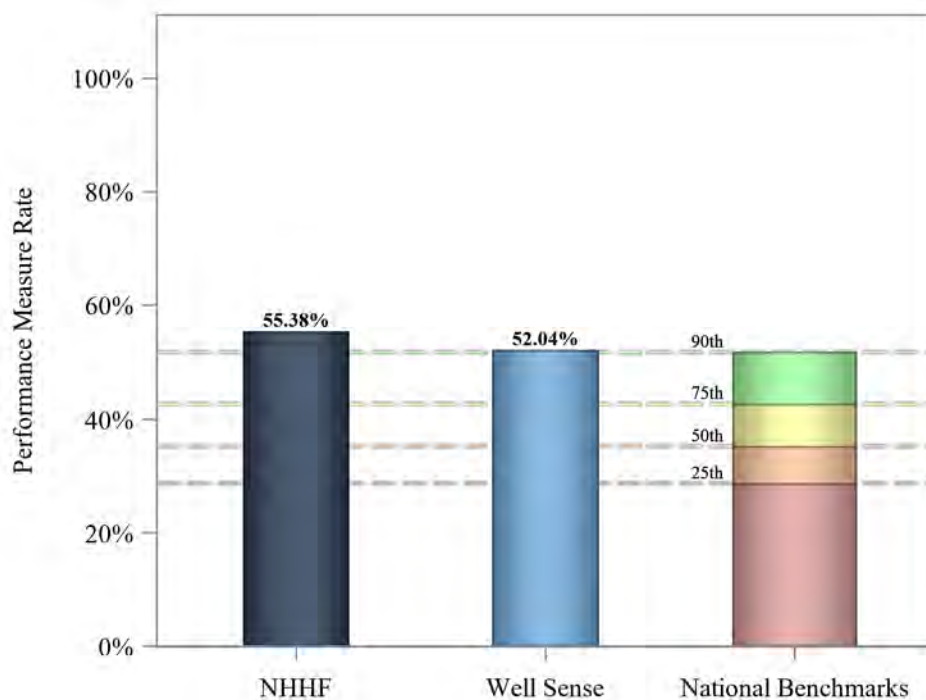
NHHF's and **WS**'s reported rates exceeded the 90th percentile.

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

FUH—30-Day Follow-Up—Total measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental illness and intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge during 2019. **NHHF**'s and **WS**'s *FUH—30-Day Follow-Up—Total* measure results are shown in Figure 4-45.

Figure 4-45—CY 2019 *FUH—30-Day Follow-Up—Total* Measure Results
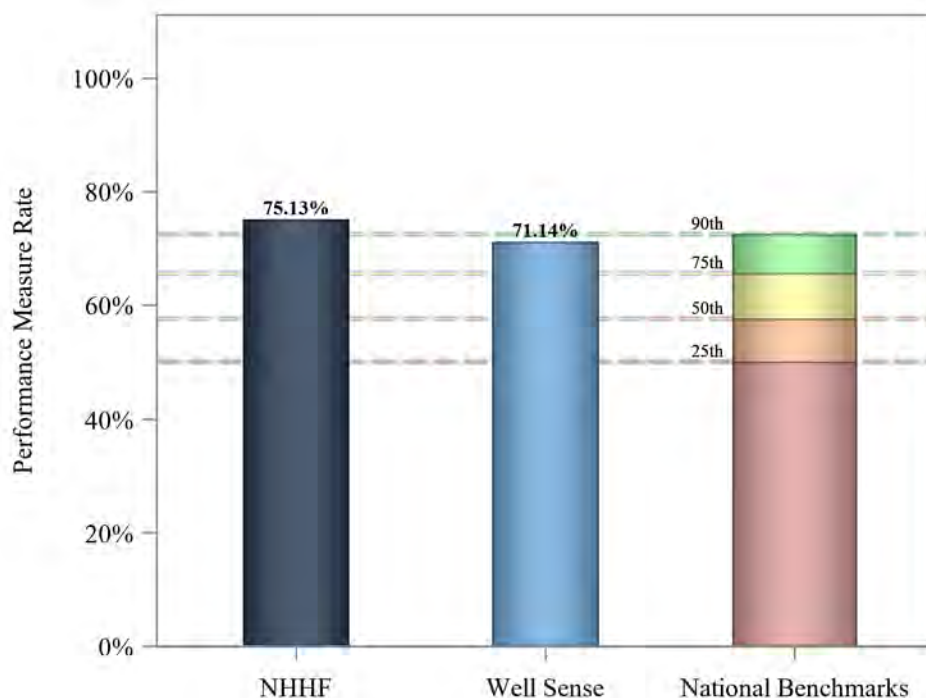
NHHF's reported rate exceeded the 90th percentile, and **WS**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

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, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during 2019. **NHHF**'s and **WS**'s *SSD* measure results are shown in Figure 4-46.

Figure 4-46—CY 2019 *SSD* Measure Results
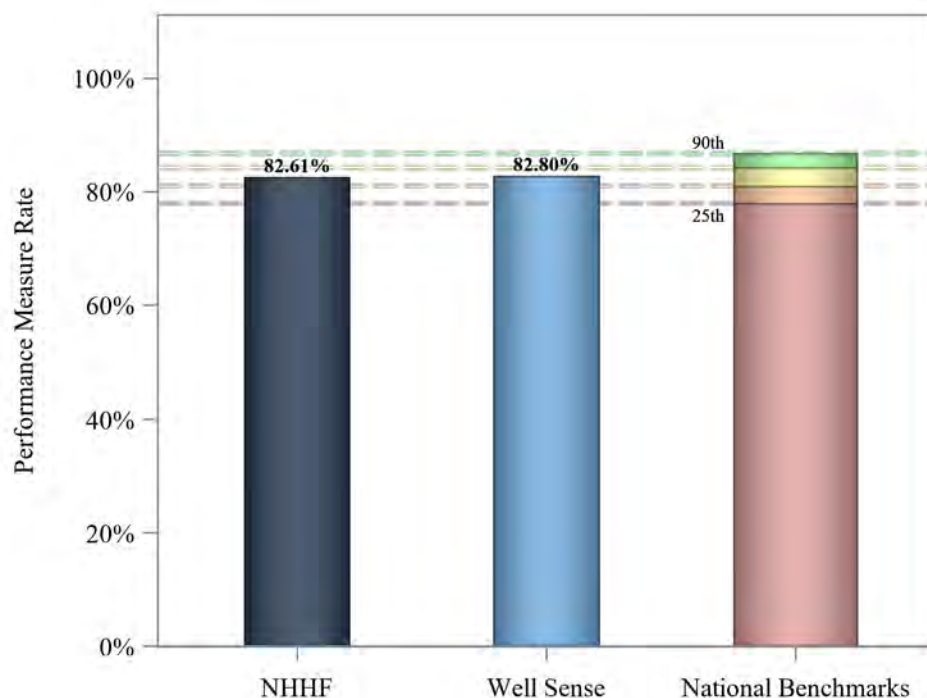
NHHF's and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th percentile. This measure is a PIP topic for **ACNH**, **NHHF**, and **WS**.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

SMD measures the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both a low-density lipoprotein-cholesterol (LDL-C) test and an HbA1c test during 2019. **NHHF**'s and **WS**'s *SMD* measure results are shown in Figure 4-47.

Figure 4-47—CY 2019 *SMD* Measure Results
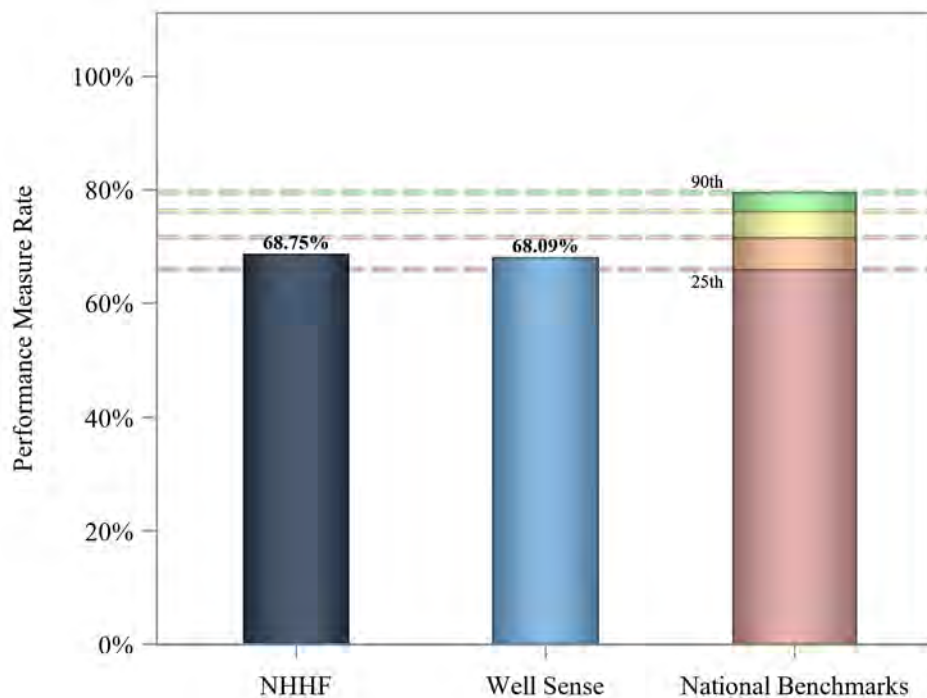
NHHF's and **WS**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

SAA measures the percentage of members 19 to 64 years of age with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during 2019. **NHHF**'s and **WS**'s *SAA* measure results are shown in Figure 4-48.

Figure 4-48—CY 2019 *SAA* Measure Results
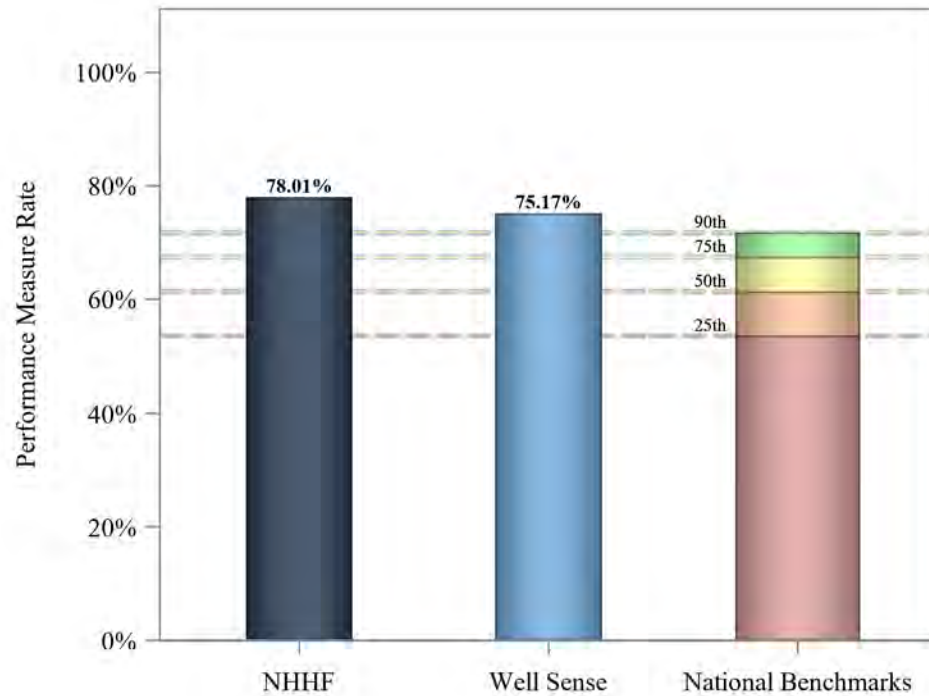
NHHF's and **WS**'s reported rates exceeded the 90th percentile.

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 2019. **NHHF**'s and **WS**'s *APM—Total* measure results are shown in Figure 4-49.

Figure 4-49—CY 2019 *APM—Total* Measure Results
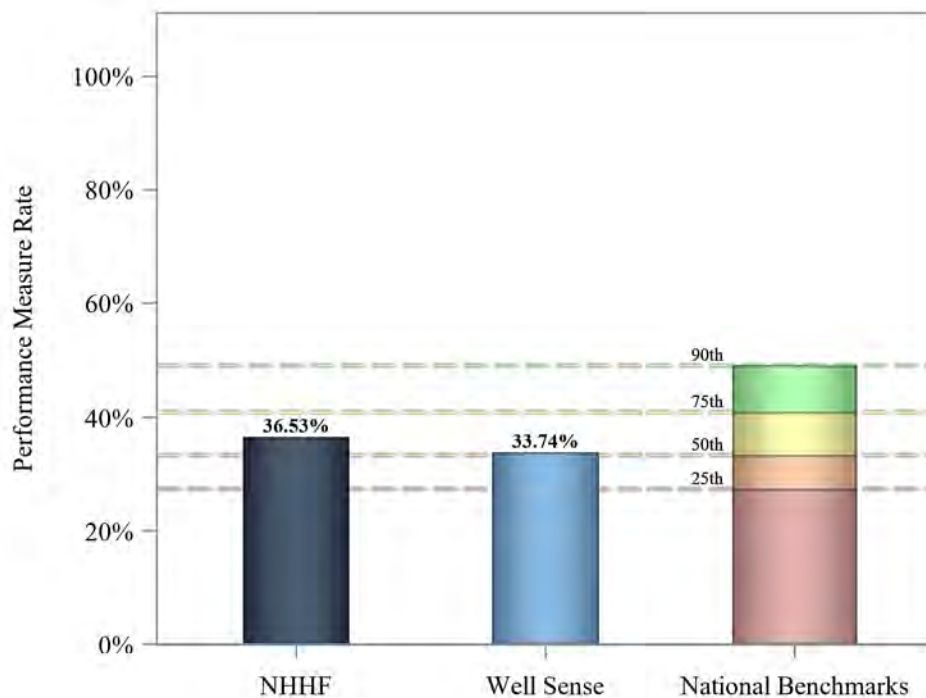
**NHHF**'s and **WS**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

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 2019. **NHHF**'s and **WS**'s *APP—Total* measure results are shown in Figure 4-50.

Figure 4-50—CY 2019 *APP—Total* Measure Results
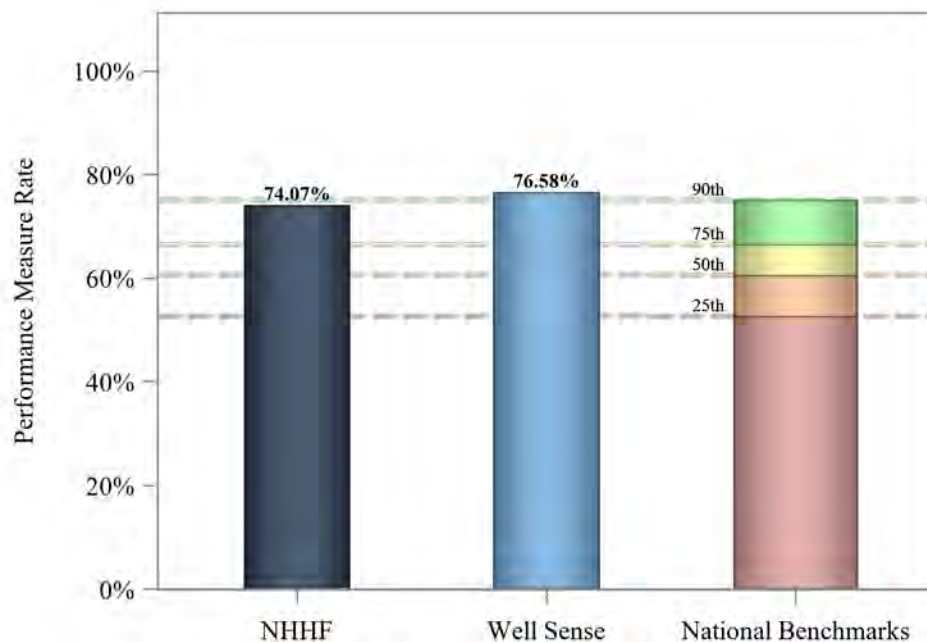
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2020 rates to benchmarks based on HEDIS 2019 technical specifications.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate exceeded the 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 **WS**'s *AMM— Effective Acute Phase Treatment* measure results are shown in Figure 4-51.

Figure 4-51—CY 2019 *AMM—Effective Acute Phase Treatment* Measure Results
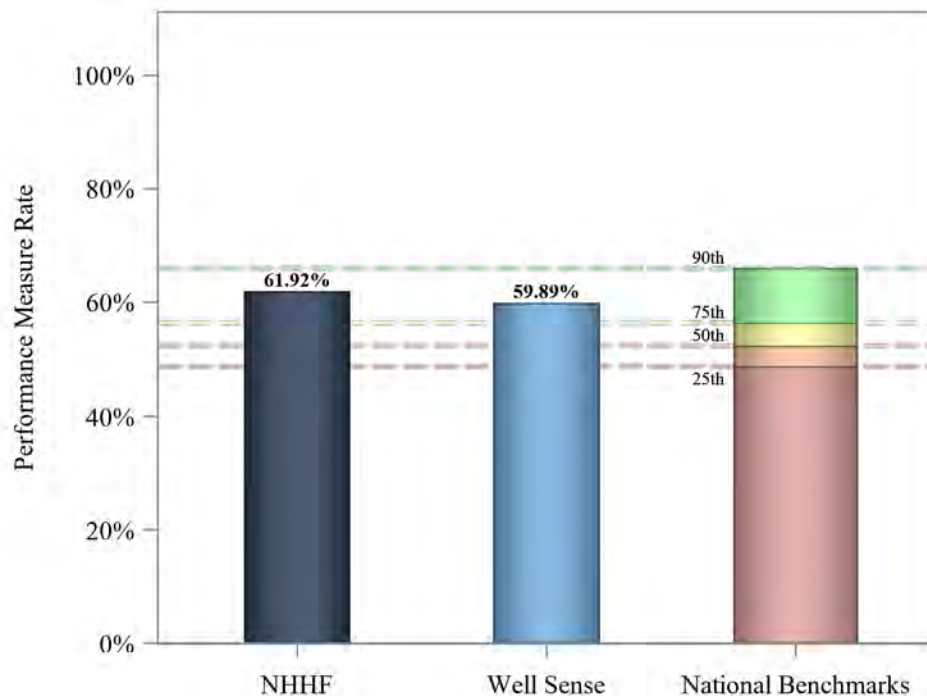
NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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 **WS**'s *AMM—Effective Continuation Phase Treatment* measure results are shown in Figure 4-52.

Figure 4-52—CY 2019 *AMM—Effective Continuation Phase Treatment* Measure Results
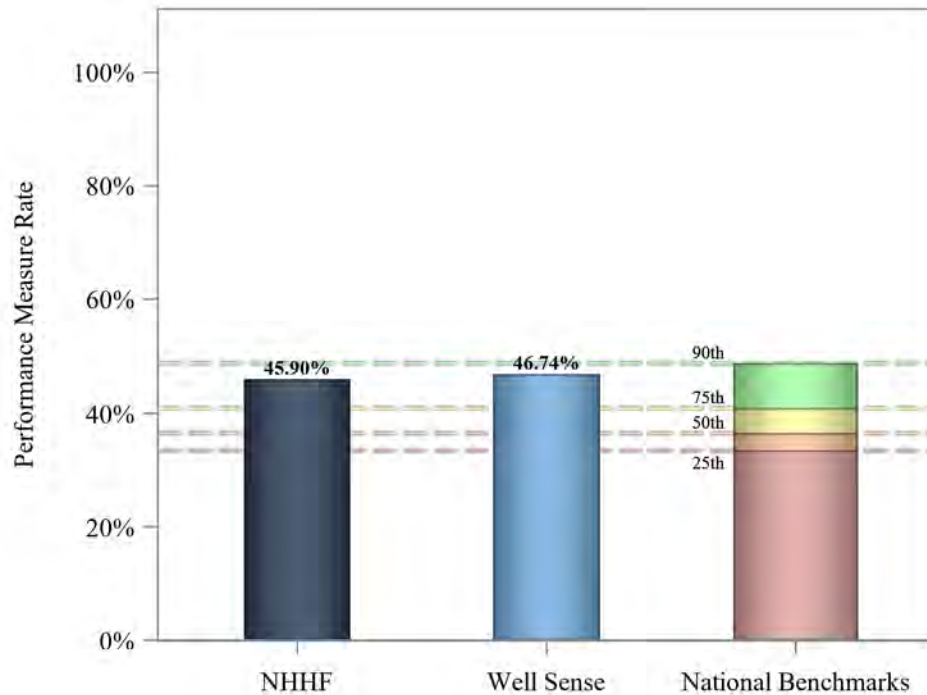
NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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

ADD—Initiation Phase measures the percentage of members 6 to 12 years of age who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication and had a follow-up care visit within 30 days of the first ADHD medication being dispensed. **NHHF**'s and **WS**'s *ADD—Initiation Phase* measure results are shown in Figure 4-53.

Figure 4-53—CY 2019 *ADD—Initiation Phase* Measure Results
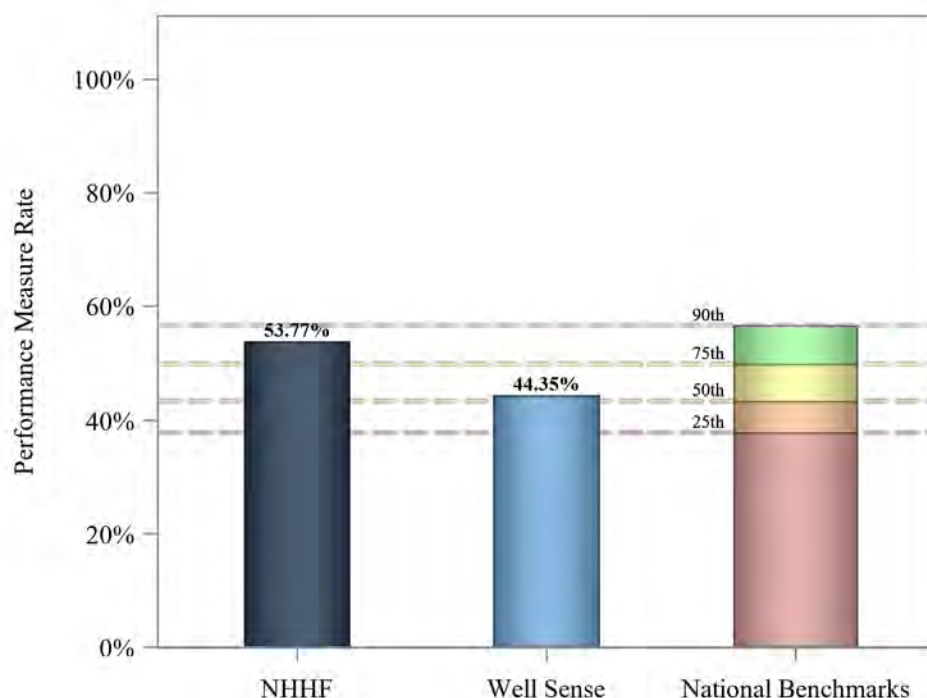
NHHF's reported rates ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

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 in addition to the follow-up care visit in the initiation phase, 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 **WS**'s *ADD—Continuation and Maintenance Phase* measure results are shown in Figure 4-54.

Figure 4-54—CY 2019 *ADD—Continuation and Maintenance Phase* Measure Results
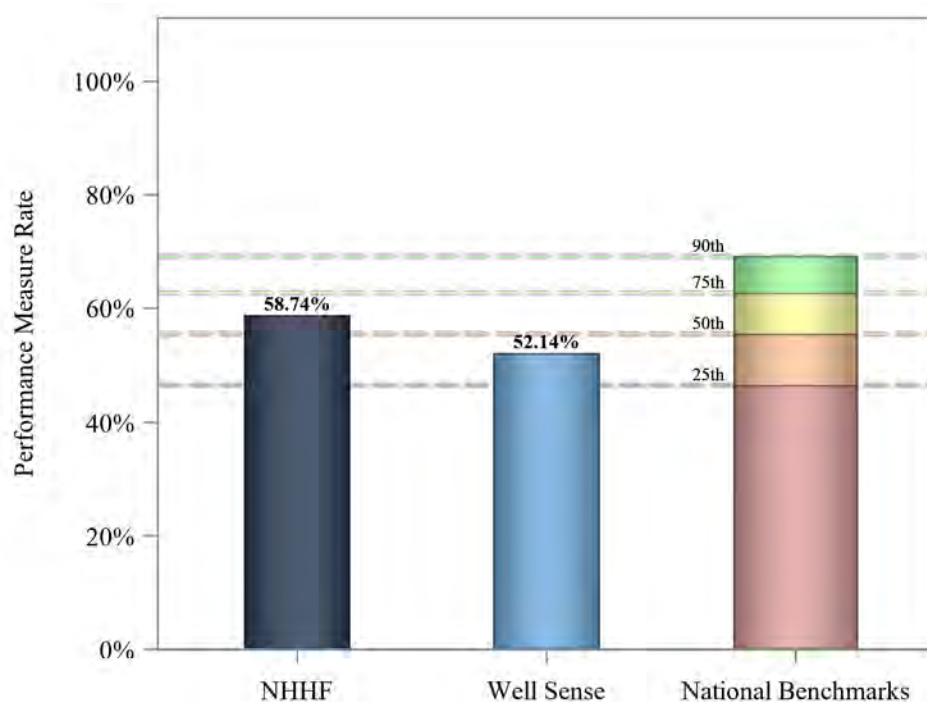
NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **WS**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

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

IET—Initiation of AOD Treatment—Total measures the percentage of adolescent and adult members 13 years of age and older with a new episode of AOD abuse or dependence who initiated appropriate AOD treatment within 14 days of the diagnosis during 2019. **NHHF**'s and **WS**'s *IET—Initiation of AOD Treatment—Total* measure results are shown in Figure 4-55.

Figure 4-55—CY 2019 *IET—Initiation of AOD Treatment—Total* Measure Results
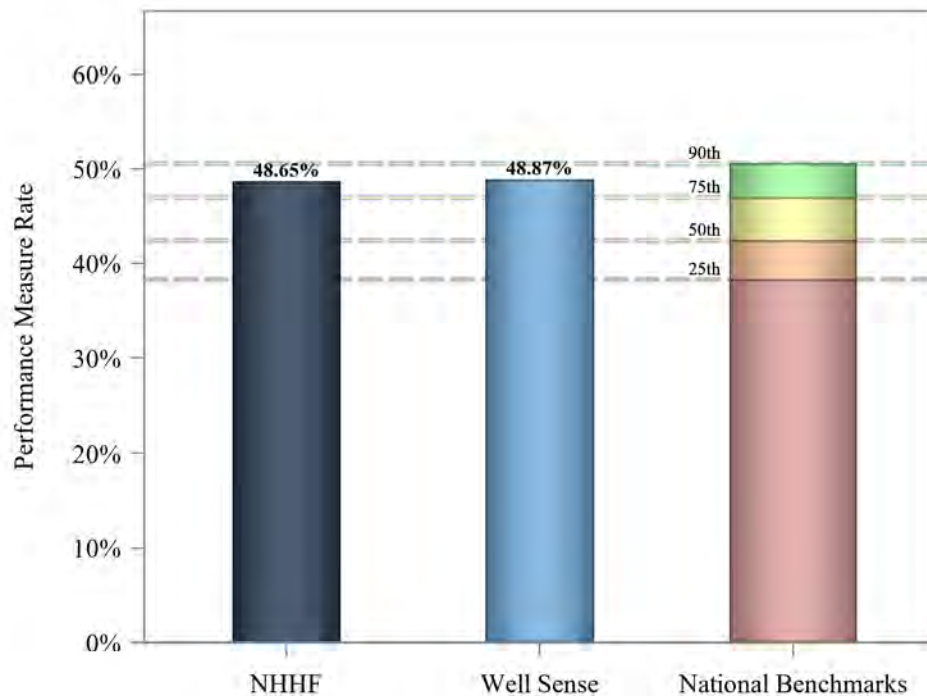
NHHF's and **WS**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

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

IET—Engagement of AOD Treatment—Total measures the percentage of adolescent and adult members 13 years of age and older with a new episode of AOD abuse or dependence who initiated AOD treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit during 2019. **NHHF**'s and **WS**'s *IET—Engagement of AOD Treatment—Total* measure results are shown in Figure 4-56.

Figure 4-56—CY 2019 *IET—Engagement of AOD Treatment—Total* Measure Results
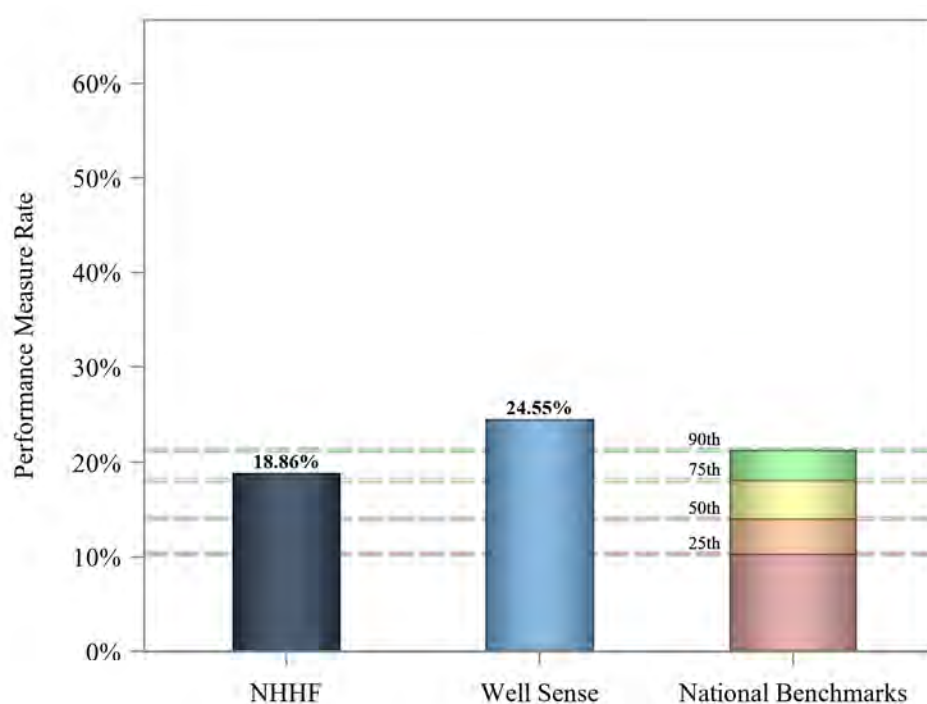
NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **WS**'s reported rate exceeded the 90th percentile. This measure is a PIP topic for **ACNH**, **NHHF**, and **WS**.

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

IAD—Any Service measures the percentage of members with an AOD claim who received any chemical dependency services during 2019. **NHHF**'s and **WS**'s *IAD—Any Service* measure results are shown in Figure 4-57. 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 4-57—CY 2019 *IAD—Any Service* Measure Results
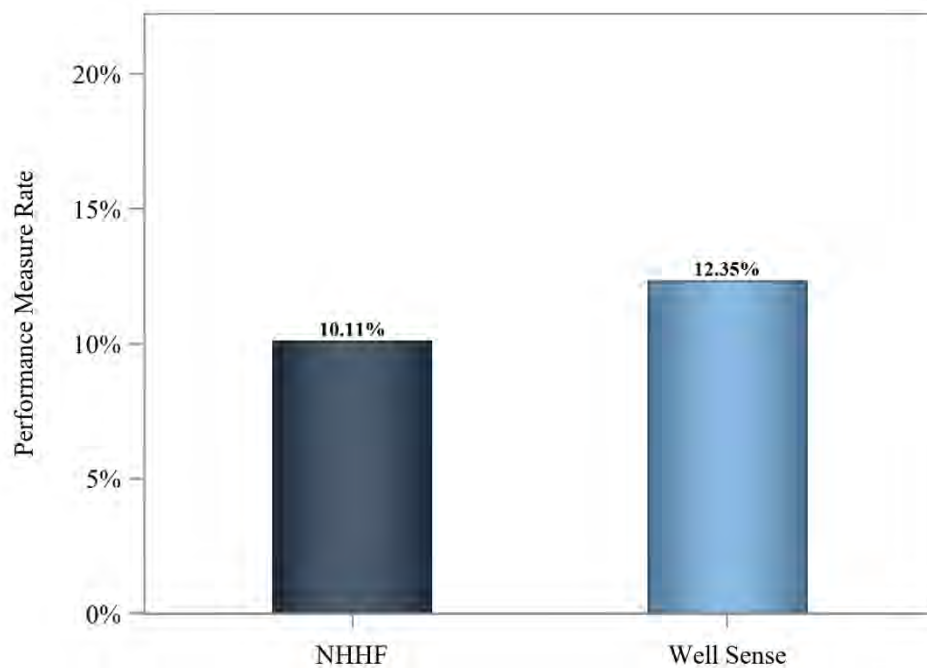
These rates are presented for informational purposes only. Therefore, comparisons to benchmarks are not included.

NHHF's reported rate was more than 2 percentage points lower than **WS**'s reported rate.

Mental Health Utilization (MPT)—Any Service

MPT—Any Service measures the percentage of members receiving any mental health services during 2019. **NHHF**'s and **WS**'s *MPT—Any Service* measure results are shown in Figure 4-58. 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 4-58—CY 2019 *MPT—Any Service* Measure Results
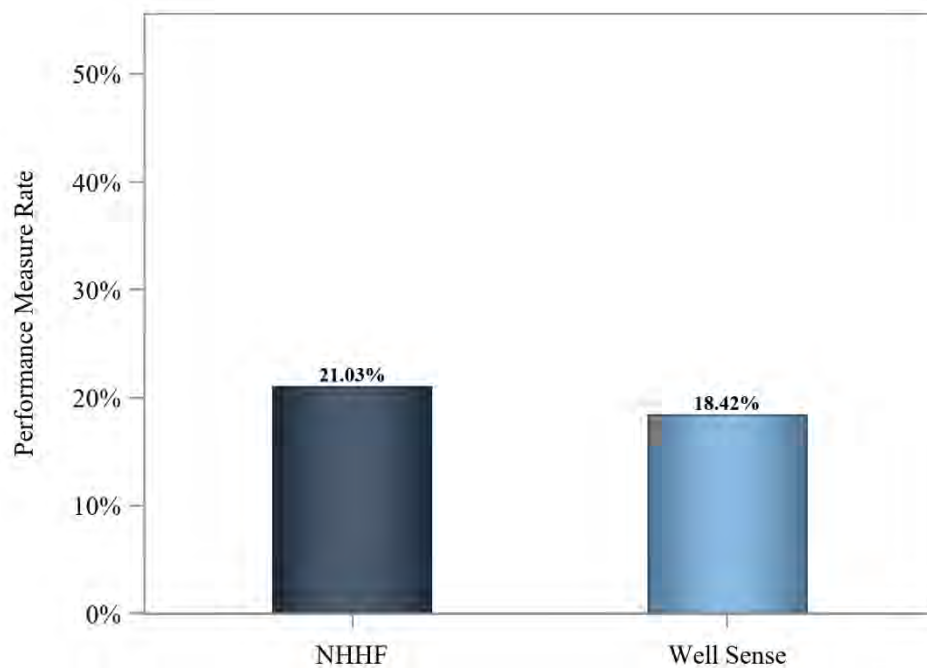
These rates are presented for informational purposes only. Therefore, comparisons to benchmarks are not included.

NHHF's reported rate was more than 2 percentage points higher than **WS**'s reported rate.

Conclusions and Recommendations

NHHF

Based on the MCO's HEDIS 2020 (CY 2019) performance measure results, **NHHF** scored at or above the 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile.

Prevention

- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years*
- *Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits**
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
- *Adolescent Well-Care Visits (AWC)*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**

Acute and Chronic Care

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing*
- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)*
- *Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits*

Behavioral Health

- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up—Total**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment*
- *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment— Engagement of AOD Treatment—Total*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment— Engagement of AOD Treatment—Total*

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

Prevention
- *Chlamydia Screening in Women (CHL)—21–24 Years*
- *Chlamydia Screening in Women (CHL)—Total*

WS

Based on the MCO's HEDIS 2020 (CY 2019) performance measure results, **WS** scored at or above the 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile.

Prevention
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**

Acute and Chronic Care
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator**
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total*
- *Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits*

Behavioral Health
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total**
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment*
- *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total**
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*

WS scored below the 25th percentile for the following measure and should focus future QI activities in this areas:

- *Chlamydia Screening in Women (CHL)—21–24 Years*

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 2020, DHHS contracted HSAG for the following four EDV activities:

- Using the EDQRS, evaluate the quality of encounter data files submitted by the three MCOs. The EDQRS was designed to import, store, and review incoming encounter data and generate automated, monthly/quarterly validation reports for DHHS.
- Conduct an IS review to assess **ACNH**'s IS/processes. The review is currently in progress.
- Perform a comparative analysis between DHHS' electronic encounter data and the data extracted from **NHHF**'s and **WS**'s data systems. The analysis is currently in progress.
- Evaluate DHHS' electronic encounter data completeness and accuracy through a comparison between DHHS' electronic encounter data and the medical records for **NHHF** and **WS**. The medical record review is currently in progress.

Methodology for EDQRS

HSAG used the same general process and files as DHHS' fiscal agent, Conduent, 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. Weekly, participating MCOs prepare and translate claims and encounter data into the 837P/I and pharmacy files. The files are simultaneously transmitted via secure file transfer protocol (SFTP) to HSAG and DHHS (and Conduent), where the files are downloaded and processed. The MCOs' 837P/I files are processed through an EDI translator by both vendors (Conduent and HSAG). It is important to note that the application and function of compliance edits implemented by Conduent 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; and (2) key encounter data quality elements (e.g., data field compliance and completeness). Additionally, while failure to pass certain edits during Conduent's processing may lead to rejection and resubmission of files/encounters by the MCOs, HSAG's edit processing is used for reporting 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 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' pharmacy files are processed simultaneously through a comparable process; however, the pharmacy files do not undergo EDI translation. Instead, the pharmacy files are processed directly into HSAG's data warehouse.

Measures in the EDQRS

The monthly EDV reports assess the encounter data completeness, accuracy, and timeliness in the following domains:

- **Submission Accuracy and Completeness (SAC)**: Two measures in this 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. One measure examines whether the submitted encounters pass X12 EDI compliance edits and the other measure assesses the level to which the MCOs' reconciliation reports align with the submitted encounter files.
- **Encounter Data Accuracy (EDA)**: Two measures in this 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.
- **Encounter Data Timeliness (EDT)**: The measures in this domain assess the MCOs' compliance with the time-based submission standard for encounter data (i.e., proportion of initial encounters compliant with the DHHS submission standard of 14 days post claims payment to the service rendering provider).

The quarterly EDV reports assess encounter data completeness and accuracy in the following domains:

- **Encounter Data Completeness (EDC)**: Two measures in this domain demonstrate the MCOs' monthly proportions of distinct professional visits by place of service category and monthly proportions of distinct institutional visits by type of bill category.
- **Payment Reconciliation Reports**: During SFY 2020, DHHS began requesting that the MCOs submit quarterly payment reconciliation reports regarding the number of unique final paid claims and the total MCO paid amount. In addition, HSAG and DHHS will generate the same reports based on their own respective databases and then conduct a three-way comparison to reconcile differences, if any. This report is currently in progress.

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

EDQRS Implementation

During SFY 2020, DHHS made the following changes to the EDQRS beginning September 1, 2019:

- Removed weekly reports.
- Reduced the total number of measures to eight and reorganized them to either monthly reports or quarterly reports.
- Updated the measure specifications.
- Added payment reconciliation reports to the quarterly reports.

- Added **ACNH** to the monthly/quarterly reports.
- Enhanced the layout for tables/charts.

Findings From Files Received in SFY 2020 for EDQRS

For encounters received from MCOs between September 1, 2019, and June 30, 2020, this section presents the aggregate rates for four standards within Exhibit A of the MCM Contract.[4-10]

Standard 5.1.3.34.2.1 specifies that "Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the New Hampshire Medicaid Management Information System (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 4-11 shows that all 837P and 837I encounters received between September 1, 2019, and June 30, 2020 passed the X12 EDI compliance edits for all MCOs.

Table 4-11—Percentage of Encounters Passing X12 EDI Compliance Edits

Encounter Type	Standard	ACNH	NHHF	WS
837P Encounters	98.0%	100.0%	100.0%	100.0%
837I Encounters	98.0%	100.0%	100.0%	100.0%

Table 4-12 displays the results from Standard 5.1.3.34.2.3 requiring that "One-hundred percent (100%) of member identification numbers shall be accurate and valid." For all encounter types, Table 4-12 shows that the member identification numbers were present on 100 percent of encounters except pharmacy encounters for **WS**. Further investigation shows that nearly all pharmacy encounters without member identification numbers were submitted to DHHS by **WS** between January 2020 and March 2020. In addition, at least 99.2 percent of member identification numbers were valid for all three encounter types for all MCOs, which was slightly lower than the standard (i.e., 100 percent).

Table 4-12—Percentage Present and Percentage Valid for Member Identification Numbers

Encounter Type	Standard	ACNH		NHHF		WS	
		% Present	% Valid*	% Present	% Valid*	% Present	% Valid*
837P Encounters	100.0%	100.0%	99.9%	100.0%	99.7%	100.0%	99.5%
837I Encounters	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%
Pharmacy Encounters	100.0%	100.0%	100.0%	100.0%	100.0%	17.9%	100.0%

* To be considered valid, the member identification number should be in the member file received from DHHS.

[4-10] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #2 to the Medicaid Care Management Services Contract.* Available at: https://www.dhhs.nh.gov/ombp/caremgt/documents/mcm-contract-121819.pdf. Accessed on: Oct 6, 2020.

Table 4-13 displays the results from Standard 5.1.3.34.2.4 requiring that "Ninety-eight percent (98%) of billing provider information will be accurate and valid." Table 4-13 shows that the billing provider numbers were present for 100 percent of encounters for all MCOs. All the validity rates met the standard (i.e., 98 percent) except the pharmacy rate for **WS**. Further investigation shows that approximately 99.9 percent of pharmacy encounters with invalid billing provider information were submitted to DHHS by **WS** between January 22, 2020, and March 25, 2020, and the submitted value was "0."

Table 4-13—Percentage Present and Percentage Valid for Billing Provider Information

Encounter Type	Standard	ACNH		NHHF		WS	
		% Present	% Valid*	% Present	% Valid*	% Present	% Valid*
837P Encounters	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
837I Encounters	98.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%
Pharmacy Encounters	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	18.2%

* To be considered valid, the billing provider number should have been included in the provider file received from DHHS for the SFY 2020 reports.

Table 4-14 displays the results from Standard 5.1.3.34.2.5 requiring that "Ninety-eight percent (98%) of servicing provider information will be accurate and valid." Table 4-14 shows that the servicing provider numbers were present for 100 percent of encounters for all MCOs. All the validity rates also met the standard (i.e., 98 percent).

Table 4-14—Percentage Present and Percentage Valid for Servicing Provider Information†

Encounter Type	Standard	ACNH		NHHF		WS	
		% Present	% Valid*	% Present	% Valid*	% Present	% Valid*
837P Encounters	98.0%	100.0%	99.6%	100.0%	99.8%	100.0%	99.9%
837I Encounters	98.0%	100.0%	99.4%	100.0%	99.6%	100.0%	99.7%

† For professional encounters, "servicing provider information" refers to the rendering provider numbers (i.e., national provider identifiers [NPIs]) or the billing provider NPIs if the rendering provider NPIs are missing. For institutional encounters, "servicing provider information" refers to the attending provider numbers (i.e., NPIs) or the billing provider NPIs if the attending provider NPIs are missing. For pharmacy encounters, "servicing provider information" is the same as the "billing provider information" in Table 4-13; therefore, they are not presented in Table 4-14.

* To be considered valid, the servicing provider number should have been included in the provider file received from DHHS for the SFY 2020 reports.

Standard 5.1.3.34.3.1 states that "Encounter data shall be submitted weekly, within fourteen (14) calendar days of claim payment." Table 4-15 presents the percentage of initial encounters submitted to DHHS within 14 calendar days of the claim payment date, and the list below shows the findings. Of note, only non-void encounters initially submitted to DHHS were included in the evaluation. In addition, if a diagnosis related group (DRG) claim had only one detailed line populated with a payment date, HSAG used the populated detail payment date to determine whether all detail lines were meeting the 14-day criteria.

- For the 837P encounters, 73.0 percent of **ACNH**'s initial encounters were submitted to DHHS within 14 days of the claim payment date. For the encounters not meeting the 14-day standard, 28.8 percent were from **ACNH**'s transportation vendor. For the non-vendor encounters not meeting the 14-day standard, nearly all were submitted to DHHS between December 27, 2019, and February 28, 2020, when **ACNH** was in its early stage of submitting encounters to DHHS. For **NHHF**, the percentage of encounters submitted to DHHS within 14 days of the claim payment date was 86.1 percent, and 93.7 percent of encounters not meeting the 14-day standard were from **NHHF**'s transportation vendor. The rate for **WS** was the highest among all three MCOs (i.e., 99.1 percent).

- For the 837I encounters, 97.7 percent and 98.7 percent of initial encounters were submitted to DHHS within 14 days of the claim payment date for **NHHF** and **WS**, respectively. For **ACNH**, the percentage of initial encounters submitted to DHHS within 14 days of the claim payment date was 76.2 percent. Among **ACNH**'s initial encounters not meeting the 14-day standard, approximately 97.8 percent were submitted to DHHS between December 27, 2019, and February 28, 2020, when **ACNH** was in its early stage of submitting encounters to DHHS.

- For the pharmacy encounters, while the rate for **WS** was 99.9 percent, the rates for **ACNH** and **NHHF** were much lower (i.e., 86.9 percent and 48.1 percent, respectively). For **ACNH**, all initial encounters not meeting the 14-day standard were because **ACNH** started its first pharmacy data submission to DHHS on December 20, 2019, while it began to provide services to its members on September 1, 2019. For **NHHF**, its relatively low rate was primarily because it held its pharmacy submissions from September 25, 2019, to December 11, 2019, as requested by DHHS to address data issues.

Table 4-15—Percentage of Initial Encounters Submitted to DHHS Within 14 Calendar Days of Claim Payment

Encounter Type	Standard	ACNH	NHHF	WS
837P Encounters	100.0%	73.0%	86.1%	99.1%
837I Encounters	100.0%	76.2%	97.7%	98.7%
Pharmacy Encounters	100.0%	86.9%	48.1%	99.9%

Conclusions and Recommendations for EDQRS

ACNH

ACNH's submitted encounters met the standards for the X12 EDI compliance edits, the accuracy for member identification numbers in its 837I and pharmacy encounters, the accuracy for billing providers in all three encounter types, and the accuracy for servicing providers in 837P/I encounters.

HSAG recommends that **ACNH** focus on two areas to improve its encounter data submissions: data accuracy related to the member identification numbers for 837P encounters and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all three encounter types.

NHHF

NHHF's submitted encounters met the standards for the X12 EDI compliance edits, the accuracy for member identification numbers in its 837I and pharmacy encounters, the accuracy for billing providers in all three encounter types, and the accuracy for servicing providers in 837P/I encounters.

HSAG recommends that **NHHF** focus on two areas to improve its encounter data submissions: data accuracy related to the member identification numbers for 837P encounters and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all three encounter types.

WS

WS's submitted encounters met the standards for the X12 EDI compliance edits and the accuracy for billing and servicing providers for its 837P/I encounters.

HSAG recommends that **WS** focus on the following areas to improve its encounter data submissions: data accuracy related to the member identification numbers for its 837P/I encounters, data completeness (i.e., percent present in Table 4-12) related to the member identification numbers for its pharmacy encounters, data accuracy related to billing provider information for its pharmacy encounters, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all three encounter types.

Other EDV Activities

HSAG is finalizing a single aggregate report that will be completed in December 2020, and the report will contain key findings for DHHS, **ACNH**, **NHHF**, and **WS**, as well as conclusions and recommendations from all four EDV activities. Therefore, the results from the IS review, comparative analysis, and medical record review will be presented in the New Hampshire SFY 2021 technical report.

Other EQR Activities

Semi-Structured Qualitative Interviews

Fall Semi-Structured Interviews

The fall study included interviewing 30 women who had recently given birth (i.e., between April 2019 and September 2019) to determine their experience with the services provided by their MCO. Fifteen women were members in **NHHF**, and 15 women were members in **WS**. Horn Research conducted the semi-structured telephone interviews between November 5, 2019, and December 6, 2019, and the sample population included members from across New Hampshire.

Findings

The interviewer asked members to share both positive and challenging experiences they had with their health plan while they were pregnant and after their baby was born. Participants indicated that the most positive experiences included having their medical bills paid, the incentives and rewards available to them, and interactions with both customer service and case management. Most women revealed that they had not had any negative experiences. Some of the challenges mentioned included coverage and billing issues, difficulties with the Medicaid recertification process, and not receiving promised incentives. The participants noted, however, that they had someone to contact for help or support at their MCO and expressed general satisfaction with their experiences.

Nine participants mentioned that the most positive experience was the MCO paying for their medical bills, and eight participants appreciated the various incentives and rewards available to them from their MCO. Seven participants indicated that they appreciated the MCO's customer service to help them through their pregnancy and delivery. Six women noted the incentives available from their health plan to include breast pumps, car seats, and reward cards, and four members mentioned the continued case management as a welcome aspect of their pregnancy and delivery.

Twenty-four participants said they did not have a negative experience with their MCO during their pregnancy. Three women had difficulties with specific coverage issues (i.e., nutritional counseling, medications, and dental work). One participant reported difficulty in getting the reward card, and another participant found that the MCO contacted her too frequently while she was pregnant.

Twenty-six of the 30 participants did not have any challenging experiences to share about their interactions with their MCO. Three women had difficulty obtaining the incentives including one person who did not receive the breast pump as soon as needed, and one participant incorrectly received a bill for the delivery. Overall, participants knew who to call for assistance when needed and said that their interactions with their MCO had been positive and helpful. Participants mentioned the MCOs' website as a useful resource in answering some of their questions.

Overall, participants reported receiving early prenatal care and expressed satisfaction with the range of choices available to them for providers and birthing centers. All participants said they had accessed

postpartum care. Nineteen participants said there were either a lot or enough choices for an obstetrician (OB) or midwife available through their health plan. Eight participants said they had required the services of another doctor, excluding their OB or PCP, during their pregnancy. Three participants said they had received care from a high-risk OB doctor or a maternal-fetal medicine specialist. One participant said she had seen a geneticist. Twenty-six participants said they had access to prenatal vitamins and other needed medications during their pregnancy. One participant said her health plan would not pay for the prenatal vitamins with iron as prescribed by her doctor, and two participants noted challenges with coverage for their anti-nausea medication. All 30 participants had their postpartum checkup with their provider.

All but a few members indicated that they had been screened for tobacco and substance use during and after pregnancy. Twenty-six women were provided information about the option to receive an intrauterine device (IUD) implant after giving birth and before being discharged from the hospital. Seven participants were offered home visits by a nurse after delivery; however, all declined the visit.

Participants were unanimous in the positive assessment of the quality of care they received during their pregnancy. A handful of participants noted challenges with care while in the hospital giving and after birth. Nearly all participants gave high praise for the quality of care they received after their pregnancy. Twenty-five participants said there was nothing that they did not like about their provider. Two women mentioned specific tests that they were not offered (i.e., genetic testing), two others mentioned not liking their providers' approach, and one indicated that she did not have one specific doctor during her pregnancy. Scheduling appointments with her provider was a problem for one participant.

Sixteen women were not familiar with the name of the programs offered by their MCO for pregnant women (i.e., *Sunny Start* and *Smart Start for Your Baby*); however, the participants did receive some of the services offered through those programs. Nine participants received case management support from their MCO, and one participant declined participation in case management. Thirteen women received educational information about pregnancy, birth, and postpartum care from the MCO, and all but five participants said they had received some kind of incentive from their MCO. Of the 25 participants who had received some kind of incentive, 23 had gotten a breast pump. Three participants said their MCO assisted in their enrollment in Women, Infants, and Children (WIC).

Fifteen participants had no suggestions for improvement during their pregnancy, and 20 had no suggestions for improvement after their baby was born. One participant said that she would have liked additional information concerning medications during delivery, and one woman was concerned about not being able to stay with her child in the neonatal intensive care unit (NICU). Five participants mentioned improving communication about the pregnancy program benefits, and two women mentioned a desire for improved access to testing during pregnancy. One participant would have liked more providers to accept her health plan, and one suggested improving transportation reimbursement.

Conclusions and Recommendations

Overall, participants expressed satisfaction with the care they received from their providers and the support they received from their MCO both during and after their pregnancy. Based on the information gathered from interview participants, two overarching recommendations have been developed.

Recommendations included improving awareness of the programs for pregnant women offered by their MCO and the benefits available during and after pregnancy. Information gained during the interviews indicated that new moms were most likely to need, want, and value the case management support and educational information during pregnancy than women with previous pregnancy. Focusing outreach and information to new moms may have the effect of optimizing resources while ensuring support for the highest need families.

Spring Semi-Structured Qualitative Study

The SFY 2020 spring study with the parents or guardians of 30 Medicaid members who were either 11 or 12 years of age at the time of sampling. Horn Research conducted the telephone interviews between April 16, 2020, and May 14, 2020, and members from all three MCOs were included in the study. A total of 57 percent of the members lived in a non-rural public health region (PHR) and 43 percent of the members lived in a rural PHR.

Findings

Participants were asked to describe their understanding of their child's health plan, positive and challenging encounters they had experienced with their MCO, their understanding of their MCO's complaint process, and their utilization of the MCO's case management services. They were also asked to describe their experience with educational materials they may have received from their MCO.

Eighteen participants said they understood their child's health insurance plan, and 12 participants indicated that they did not understand their child's health insurance plan. Those who did not understand their child's health insurance plan believed that knowledge was unnecessary because their child's health needs had been covered. The positive attributes of MCOs included the coverage provided by the plan, the provider network, the ease of use, and the MCO's customer service. The bulk of participants had not experienced any challenges with their MCO.

Five participants said they liked the MCOs' network of providers, and five participants indicated that they were pleased with the various perks they receive through their child's health insurance plan. Four participants mentioned that they liked how easy it was to use their child's health insurance benefits. When asked about negative experiences with their MCO, 20 participants said they had not experienced any challenges. Four participants indicated that they had difficulty finding dental providers on their MCO's network.[4-11] Two participants noted challenges centering around communication from their

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[4-11] The New Hampshire Medicaid Children's Dental Benefit is not provided through the New Hampshire MCM Program but is a service provided by the New Hampshire Medicaid FFS program.

MCO: One person was not aware of her child loosing coverage because the parent/guardian did not send in the necessary documents, and another felt that the MCO could furnish more complete provider information (i.e., locations of the providers' offices). One person indicated that she had a negative experience with her MCO's rewards program, and one participant had experienced a delay in receiving her child's insurance card.

When asked how they get support when they have questions about their coverage, 17 participants said they call the number on the back of the insurance card. The majority of those participants said they had easily received the information they needed. Three participants, not all enrolled in the same MCO, said they had some challenges in getting their questions answered by calling the customer service number. Two participants said they use both email and the MCO's website to resolve questions, and two participants indicated that they contacted their case manager with any questions.

Twenty-five participants said they were not aware of their MCO's complaint process; however, the participants did think they could contact their MCO's customer service department if they had a complaint. Five participants said they were aware of the complaint process but had never used it.

When asked about case management services, 19 participants said their child did not receive those services, four participants said their child received those services through their school as part of their Individualized Education Program (IEP), and two participants said their case management services were furnished by a community-based organization. One participant said her child was currently receiving case management from the MCO and the MCO did a great job meeting the needs of the child and family.

When asked whether they had received educational materials from their MCO and whether they liked and used the material, eight participants said they did not recall and seven participants said they had not received any. All 15 of these participants indicated they were not interested in receiving educational materials from their MCO. Fourteen participants said they had received educational information from their MCO, and eight of those participants said they appreciated the information. Of those who had received the information, but did not want it, the most common comments were that the information was not helpful and was too general in nature.

Of the 12 participants whose children take medication regularly, only four had experienced challenges with access. Two participants discussed pharmacies not accepting their insurance, one experienced challenges with pre-authorization for insulin, and one had an issue with the pharmacy delivering the medication to the wrong address.

Twenty-two participants indicated their child had not needed occupational, speech, or physical therapy. Those who had said they accessed the therapies through their child's school and were satisfied with the support their child received. Seven participants said their child had received occupational and/or speech therapy at school, and those participants universally agreed that the therapies provided at school were effective. One participant mentioned that her son received visual therapy, but it was not covered by the MCO. Twenty-seven interview participants said their child had not needed access to any medical equipment or supplies.

Twenty-four participants described their relationship with their child's PCP as positive but noted a long wait time when scheduling appointments. Participants frequently noted their PCP was willing to take the time to listen and get to know their family. Three participants said their PCP communicates well with their children's specialists. All but one participant said the PCP had broached the topic of weight and nutrition with their child. Eleven participants indicated that the discussion was short and not very informative. Seven participants said the discussion was somewhat more robust and impactful. One participant said she liked her provider, but wished she was more familiar with mental health issues.

Twenty-two participants noted that their children were up-to-date with all vaccines. Four participants followed an alternate vaccine schedule, and four had declined the flu vaccine. When asked specifically about the HPV vaccine, 10 participants said their child had already received both doses. Nine participants said their child had received the first dose and planned to get the second dose when it is scheduled by their physician. Eleven participants, with at least one from each MCO, said their child had not yet received their first HPV vaccine dose. Of these, five said they had not yet been offered the vaccine, but intended to have their child receive it.

Participants were asked to describe their experience with the evaluation of their child's mental and emotional health by their PCP. Ten participants said their child's provider does an extensive evaluation of their child's emotional health on an on-going basis. Seven participants said the provider used a screening tool to evaluate their child's mental health, but not all thought it was effective. Five participants said the provider casually checks with their child to see how he/she is doing. Four participants said the provider had not reviewed their child's emotional health during the previous visit and an additional four participants said they did not know whether the provider had done any type of mental health evaluation.

Conclusions and Recommendations

Overall, participants expressed satisfaction with the care they received from their providers and the support they received from their MCO. Based on the information gathered from interview participants, three recommendations emerged from the discussions: (1) participants noted challenges finding mental health providers covered by their MCO in their local communities and limited mental health evaluation and support from their child's PCP; (2) continued communication on the importance, value, and safety of vaccines, especially HPV and the flu vaccine, may increase parents' amenability to immunization; and (3) an additional benefit from the MCOs to provide funding for sports fees and equipment would enable families to support and encourage their children's physical activity.

Secret Shopper Survey

DHHS contracted with HSAG during SFY 2020 to conduct a secret shopper telephone survey among PCPs contracted with a Medicaid MCO. The secret shopper telephone survey allows for objective data collection from healthcare providers while minimizing potential bias introduced by knowing the identity of the surveyor. HSAG evaluated the providers in New Hampshire's MCM network to address the following survey objectives:

- Determine whether providers accept members enrolled with a Medicaid MCO
- Determine whether providers are accurately identified in the MCOs' provider data as PCPs
- Determine whether providers accept new patients
- Determine appointment availability for new Medicaid members requesting routine well-checks or nonurgent problem-focused ("sick") visits

The three participating MCOs, **ACNH**, **NHHF**, and **WS**, submitted provider data for HSAG's use. To include a comparison of the MCM Program results to a commercial insurance plan, HSAG assessed appointment availability using the Anthem State Employee Plan (Anthem) offered in New Hampshire by Anthem BlueCross BlueShield. HSAG completed calls to all sampled provider locations during February and March 2020,[4-12] recording survey responses in an electronic data collection tool.

Results

HSAG attempted to contact 1,592 sampled provider locations (i.e., "cases"), with an overall response rate of 67.5 percent among the health plans. Of the responsive cases, 85.6 percent (919 cases) accepted the health plan requested by the caller (i.e., the Medicaid MCO or Anthem).

Among the cases in which the provider accepted patients with the health plan, 84.3 percent (775 cases) confirmed that the requested provider was a PCP. Survey results indicate that the MCOs' provider data contain inaccuracies regarding providers' status as PCP. Of the cases in which the survey respondent indicated that the sampled provider was not a PCP, the majority of cases noted that the sampled provider was a nurse practitioner (NP).

Moreover, among the survey respondents who indicated that the sampled provider accepted the MCO and was confirmed to be a PCP, 54.3 percent (421 cases) responded that the provider location was accepting new patients, with similar results across all health plans. However, among the cases accepting the health plan, confirmed as a PCP, and accepting new patients, only 6.9 percent (29 cases) offered an appointment date to the caller.

Of the nonresponse cases, 54.4 percent (282 cases) of the providers were not at the sampled location. Overall, **NHHF** had the greatest number of providers (83 cases) for whom the survey respondent was unable to confirm that the provider practiced at the sampled location.

Regardless of the health plan or visit type, very few survey respondents were offered an appointment, even though the sampled provider location accepted the health plan and accepted new patients. Table 4-16 displays the survey respondents' stated limitations by health plan. One case may have multiple limitations affecting access to care, including the ability to obtain appointment availability information.

[4-12] HSAG began survey calls on February 10, 2020, and completed all calls no later than March 13, 2020, prior to the federal emergency declaration regarding the COVID-19 pandemic and subsequent impacts to PCPs' scheduling of routine well checks and nonurgent sick visits.

Table 4-16—Access to Care Limitations, by MCO

Limitation[1]	ACNH	NHHF	WS	Anthem
No Limitations Noted	1	3	3	1
One or More Limitations Noted	81	108	112	112
Must fill out questionnaire first	27	3	20	NA[3]
Requires medical record review	38	47	54	44
Requires pre-registration or personal information to schedule	62	100	103	99
Other[2]	16	10	23	22

[1] Callers selected all potential limitations reported for each case in which the sampled provider location was reached, was accepting the health plan, was confirmed to be a PCP, and was accepting new patients. An individual case may have multiple limitations or no limitations.

[2] "Other" includes the number of unique cases reporting one or more other limitations.

[3] NA indicates that the limitation was not reported by any of the cases for the health plan.

Among the limited number of MCO cases that offered appointment availability, the overall median wait time[4-13] was 15 calendar days for a routine well-check visit and three calendar days for a nonurgent sick visit.

Recommendations

Due to the nature of the survey methodology and script, the full Secret Shopper Report includes limitations to consider when generalizing survey results across PCPs contracted with each New Hampshire Medicaid MCO. Based on the findings detailed in the report and the accompanying case-level survey data files submitted to DHHS, HSAG offers the following recommendations to evaluate and address potential MCO provider data quality and/or access to care concerns:

- Overall, HSAG was unable to reach 32.5 percent of the sampled cases. Callers noted that a key nonresponse reason involved call attempts in which the provider was no longer practicing at the location listed in the provider data supplied by the MCO. Since the MCOs supplied HSAG with the provider data used for this survey, DHHS should supply each MCO with case-level survey data containing identified provider data deficiencies (e.g., incorrect or disconnected telephone numbers) and require the MCOs address these deficiencies.

- The MCOs' provider data included a PCP indicator, and all sampled cases were identified as PCPs by their respective MCO. However, HSAG's survey results identified cases in which the survey respondent noted that the requested provider was not a PCP. DHHS should consider conducting an independent provider directory review to verify that the MCOs' publicly available provider data contain accurate information for their members.

[4-13] The average and median appointment wait times were heavily skewed, due to the limited number of cases offering appointment availability. As such, HSAG suggests using caution in drawing conclusions about MCOs' compliance with contract requirements for appointment availability based only on the PCP Secret Shopper Survey results.

- Survey responses include several barriers to obtaining appointment availability, including offices requiring pre-registration, Medicaid eligibility verification, the MCO's assignment of the member with the PCP, and/or medical record review prior to offering an appointment date. Certain barriers are unique to the secret shopper methodology (e.g., callers will not supply personal information to pre-register with a practice); however, other limitations suggest barriers for all Medicaid members attempting to schedule appointments. DHHS and the MCOs should consider conducting a review of the provider offices' requirements to ensure these barriers are not unduly burdening the members' ability to access primary care.
  - Additionally, DHHS should consider using a revealed caller survey approach for future appointment availability evaluations, based on the finding that a majority of offices require a secret shopper caller to supply personal information before offering an appointment.
- While average and median appointment wait times were collected for relatively few cases, differences in appointment wait times by MCO suggest that providers willing to serve Medicaid members may not be contracted with all Medicaid MCOs. DHHS should consider comparing each MCO's provider network data to DHHS data concerning the providers contracted to serve New Hampshire Medicaid members (i.e., a saturation analysis) to determine the extent to which each MCO is contracted with available providers.

Provider Satisfaction Survey

During SFY 2020, HSAG completed the survey preparation activities for the administration of a provider satisfaction survey to PCPs and specialists contracted with one or more of New Hampshire Medicaid's MCOs. A customized provider satisfaction survey instrument was developed by HSAG in collaboration with DHHS. The cover letter's text was approved by DHHS. In addition, HSAG and DHHS identified the eligible survey population and finalized a sampling plan.

When HSAG created the original timeline for the SFY 2020 Provider Satisfaction Survey in August 2019, the mailing of provider surveys was to begin in July 2020. However, due to the travel restrictions and stay-at-home orders in many states in response to the COVID-19 pandemic, DHHS and HSAG agreed to delay the administration of the survey until later in 2020. As a result of this delay, the provider satisfaction survey findings will be included in the SFY 2021 technical report.

5. Assessment of the New Hampshire MCM Quality Strategy

Background

HSAG conducted a review of the New Hampshire MCM Quality Strategy dated SFY 2020 to verify that it met the requirements detailed in the revised federal regulations, specifically, 42 CFR §438.340. The final rule issued by CMS, Department of HHS, was published in the Federal Register on May 6, 2016. According to 42 CFR, the final rule:

> *"...modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Plan (CHIP) beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes."*[5-1]

The New Hampshire MCM Quality Strategy includes seven goals of the MCM Quality Program: (1) assure the quality and appropriateness of care delivered to the New Hampshire Medicaid population enrolled in managed care; (2) assure New Hampshire members have access to care and a quality experience of care; (3) assure MCO contract compliance; (4) assure MCO quality program infrastructure; (5) assure the quality and validity of MCO data; (6) manage continuous performance improvement; and (7) conduct targeted population quality activities. HSAG works with DHHS to ensure that the EQR activities support and enhance the strategies and goals established in the New Hampshire MCM Quality Strategy to improve the health and well-being of the State's Medicaid beneficiaries.

Methodology

New Hampshire DHHS provided HSAG with the most recent version of the New Hampshire MCM Quality Strategy.[5-2] After receiving the document, HSAG developed a review tool, shown in Appendix C, which included the current requirements for state quality strategies as described in 42 CFR §438.340.

[5-1] National Archives and Records Administration. *The Federal Register*. May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Sept 18, 2020.

[5-2] New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy for SFY 2020*. Available at: https://medicaidquality.nh.gov/care-management-quality-strategy. Accessed on: Sept 8, 2020.

HSAG compared each requirement of the New Hampshire MCM Quality Strategy to the federal requirements and determined if evidence of each requirement was found in the document.

Findings

HSAG's review determined that all of the federal requirements were addressed in the New Hampshire MCM Quality Strategy. Two federal requirements were not applicable to New Hampshire because there were no PCCM entities in the New Hampshire MCM Program, and there were no recognized tribes in New Hampshire. Table 5-1 shows the summary results of HSAG's review of the New Hampshire MCM Quality Strategy. Additional details concerning the findings from the review are included in Appendix C.

Table 5-1—Results of SFY 2020 Quality Strategy Review

	Citation	Section	Topic	Addressed/Not Addressed/Partially Addressed in Quality Strategy
1.	§438.340	(a)	General Rule	Addressed
2.	§438.340	(b)(1)	Clinical Practice Guidelines	Addressed
3.	§438.340	(b)(2)	Goals and Objectives for Continuous Quality Improvement	Addressed
4.	§438.340	(b)(3)(i)	Quality Metrics and Performance Targets	Addressed
5.	§438.340	(b)(3)(ii)	Performance Improvement Projects	Addressed
6.	§438.340	(b)(4)	Annual External Independent Review	Addressed
7.	§438.340	(b)(5)	Transition of Care Policy	Addressed
8.	§438.340	(b)(6)	Identifying, Evaluating, and Reducing Health Disparities	Addressed
9.	§438.340	(b)(7)	Sanctions	Addressed
10.	§438.340	(b)(8)	Assessing Outcomes for PCCM Entities	Not Applicable
11.	§438.340	(b)(9)	Identification of Persons Needing Long-Term Services and Supports and Persons with Special Needs	Addressed
12.	§438.340	(b)(10)	Non-Duplication of External Quality Review (EQR) Activities	Addressed
13.	§438.340	(b)(11)	Definition of Significant Change	Addressed
14.	§438.340	(c)(1)(i)	Public Comment	Addressed
15.	§438.340	(c)(1)(ii)	Consulting with Tribes	Not Applicable
16.	§438.340	(c)(2)	Updating Quality Strategy	Addressed
17.	§438.340	(c)(2)(i)	Evaluation of the Effectiveness of the Quality Strategy	Addressed

	Citation	Section	Topic	Addressed/Not Addressed/Partially Addressed in Quality Strategy
18.	§438.340	(c)(2)(ii)	Quality Strategy Review Posted to Website	Addressed
19.	§438.340	(c)(2)(iii)	Recommendations to the Quality Strategy	Addressed
20.	§438.340	(c)(3)(i)	Submitting the Quality Strategy to CMS	Addressed
21.	§438.340	(c)(3)(ii)	Submitting Revised Quality Strategies to CMS	Addressed
22.	§438.340	(d)	Availability of the Final Quality Strategy on the Website	Addressed

One issue not defined in 42 CFR §438.340 was the listing of mandatory activities that the EQRO must perform. In Section II—Medicaid Managed Care Quality Program, Part A—DHHS Managed Care Quality Program Overview listed the federally mandatory EQRO scope of work for the New Hampshire Medicaid EQRO. The list included validating PIPs, validating MCO quality performance measures, preparing an EQRO technical report for each Medicaid MCO, and validating MCO network adequacy after receiving guidance about the activity from CMS.

The four mandatory EQR activities defined by CMS in 42 CFR §438.358(b) included validation of PIPs, validation of performance measures, a review conducted within the previous three-year period to determine the MCO's compliance with the standards, and validation of network adequacy (pending the publications of the protocols for that activity). The creation of the EQR Technical Report is not considered a mandatory activity as defined in 42 CFR §438.358; however, an annual detailed technical report is required in 42 CFR §438.364. To ensure compliance with 438.358(b), DHHS must include a review conducted within the previous three-year period to determine the MCO's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330 as one of the mandatory EQR activities.

The New Hampshire MCM Program now has performance measure rate requirements for four preventive care measures and six annual treatment measures. Goal 1 Objectives 1.1 and 1.2 indicate that the preventive care measure rates and annual treatment measure rates are to be equal to or higher than the 75th percentile of the national Medical managed care health plan rates by the end of SFY 2022. Beginning September 1, 2019, the four preventive care measures and six annual treatment measures will be targeted to produce rates equal to or higher than the national average.

Table 5-2 includes the CY 2019 results of the preventive care measures and annual treatment measures listed in the Quality Strategy. Since DHHS established the requirement to produce rates equal to or higher than the national average effective September 1, 2019, these rates are for informational purposes only due to the fact that the results from September 1, 2019–December 31, 2019, cannot be isolated from the annual rates to determine compliance for those four months. National benchmarks are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS CY 2018, the most current

benchmarks available. Since **ACNH** was not in operation during CY 2019, there were no HEDIS rates available for that MCO.

Table 5-2—CY 2019 HEDIS Results for the Preventive Care Measures and Annual Treatment Measures Included in the SFY 2020 Quality Strategy

	Measure	Description	CY 2019 Rate Achieved was Equal to or Higher than the 50th Percentile	
Preventive Care Measures			**NHHF**	**WS**
1.	CMS Adult Core Set/HEDIS (IMA)	*Immunizations for Adolescents—Combination 1*	No	No
2.	CMS Adult Core Set/HEDIS (IMA)	*Immunizations for Adolescents—Combination 2*	No	No
3.	CMS Adult Core Set/HEDIS (CHL)	*Chlamydia Screening in Women—16–20 Years*	No	No
		Chlamydia Screening in Women—21–24 Years	No	No
		Chlamydia Screening in Women—Total	No	No
4.	CMS Adult Core Set/HEDIS (PPC)	*Prenatal and Postpartum Care—Postpartum Care*	*	*
Annual Treatment Measures			**NHHF**	**WS**
5.	CMS Adult Core Set/HEDIS (SAA)	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	Yes	Yes
6.	CMS Adult Core Set/HEDIS (SSD)	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	Yes	Yes
7.	CMS Adult Core Set/HEDIS (ADD)	*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*	Yes	No
8.	CMS Adult Core Set/HEDIS (IET)	*Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*	Yes	Yes
9.	CMS Adult Core Set/HEDIS (APP)	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*	Yes	Yes
10.	HEDIS (LBP)	*Use of Imaging Studies for Low Back Pain*	Yes	Yes

* Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 (i.e., CY 2019) and prior years.

NHHF achieved a rate equal to or higher than the 50th percentile for six measures of the nine measures that can be compared year-to-year in Table 5-2, and **WS** achieved a rate equal to or higher than the 50th percentile for five measures of the nine measures that can be compared year-to-year in Table 5-2. Detailed findings from the comparison of the New Hampshire MCM Quality Strategy dated SFY 2020 to the requirements found in 42 CFR §438.340 are found in Appendix C.

The following section presents HSAG's recommendations made in the prior year's EQR report (i.e., SFY 2019 EQR Technical Report) and an assessment of the actions that were implemented to correct the areas of improvement. The results are reported for **NHHF** and **WS**. Since **ACNH** did not enter the New Hampshire MCM Program until September 2019 (i.e., SFY 2020), no results are included for that MCO.

New Hampshire Healthy Families

The SFY 2019 EQR Technical Report contained opportunities for improvement for **NHHF** in the contract compliance audit, PIPs, HEDIS, and EDV. Table 6-1 through Table 6-23 display the self-reported follow-up activities conducted by **NHHF** during SFY 2019 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG conducted a contract compliance audit to assess MCO performance with respect to requirements found in 42 CFR §438 and the DHHS contract with **NHHF**. HSAG reviewed 12 standards containing 105 applicable elements for **NHHF**. HSAG received a CAP for each element found non-compliant in four standards (i.e., Member Enrollment and Disenrollment, Access to Care, Network Management, and SUD), and all items were found to be compliant with the revisions instituted by **NHHF** in the CAPs completed on March 1, 2019.

Table 6-1—Contract Compliance—Opportunities for Improvement and MCO Response #1

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard VII– Member Enrollment and Disenrollment	**3. Disenrollment Reasons Without Cause** A member may request disenrollment without cause at the following times: a. During the 90 days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later; or e. During open enrollment related to re-negotiation and re-procurement.	Partially Met	Met
NHHF's Contract Compliance CAP Response #1			
NHHF updated policy NH.ELIG.02-Disenrollment to reflect the following: Members may request disenrollment without cause: During the 90 days following the date of the member's enrollment with the MCO or the date that DHHS (or its agent) sends the member notice of the enrollment, whichever is later; and during open enrollment related to re-negotiation and re-procurement. The updated policy language meets the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-2—Contract Compliance—Opportunities for Improvement and MCO Response #2

HSAG Contract Compliance Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XI–Access to Care	**3. Abortions are provided only in the following situations:** a. If the pregnancy is the result of an act of rape or incest; or b. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the women in danger of death unless an abortion is performed.	Partially Met	Met
NHHF's Contract Compliance CAP Response #2			
NHHF submitted the updated Covered Benefits and Services Policy and Procedure and revisions to the **NHHF** Provider Manual. The updated policy and manual specified that abortions are provided only in the following situations: If the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. The updated language meets the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-3—Contract Compliance—Opportunities for Improvement and MCO Response #3

HSAG Contract Compliance Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XII–Network Management	**5. Provider Training** The MCO provides training to all providers and their staff regarding the requirements of the MCO Agreement with DHHS including the grievance and appeals system. The MCO's provider training is completed within 30 calendar days of entering into a contract with a provider, and the MCO provides ongoing training as required by the MCO or DHHS.	Partially Met	Met
NHHF's Contract Compliance CAP Response #3			
NHHF revised the New Provider Orientation tracker to include a completed date to ensure that network provider training is completed within 30 calendar days of entering into a contract with a provider. The information contained in the revised New Orientation Tracker meets the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-4—Contract Compliance—Opportunities for Improvement and MCO Response #4

HSAG Contract Compliance Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XII– Network Management	9. **Anti-gag Clause for Providers** The MCO does not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient: d. For the member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.	Partially Met	Met
NHHF's Contract Compliance CAP Response #4			
NHHF updated language in the Member Rights section of the **NHHF** Provider Manual to include the following statement: **NHHF** members have the right to participate with practitioners in making decisions regarding his/her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions. The updated language in the Provider Manual meets the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-5—Contract Compliance—Opportunities for Improvement and MCO Response #5

HSAG Contract Compliance Opportunities for Improvement #5			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV– Substance Use Disorder	2. **Initial Eligibility Screening for SUD Services** The SUD provider conducts an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but no later than two business days following the date of first contact.	Not Met	Met
NHHF's Contract Compliance CAP Response #5			
NHHF submitted the revised Substance Use Disorder Policy and the SUD Treatment Review Tool. The policy and the review tool included the requirement that the SUD provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, not later than two business days following the date of first contact. The revised policy and review tool meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-6—Contract Compliance—Opportunities for Improvement and MCO Response #6

HSAG Contract Compliance Opportunities for Improvement #6			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV–Substance Use Disorder	**3. Members Screening Positive for SUD Services** Members who have screened positive for SUD services receive an American Society for Addiction Medicine (ASAM) Level of Care (LOC) Assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three days after admission.	Not Met	Met
NHHF's Contract Compliance CAP Response #6			
NHHF submitted the revised Substance Use Disorder Policy and the SUD Treatment Review Tool. The policy and the review tool included the requirement that members who have screened positive for SUD services receive an ASAM LOC Assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC Assessment and no later than three days after admission. The revised policy and review tool meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.			

Table 6-7—Contract Compliance—Opportunities for Improvement and MCO Response #7

HSAG Contract Compliance Opportunities for Improvement #7			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV–Substance Use Disorder	**6. Pregnant Women with an ASAM LOC** Pregnant women will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor: a. Assists the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance includes actively reaching out to identify providers on the behalf of the client; and b. Provides interim services until the appropriate LOC becomes available at either the contractor agency or an alternative provider. Interim services include: i. At least one 60-minute individual or group outpatient session per week; ii. Recovery support services as needed by the client; and iii. Daily calls to the client to assess and respond to any emergent needs.	Partially Met	Met

NHHF's Contract Compliance CAP Response #7
NHHF submitted the revised Substance Use Disorder Policy and the SUD Treatment Review Tool. The policy and the review tool included the requirement that if a client is identified as pregnant, she is admitted to the identified level of care within 24 hours of the ASAM LOC Assessment. The revised policy and review tool meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **NHHF** completed the CAP for this element.

Table 6-8—Contract Compliance—Opportunities for Improvement and MCO Response #8

HSAG Contract Compliance Opportunities for Improvement #8			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Provider Directory and MCO Website	The MCO's provider directory and website contain information concerning whether the provider has completed competence training.	Partially Met	Met
NHHF's Contract Compliance CAP Response #8			
The **NHHF**'s provider directory, effective June 30, 2019, included the identification of providers who completed cultural competency training, and the website also contained that information on the same date.			

Table 6-9—Contract Compliance—Opportunities for Improvement and MCO Response #9

HSAG Contract Compliance Opportunities for Improvement #9			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Appeals File Review	The MCO must ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the authorized provider requests an expedited resolution. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution.	Partially Met	Met
NHHF's Contract Compliance CAP Response #9			
NHHF documented the provision of re-education for grievance and appeals staff members related to oral appeals and the requirement that oral appeals must be confirmed in writing. This element is complete.			

PIPs

HSAG validated three PIPs submitted by **NHHF**: *Comprehensive Diabetes Screening—Vision Screening*, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, and *Well-Child Visits for 3-to-6-Year-Olds*. HSAG validated the three PIPs through the Design, Implementation, and Outcomes phases of the PIP process. One PIP, *Comprehensive Diabetes Screening—Vision Screening*, successfully demonstrated sustained improvement. The 2019 New Hampshire EQR Technical Report contained opportunities for improvement for the two additional PIPs as noted below.

Table 6-10—PIP Validation—Opportunities for Improvement and MCO Response #10

HSAG PIP Opportunities for Improvement #10			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	No Statistically Significant Improvement	Statistically Significant Improvement
NHHF's PIP Response #10			
The opportunity identified during the PIP was sustained through year-round coordination with the Provider Network Team, specifically focused on Behavioral Health providers. **NHHF** consistently shared member detail for the Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD) measure throughout the year. The plan also engages in meetings with the key behavioral health providers and their quality contacts to further clarify actionable activity to improve the rate. By June of 2019 there was no impact to the intervention but outreach continued with these behavioral health providers and by calendar year end there was a significant improvement (9.2) in the rate year over year for this subgroup of providers and members attributed. This measure has become part of the Rapid-Cycle PIP process for 2020 through a narrowed focus approach. It is thought that continued attention will improve the overall rate.			

Table 6-11—PIP Validation—Opportunities for Improvement and MCO Response #11

HSAG PIP Opportunities for Improvement #11			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	*Well-Child Visits for 3-to-6-Year-Olds*	No Statistically Significant Improvement	Statistically Significant Improvement
NHHF's PIP Response #11			
NHHF continues to outreach to members eligible for EPSDT services who are non-compliant with visits, including Well Child Visits for Children Ages 3-6 years old (W34). The plan concludes that direct member contact is still the best outreach to encourage compliancy with well visits. This outreach helps to ensure that EPSDT services are being provided to our members and that the members understand that these services are covered by their plan. In 2019, we reached a total of 75% of our non-compliant members, over 800 more members than in 2018, and we saw a rate improvement of almost 2 points. **NHHF** will continue direct member outreach to further improve our well visit compliance.			

HEDIS

NHHF contracted with an NCQA LO to have its measure rates reviewed by a CHCA. **NHHF** also contracted with an external software vendor to assist in HEDIS measure production and rate calculation. The rates for two HEDIS measures fell below the 25th percentile for the HEDIS Audit Means and Percentiles (national Medicaid HMO percentiles). The opportunities for improvement in HEDIS for **NHHF** are shown in the tables below.

Table 6-12—HEDIS—Opportunities for Improvement and MCO Response #12

HSAG HEDIS Opportunities for Improvement #12			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below Medicaid 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #12			
NHHF acknowledges the low rate for this measure, with the lowest being the women 16–20 years of age. **NHHF** requested input from Providers who were a part of the QI Committee as well as independent Pediatric Providers to assess the barriers to this testing. **NHHF** has developed a Quick Reference Guide that includes the appropriate coding for completion of this screening, to aid providers with ease of billing. **NHHF** included this measure in the Alternative Payment Model for provider groups that make up the largest percentage of members in the plan's population (Shared Savings Value Model & Health Benefit Ratio Model contracts). **NHHF** also provided a member reminder mailer for appropriate testing for Women, which includes Chlamydia screening. **NHHF** will continue to work with all stakeholder to identify and overcome barriers to this screening.			

Table 6-13—HEDIS—Opportunities for Improvement and MCO Response #13

HSAG HEDIS Opportunities for Improvement #13			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*	Below Medicaid 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #13			
NHHF has initiated significant interventions to improve the IET Initiation measure. The measure is included in the Alternative Payment Model for the majority of the plan's large provider groups to encourage them to monitor the members on their panels for diagnosis events. **NHHF** initiated a contract with Collective Medical Technology (CMT). This service tracks ADT for participating facilities and allows the plan to have the ability to see real-time admissions for appropriate diagnosis. With this information, a newly formed team of Care Managers attempt to make immediate contact with members to assist with coordination of follow up care.			

EDV

During SFY 2019, HSAG continued to use an EDQRS to evaluate the quality of encounter data files submitted by the MCOs. The opportunities for improvement in EDV for **NHHF** are shown in the tables below.

Table 6-14—EDV—Opportunities for Improvement and MCO Response #14

HSAG EDV Opportunities for Improvement #14			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.8%	100%
NHHF's EDV Response #14			
The small discrepancy in member identification numbers is due to a timing issue with retroactive eligibility terminations. **NHHF** ensures eligibility process has loaded current file upon encounter file creation and submission. **NHHF** also reviews eligibility encounter rejects on a regular basis for resubmission.			

Table 6-15—EDV—Opportunities for Improvement and MCO Response #15

HSAG EDV Opportunities for Improvement #15			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	99.8%	100%
NHHF's EDV Response #15			
The small discrepancy in member identification numbers is due to a timing issue with retroactive eligibility terminations. **NHHF** ensures eligibility process has loaded current file upon encounter file creation and submission. **NHHF** also reviews eligibility encounter rejects on a regular basis for resubmission.			

Table 6-16—EDV—Opportunities for Improvement and MCO Response #16

HSAG EDV Opportunities for Improvement #16			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	99.9%	100%
NHHF's EDV Response #16			
The small discrepancy in member identification numbers is due to a timing issue with retroactive eligibility terminations. **NHHF** ensures eligibility process has loaded current file upon encounter file creation and submission. **NHHF** also reviews eligibility encounter rejects on a regular basis for resubmission.			

Table 6-17—EDV—Opportunities for Improvement and MCO Response #17

HSAG EDV Opportunities for Improvement #17			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Validity of Servicing Provider Information—Percent Valid	82.8%	98.0%
NHHF's EDV Response #17			

For both MCOs, five National Provider Identifiers (NPIs) were identified in the report: 1033118104 - WENTWORTH DOUGLASS HOSPITAL, 1053495234 – LRGHEALTHCARE-LACONIA, 1629181516 - CHESHIRE MEDICAL CENTER, 1174570683 - HCA HEALTH SERVICES OF NEW HAMPSHIRE INC, 1700960895 – LRGHEALTHCARE-FRANKLIN.
    a. Initial step taken was to look up the 5 NPIs in the DHHS NH State provider file and the 5 NPIs did not exist in the file.
        i. **NHHF** is working with our provider relations team as to why these 5 NPIs are not registered with DHHS.
        ii. **NHHF** provider relations team will take additional steps on getting providers registered or get corrected information in our claims adjudication system.			

Table 6-18—EDV—Opportunities for Improvement and MCO Response #18

HSAG EDV Opportunities for Improvement #18			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Timeliness—Weekly Submissions	98.1%	100%
NHHF's EDV Response #18			
NHHF has reporting in place to identify weekly submissions. a. In the event that a submission can't take place for 837P, 837I or NCPDP, Encounter Business Operations (EBO) contacts our DHHS encounters contact and communicates when a file will be received.			

Table 6-19—EDV—Opportunities for Improvement and MCO Response #19

HSAG EDV Opportunities for Improvement #19			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Timeliness—Weekly Submissions	98.1%	100%
NHHF's EDV Response #19			
NHHF has reporting in place to identify weekly submissions. a. In the event that a submission can't take place for 837P, 837I or NCPDP, EBO contacts our DHHS encounters contact and communicates when a file will be received.			

Table 6-20—EDV—Opportunities for Improvement and MCO Response #20

HSAG EDV Opportunities for Improvement #20			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	NCPDP: Timeliness—Weekly Submissions	88.5%	100%
NHHF's EDV Response #20			
NHHF has reporting in place to identify weekly submissions. a. In the event that a submission can't take place for 837P, 837I or NCPDP, EBO contacts our DHHS encounters contact and communicates when a file will be received.			

Table 6-21—EDV—Opportunities for Improvement and MCO Response #21

HSAG EDV Opportunities for Improvement #21			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Timeliness—Submission Within 30 Days of Claim Payment	82.6%	100%
NHHF's EDV Response #21			
EBO agrees with these numbers from a FY19 perspective. As we moved into the FY20 contract with the 14 day timeliness, we created reports internally as well as for vendors to ensure we are meeting this contractual requirement. These reports are sent to the health plan via email on a weekly basis. Further, we took remediation action with one vendor in March 2020 to ensure they were submitting data to meet the 14 day timeliness standard. They are now compliant and we continue to monitor closely.			

Table 6-22—EDV—Opportunities for Improvement and MCO Response #22

HSAG EDV Opportunities for Improvement #22			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Submission Within 30 Days of Claim Payment	97.5%	100%
NHHF's EDV Response #22			
EBO agrees with these numbers from a FY19 perspective. As we moved into the FY20 contract with the 14 day timeliness, we created reports internally as well as for vendors to ensure we are meeting this contractual requirement. These reports are sent to the health plan via email on a weekly basis. Further, we took remediation action with one vendor in March 2020 to ensure they were submitting data to meet the 14 day timeliness standard. They are now compliant and we continue to monitor closely.			

Table 6-23—EDV—Opportunities for Improvement and MCO Response #23

HSAG EDV Opportunities for Improvement #23			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	NCPDP: Submission Within 30 Days of Claim Payment	91.5%	100%
NHHF's EDV Response #23			
EBO agrees with these numbers from a FY19 perspective. As we moved into the FY20 contract with the 14 day timeliness, we created reports internally as well as for vendors to ensure we are meeting this contractual requirement. These reports are sent to the health plan via email on a weekly basis. Further, we took remediation action with one vendor in March 2020 to ensure they were submitting data to meet the 14 day timeliness standard. They are now compliant and we continue to monitor closely.			

Well Sense Health Plan

The SFY 2019 EQR Technical Report contained opportunities for improvement for **WS** in the contract compliance audit, PIPs, HEDIS, and EDV. Table 6-24 through Table 6-47 display the self-reported follow-up activities conducted by **WS** during SFY 2019 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG conducted a contract compliance audit to assess MCO performance with respect to requirements found in 42 CFR §438 and the DHHS contract with **WS**. HSAG reviewed 12 standards containing 105 applicable elements for **WS**. HSAG received a CAP for each element found non-compliant in four standards (i.e., Behavioral Health, Network Management, UM, and SUD), and all items were found to be compliant with the revisions instituted by **WS** in the CAPs completed on March 22, 2020.

Table 6-24—Contract Compliance—Opportunities for Improvement and MCO Response #1

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard VI–Behavioral Health	2. **Coordination of Care Policies Submitted to DHHS** The MCO developed policies governing the coordination of care with PCPs and community mental health programs, and the policies are to be submitted to DHHS for review and approval 90 calendar days prior to the beginning of each Agreement year.	Partially Met	Met
WS's Contract Compliance CAP Response #1			
WS revised policies and procedures to include the requirement that policies concerning coordination of care with PCPs and community mental health programs would be submitted to DHHS for review and approval 90 calendar days prior to the beginning of each Agreement year. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-25—Contract Compliance—Opportunities for Improvement and MCO Response #2

HSAG Contract Compliance Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XII– Network Management	**5. Provider Training** The MCO provides training to all providers and their staff regarding the requirements of the MCO Agreement with DHHS including the grievance and appeals system. The MCO's provider training is completed within 30 calendar days of entering into a contract with a provider, and the MCO provides ongoing training as required by the MCO or DHHS.	Not Met	Met
WS's Contract Compliance CAP Response #2			
WS submitted the revised Provider Training Administrative Policy and the Provider Orientation and General Overview PowerPoint slides. HSAG's review of the Provider Training Policy noted that new providers joining **WS** will receive training within 30 days of initially entering a contract and no later than 30 days from being credential approved. HSAG's review of the Provider Orientation and General Overview PowerPoint slides confirmed that **WS** included additional information to address State fair hearings. Provider training is tracked in the Onyx system. The updated Provider Training Administrative Policy, provider training PowerPoint slides, and the tracking system meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-26—Contract Compliance—Opportunities for Improvement and MCO Response #3

HSAG Contract Compliance Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XIII– Utilization Management	**1. Development of UM Policies, Procedures, and Criteria** The MCO's written UM policies, procedures, and criteria are: f. Available upon request to DHHS, providers, and members.	Partially Met	Met
WS's Contract Compliance CAP Response #3			
WS submitted the 2019 UM Program Plan. HSAG's review of the UM Program Plan confirmed revisions including language confirming that **WS** provides criteria, policies, and procedures to members, providers, and regulatory agencies upon request. The updated UM Program Plan meets the requirement of this element. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-27—Contract Compliance—Opportunities for Improvement and MCO Response #4

HSAG Contract Compliance Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV– Substance Use Disorder	**2. Initial Eligibility Screening for SUD Services** The SUD provider conducts an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the member or referring agency, but no later than two business days following the date of first contact.	Partially Met	Met
WS's Contract Compliance CAP Response #4			
WS submitted the SUD Residential Audit Tool and the Well Sense Beacon Provider Manual. HSAG's review of the SUD Residential Audit Tool confirmed the inclusion of the requirement that the initial eligibility screening for services is conducted ideally at the time of first contact (direct communication by phone or in person) with the member or referring agency, but no later than two business days following the date of first contact. HSAG's review of the **WS** Beacon Provider Manual confirmed that initial eligibility screening for SUD services is required to occur as soon as possible, ideally at the time of first contact (direct communication by phone or in-person) with the member or referring agency, but no later than two business days following the date of first contact. The revised audit tool and provider manual meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-28—Contract Compliance—Opportunities for Improvement and MCO Response #5

HSAG Contract Compliance Opportunities for Improvement #5			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV– Substance Use Disorder	**3. Members Screening Positive for SUD Services** Members who have screened positive for SUD services receive an American Society for Addiction Medicine (ASAM) Level of Care (LOC) Assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three days after admission.	Partially Met	Met
WS's Contract Compliance CAP Response #5			
WS submitted the updated SUD Residential Audit Tool indicating that members who have screened positive for SUD services receive an ASAM LOC assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment, and no later than three days after admission. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-29—Contract Compliance—Opportunities for Improvement and MCO Response #6

HSAG Contract Compliance Opportunities for Improvement #6			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV– Substance Use Disorder	**4. Members Identified for Withdrawal Management, Outpatient, or Intensive Outpatient SUD Services** Members identified for withdrawal management, outpatient, or intensive outpatient services start receiving services within seven business days from the date the ASAM LOC assessment was completed.	Partially Met	Met
WS's Contract Compliance CAP Response #6			
WS submitted the updated SUD Residential Audit Tool which indicated that members identified for withdrawal management, outpatient, or intensive outpatient services start receiving services within seven business days from the date the assessment LOC was completed. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.			

Table 6-30—Contract Compliance—Opportunities for Improvement and MCO Response #7

HSAG Contract Compliance Opportunities for Improvement #7			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Standard XV– Substance Use Disorder	**6. Pregnant Women with an ASAM LOC** Pregnant women will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor: a. Assists the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance includes actively reaching out to identify providers on the behalf of the client; and b. Provides interim services until the appropriate LOC becomes available at either the contractor agency or an alternative provider. Interim services include: i. At least one 60-minute individual or group outpatient session per week; ii. Recovery support services as needed by the client; and iii. Daily calls to the client to assess and respond to any emergent needs.	Partially Met	Met

WS's Contract Compliance CAP Response #7
WS submitted the updated SUD Residential Audit Tool which maintained that pregnant women will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. The audit tool also noted that if the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor must assist the pregnant woman with identifying alternative providers and with accessing services with the alternative providers. The audit tool further requires that the contractor provides interim services (at least one 60-minute individual or group outpatient session per week, recovery support services as needed by the client, and daily calls to the client to assess and respond to any emergent needs) until the appropriate LOC becomes available at either the contractor agency or an alternate provider. **WS** also submitted the updated Beacon Provider Manual, which included information specific to the requirements of this element. The updates to the SUD Residential Audit Tool and the Beacon Provider Manual meet the requirements of this element. HSAG will follow-up on this element during the next compliance review. **WS** completed the CAP for this element.

Table 6-31—Contract Compliance—Opportunities for Improvement and MCO Response #8

HSAG Contract Compliance Opportunities for Improvement #8			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance: Provider Directory and MCO Website	The MCO's provider directory and website contains information concerning whether the provider has completed competence training.	Partially Met	Met
WS's Contract Compliance CAP Response #8			
The **WS** provider directory, effective June 1, 2019, included the identification of providers who completed cultural competency training, and the **WS** website also contained that information on the same date.			

Table 6-32—Contract Compliance—Opportunities for Improvement and MCO Response #9

HSAG Contract Compliance Opportunities for Improvement #9			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Appeals File Review	The MCO shall resolve at least 100 percent of member appeals within 30 calendar days from the date the appeal was filed with the MCO. The date of filing shall be considered either an oral request for appeal or a written request from either the member or provider, whichever date is the earliest.	Partially Met	Met
WS's Contract Compliance CAP Response #9			
WS submitted the revised Member Appeals Policy, which maintained that the date an appeal is considered received at the Plan is the date an oral or written request is received, whichever is earlier. **WS** also offered an explanation of the process changes to ensure appropriate processing of appeals. The updated Member Appeals Policy and reported process modifications meet the requirements of this element. This element is complete.			

PIPs

HSAG validated three PIPs submitted by **WS**: *Chlamydia Screening*, *Reducing Hospital Readmissions (to New Hampshire Hospital)—60 Days of Discharge*, and *Well-Child Visits for 3-to-6-Year-Olds*. HSAG validated the three PIPs through the Design, Implementation, and Outcomes phases of the PIP process. One PIP, *Chlamydia Screening,* achieved statistically significant improvement over baseline at Remeasurement 2. The 2019 New Hampshire EQR Technical Report contained opportunities for improvement for the two additional PIPs as noted below.

Table 6-33—PIP Validation—Opportunities for Improvement and MCO Response #10

HSAG PIP Opportunities for Improvement #10			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	*Reducing Hospital Readmissions (to New Hampshire Hospital)—60 Days of Discharge*	No Statistically Significant Improvement	Statistically Significant Improvement
WS's PIP Response #10			
August 2020: While statistical significance is important, QI is focused on sustained improvement over time. **WS** successfully sustained improvement over baseline with this project however the results did not meet the statistically significant improvement requirement. **WS** continues to develop and implement interventions to achieve statistically significant improvement within the parameters of each improvement project.			

Table 6-34—PIP Validation—Opportunities for Improvement and MCO Response #11

HSAG PIP Opportunities for Improvement #11			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	*Well-Child Visits for 3-to-6-Year-Olds*	No Statistically Significant Improvement	Statistically Significant Improvement
WS's PIP Response #11			
August 2020: While statistical significance is important, QI is focused on sustained improvement over time. **WS** successfully sustained improvement over baseline based on the administrative rates monitored throughout the year, however based on the sample in the hybrid results; we were unable to demonstrate the same trend. **WS** continues to develop and implement interventions to achieve statistically significant improvement within the parameters of each improvement project.			

HEDIS

WS contracted with an NCQA LO to have its measure rates reviewed by a CHCA. **WS** also contracted with an external software vendor to assist in HEDIS measure production and rate calculation. The rates for two HEDIS measures fell below the 25th percentile for the HEDIS Audit Means and Percentiles (national Medicaid HMO percentiles). The opportunities for improvement in HEDIS for **WS** are shown in the tables below.

Table 6-35—HEDIS—Opportunities for Improvement and MCO Response #12

HSAG HEDIS Opportunities for Improvement #12			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below Medicaid 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #12			
August 2020: **WS** continues to implement interventions to improve this measure, however there are many barriers that prevent the rate from increasing. Some barriers include provider concern for member confidentiality. Commercial payers are required to send evidence of benefits documents to the household after a treatment which may contain the chlamydia testing in the document. This is a concern for providers that the guardian/parent may find out and raise concerns about the test. In order to prevent breach of confidentiality, providers are choosing to perform the chlamydia test without sending a claim or members are going to clinics where the tests are performed for free based on grants. The stigma of having these tests is a barrier with providers and with guardians/parents of members that fall under the age cohort with the lowest compliance (16-20). **WS** continues to work with providers to share best practices, offers incentives to members, and education to parents/guardians. **WS** will continue to develop and implement interventions to achieve improvement in the rate and performance compared to national benchmarks.			

Table 6-36—HEDIS—Opportunities for Improvement and MCO Response #13

HSAG HEDIS Opportunities for Improvement #13			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Prenatal and Postpartum Care (PPC)— Postpartum Care*	Below Medicaid 25th Percentile	Equal to or Higher than the National Average
Well Sense's HEDIS Response #13			
August 2020: **Well Sense** continues to work towards improving this measure; however, barriers encountered most often include visits occurring outside of the measure timeframe. With the new HEDIS specifications established for HEDIS 2020 (Data Year 2019), **Well Sense**'s postpartum visit rate increased to above the current 2019 NCQA Quality Compass HEDIS Medicaid 90th percentile. It is expected the benchmarks will change with this new specification, however initial results support what **Well Sense** has noticed when reviewing medical records: that most members are receiving postpartum care, just not within the previous narrow timeframe. **Well Sense** continues to outreach to members to encourage going to their postpartum visits and offers a diaper incentive to reward those members that complete this visit. **Well Sense** continues to assess performance to see if there are other initiatives to further improve the postpartum rate among the membership.			

EDV

During SFY 2019, HSAG continued to use an EDQRS to evaluate the quality of encounter data files submitted by the MCOs. The opportunities for improvement in EDV for **WS** are shown in the tables below.

Table 6-37—EDV—Opportunities for Improvement and MCO Response #14

HSAG EDV Opportunities for Improvement #14			
EQR Activity	Measure Standard	MCO Results	Standard
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.2%	100%
WS's EDV Response #14			
August 2020: **WS** will include the incorporation of the member file received from DHHS in the weekly data submission process, along with other steps as recommended in the EQRO technical report. **WS** will seek guidance from DHHS/HSAG in these efforts as needed.			

Table 6-38—EDV—Opportunities for Improvement and MCO Response #15

HSAG EDV Opportunities for Improvement #15			
EQR Activity	Measure Standard	MCO Results	Standard
EDV	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	99.0%	100%
WS's EDV Response #15			
August 2020: **WS** will include the incorporation of the member file received from DHHS in the weekly data submission process, along with other steps as recommended in the EQRO technical report. **WS** will seek guidance from DHHS/HSAG in these efforts as needed.			

Table 6-39—EDV—Opportunities for Improvement and MCO Response #16

HSAG EDV Opportunities for Improvement #16			
EQR Activity	Measure Standard	MCO Results	Standard
EDV	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	99.9%	100%
WS's EDV Response #16			
August 2020: **WS** will continue its efforts to ensure the validity of Member identification numbers passed between the Plan and its pharmacy benefit manager (PBM). **WS** is developing an oversight reporting process with the PBM to monitor submissions, errors, and prompt resolution of errors. This is ongoing.			

Table 6-40—EDV—Opportunities for Improvement and MCO Response #17

HSAG EDV Opportunities for Improvement #17			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Validity of Servicing Provider Information—Percent Valid	96.4%	98.0%
WS's EDV Response #17			
August 2020: **WS** will include the incorporation of the daily provider file received from DHHS in the weekly data submission process, as recommended in the EQRO technical report. **WS** will seek guidance from DHHS/HSAG in these efforts as needed.			

Table 6-41—EDV—Opportunities for Improvement and MCO Response #18

HSAG EDV Opportunities for Improvement #18			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Validity of Servicing Provider Information—Percent Valid	80.8%	98.0%
WS's EDV Response #18			
August 2020: **WS** will include the incorporation of the daily provider file received from DHHS in the weekly data submission process, as recommended in the EQRO technical report. **WS** will seek guidance from DHHS/HSAG in these efforts as needed.			

Table 6-42—EDV—Opportunities for Improvement and MCO Response #19

HSAG EDV Opportunities for Improvement #19			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Timeliness—Weekly Submissions	98.1%	100%
WS's EDV Response #19			
August 2020: **WS** will augment tracking and operational processes to ensure that files are submitted on a weekly basis consistently, as part of a larger scale effort to improve encounter data quality and submission processes, directed by the **WS** Encounter Steering committee.			

Table 6-43—EDV—Opportunities for Improvement and MCO Response #20

HSAG EDV Opportunities for Improvement #20			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Timeliness—Weekly Submissions	98.1%	100%
WS's EDV Response #20			

August 2020: **WS** will augment tracking and operational processes to ensure that files are submitted on a weekly basis consistently, as part of a larger scale effort to improve encounter data quality and submission processes, directed by **WS** Encounter Steering committee.

Table 6-44—EDV—Opportunities for Improvement and MCO Response #21

HSAG EDV Opportunities for Improvement #21			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	NCPDP: Timeliness—Weekly Submissions	98.1%	100%
WS's EDV Response #21			

August 2020: **WS** monitors the weekly delivery of the PBM encounter file and immediately escalates any issues for prompt resolution. This monitoring will continue for the duration of the contract.

Table 6-45—EDV—Opportunities for Improvement and MCO Response #22

HSAG EDV Opportunities for Improvement #22			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Timeliness— Submission Within 30 Days of Claim Payment	66.2%	100%
WS's EDV Response #22			

August 2020: The rate for **WS** is due to missing detail payment dates in the submitted encounter data. If supplementing missing detail payment dates with header payment dates, the rate for **WS** would increase from 66.2 percent to 88.1 percent.

- **WS** will consider implementing the suggestion above from HSAG for ongoing encounter data submissions after discussing with DHHS.
- **WS** will also continue working with our 3rd party vendors to ensure timely delivery of claims post adjudication that are processed locally by **WS** before creating and sending encounter data. **WS** will enhance internal reporting capabilities to identify and communicate with DHHS if potential issues are present in this category.
- Note: During both SFY 2019 and SFY 2020 **WS** has been submitting historical data as part of a data reconciliation project that may cause this rate to appear lower than expected.

Table 6-46—EDV—Opportunities for Improvement and MCO Response #23

HSAG EDV Opportunities for Improvement #23			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Submission Within 30 Days of Claim Payment	66.8%	100%
WS's EDV Response #23			

August 2020: For both MCOs, the noncompliance was primarily due to missing detail payment dates in the submitted data. If supplementing missing detail payment dates with header payment dates, **WS** would increase 75.5 percent.

- **WS** will consider implementing the suggestion above from HSAG for ongoing encounter data submissions after discussing with DHHS.
- **WS** will also continue working with our 3rd party vendors to ensure timely delivery of claims post adjudication that are processed locally by **WS** before creating and sending encounter data. **WS** will enhance internal reporting capabilities to identify and communicate with DHHS if potential issues are present in this category.
- Note: During both SFY 2019 and SFY 2020 **WS** has been submitting historical data as part of a data reconciliation project that may cause this rate to appear lower than expected.

Table 6-47—EDV—Opportunities for Improvement and MCO Response #24

HSAG EDV Opportunities for Improvement #24			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	NCPDP: Submission Within 30 Days of Claim Payment	64.1%	100%
WS's EDV Response #24			

August 2020: **WS** has seen an increase in this measure from 5% to the current result, and continues to monitor this with the PBM, escalating as necessary. **WS** is developing an oversight reporting process with the PBM to monitor submissions, errors, and prompt resolution of errors. This is ongoing.

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
- **ACNH**—AmeriHealth Caritas New Hampshire
- **ADD**—Follow-Up Care for Children Prescribed ADHD Medication
- **ADHD**—attention-deficit/hyperactivity disorder
- **AMB**—Ambulatory Care
- **AMM**—Antidepressant Medication Management
- **AMR**—Asthma Medication Ratio
- **AOD**—Alcohol and Other Drug
- **APM**—Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **APP**—Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics
- **ASAM**—American Society for Addiction Medicine
- **AWC**—Adolescent Well-Care Visits
- **BBA**—Federal Balanced Budget Act of 1997
- **BCCP**—Breast and Cervical Cancer Program
- **BMI**—body mass index
- **CAHPS**—Consumer Assessment of Healthcare Providers and Systems
- **CAP**—Children and Adolescents' Access to Primary Care Practitioners
- **CAP**—corrective action plan
- **CBP**—Controlling High Blood Pressure
- **CCC**—Children with Chronic Conditions
- **CCS**—Cervical Cancer Screening
- **CDC**—Comprehensive Diabetes Care
- **CFR**—Code of Federal Regulations
- **CHCA**—Certified HEDIS compliance auditor
- **CHIP**—Children's Health Insurance Plan
- **CHIPRA**—Children's Health Insurance Program Reauthorization Act of 2009
- **CHL**—Chlamydia Screening in Women

- **CIS**—Childhood Immunization Status
- **CMS**—Centers for Medicare & Medicaid Services
- **CMT**—Collective Medical Technology
- **COPD**—chronic obstructive pulmonary disease
- **COVID-19**—coronavirus disease 2019
- **CT**—Computerized Tomography
- **CWP**—Appropriate Testing for Children with Pharyngitis
- **CY**—calendar year
- **DHHS**—State of New Hampshire, Department of Health and Human Services
- **DRA**—Deficit Reduction Act
- **DRG**—diagnosis related group
- **DTaP**—diphtheria, tetanus, and acellular pertussis vaccine
- **EBI**—Enterprise Business Intelligence
- **EBO**—Encounter Business Operations
- **eCOM**—Electronic Clinical Quality Measure
- **ED**—emergency department
- **EDA**—encounter data accuracy
- **EDC**—encounter data completeness
- **EDI**—electronic data interchange
- **EDQRS**—Encounter Data Quality Reporting System
- **EDT**—Encounter Data Timeliness
- **EDV**—encounter data validation
- **EMR**—electronic medical record
- **EPSDT**—Early and Periodic Screening, Diagnostic, and Treatment
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FAR**—final audit report
- **FFS**—fee-for-service
- **FMEA**—failure modes and effects analysis
- **FUH**—Follow-up After Hospitalization for Mental Illness
- **GAHCP**—Granite Advantage Health Care Program
- **HbA1c**—hemoglobin A1c; a measure of longer-term glucose management
- **HEDIS**—Healthcare Effectiveness Data and Information Set
- **HepA**—hepatitis A vaccine

- **HepB**—hepatitis B vaccine
- **HHS**—Health and Human Services
- **HiB**—Haemophilus influenzae type B
- **HMO**—Health Maintenance Organization
- **HPV**—human papillomavirus
- **HSAG**—Health Services Advisory Group, Inc.
- **I**—institutional
- **IAD**—Identification of Alcohol and Other Drug Services
- **ICD**—International Classification of Diseases
- **IDSS**—Interactive Data Submission System
- **IET**—Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
- **IMA**—Immunizations for Adolescents
- **IPV**—polio vaccine
- **IS**—information systems
- **ISCAT**—Information System Capability Assessment Tool
- **IUD**—intrauterine device
- **LBP**—Use of Imaging Studies for Low Back Pain
- **LDL-C**—Low-density lipoprotein-cholesterol
- **LO**—National Committee for Quality Assurance-Licensed Organization
- **LOC**—Level of Care
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MFCU**—Medicaid Fraud Control Unit
- **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
- **N**—number
- **NA**—not applicable; for HEDIS, small denominator
- **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
- **NHHF**—New Hampshire Healthy Families
- **NHHPP**—New Hampshire Health Protection Program
- **NICU**—neonatal intensive care unit
- **NP**—nurse practitioner
- **NPI**—National Provider Identifier
- **NR**—not reported
- **OB**—obstetrician
- **OB/GYN**—obstetrician/gynecologist
- **P**—professional
- **PAHP**—prepaid ambulatory health plan
- **PAP**—Premium Assistance Program
- **PBM**—Pharmacy Benefit Manager
- **PCCM**—primary care case management
- **PCE**—Pharmacotherapy Management of COPD Exacerbation
- **PCP**—primary care provider
- **PCV**—pneumococcal conjugate vaccine
- **PDSA**—Plan-Do-Study-Act
- **PHO**—physician-hospital organization
- **PHR**—public health region
- **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
- **SAC**—Submission Accuracy and Completeness
- **SDOH**—social determinants of health
- **SFTP**— secure file transfer protocol
- **SFY**—state fiscal year
- **SMART**—specific, measurable, attainable, relevant, and time-bound

- **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 Medications
- **SUD**—substance use disorder
- **Tdap**—tetanus, diphtheria, and acellular pertussis vaccine
- **UM**—utilization management
- **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
- **WIC**—Women, Infants, and Children
- **WS**—Well Sense

MCO Contractual Compliance

According to 42 CFR §438.358(b)(1)(iii),[B-1] for each MCO, PIHP, or PAHP a review, conducted within the previous three-year period, must be performed to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in 42 CFR §438 Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330.[B-2] Conducting a compliance review is one of the mandatory EQR activities. 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-3] 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' agreements with **ACNH**, **NHHF**, and **WS**.
- 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, compliance review activities, and timelines; and compliance review agenda.

[B-1] U.S. Government Printing Office. (2020). U.S. Code of Federal Regulations. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358#title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 3, 2020.

[B-2] U. S. Government Printing Office. (2019). *Activities related to external quality reviews*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Oct 6, 2020.

[B-3] Ibid.

- Collect data and documents from the MCOs and review the information before and during the compliance review.
- Conduct the compliance 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 9-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 compliance 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 to the MCOs.**
	HSAG prepares and forwards a letter to the MCOs and requests that the MCOs submit information and documents to HSAG by a specified date. 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 compliance review.
Step 4:	**Develop a 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 review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective compliance review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the review so that all participants understand the process and time frames allotted for the audits.
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. Frequently when an MCO is new to a state, HSAG conducts a webinar to explain information about the compliance review activity.

Step 6:	Receive MCOs' documents for HSAG's desk review and evaluate the information before conducting the compliance review.
	The HSAG team reviews the documentation received from the MCOs to gain insight into access to care and timeliness and quality of care, and the organization's structure, services, operations, resources, IS, quality program, and delegated functions. The team then begins compiling the information and preliminary findings before the compliance 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 interviews. • Identify information not found in the desk review documentation to be requested during the compliance review.
Step 7:	Conduct the compliance review.
	Staff members from the MCO answer questions during the compliance review to assist the HSAG team in locating specific documents or other sources of information. HSAG's activities completed during the compliance review included the following: • Conduct an opening conference that included introductions, HSAG's overview of the compliance 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 team reviews additional documentation and uses the review tool to identify relevant information sources. Documents required for the compliance review include, but are 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. During the compliance review, MCO staff members also discuss the organization's information system data collection process and reporting capabilities related to the standards included in the review. • Summarize findings at the completion of the compliance 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 not applicable (*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 a final report that includes an appendix with the elements included in the corrective action plan. HSAG works with the MCOs to correct all elements that scored below 100 percent compliance.

Determining Conclusions

HSAG uses scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCOs' performance complies with the requirements. HSAG uses a designation of *NA* when a requirement is 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). HSAG also assists in reviewing the CAPs from the MCOs to determine if their proposed corrections will meet the intent of the requirements that were scored *Partially Met* or *Not Met*.

Requirements Reviewed During the SFY 2014–2020 Compliance Reviews

The SFY 2014 compliance activities consisted of reviewing 14 standards containing 294 elements for **NHHF** and 295 elements for **WS**. Since that time, HSAG has reviewed one-third of the elements in the standards each year with a few exceptions. In SFY 2016, DHHS requested that HSAG include all elements from the SUD standard, which increased the number of standards to 15.

If a standard was not included in the compliance reviews after SFY 2014, DHHS agreed to eliminate the review of that standard due to the few number of elements that year, and HSAG added those elements to the standard in the next year's compliance review. The only exception to that process was the SUD review, which contained the entire standard each time it was reviewed, and the Care Management/Care Coordination standard. In SFY 2016 HSAG conducted a quality study concerning the care management/care coordination processes and systems at **NHHF** and **WS**. Due to many of the same requirements being contained in the quality study and the compliance review, DHHS requested that the results of the quality study be used to satisfy the requirement to review that standard in SFY 2016. Table B-2 displays the names of the standards and indicates their inclusion in the compliance reviews from SFY 2014–2019.

Table B-2—Standards Included in the NHHF and WS Compliance Reviews from SFY 2014–2019

	Standard Name	2014	2015	2016	2017	2018	2019
I.	Delegation and Subcontracting	X	X	X	X	X	
II.	Plans Required by the Contract	X	X	X	X	X	X
III.	Emergency and Post-Stabilization Care	X	X	X	X	X	
IV.	Care Management/Care Coordination	X	X		X	X	X
V.	Wellness and Prevention	X	X		X	X	
VI.	Behavioral Health	X	X	X	X	X	X
VII.	Member Enrollment and Disenrollment	X	X	X	X	X	X
VIII.	Member Services	X	X	X	X	X	X
IX.	Cultural Considerations	X	X	X	X	X	X
X.	Grievances and Appeals	X	X	X	X	X	X
XI.	Access to Care	X	X	X	X	X	X
XII.	Network Management	X	X	X	X	X	X

	Standard Name	2014	2015	2016	2017	2018	2019
XIII.	UM	X	X	X	X	X	X
XIV.	Quality Management	X	X	X	X	X	X
XV.	SUD			X			X

Due to the travel restrictions and stay-at-home orders in many states in response to the COVID-19 pandemic, DHHS and HSAG agreed to perform this year's review virtually through the use of Webex, which supported an end-to-end encryption program. The use of Webex allowed HSAG and the MCOs to display documents and databases discussed during the review. The compliance review process remained the same as in prior years and included pre-review, virtual review, and post-review activities.

In SFY 2020, one standard was retired (i.e., Plans Required by Contract) and two standards were added to the review (i.e., Fraud, Waste, and Abuse; and Financial/Third Party Liability). A new MCO, **ACNH**, was added to the MCM Program in SFY 2020, and DHHS requested that HSAG review all the standards for that MCO. **NHHF** and **WS** continued on the schedule of including one-third of the standards in the SFY 2020 compliance review. Table B-3 displays the standards and indicates their inclusion in the compliance reviews conducted in SFY 2020.

Table B-3—Standards Included in the ACNH, NHHF, and WS Compliance Reviews in SFY 2020

Standard	Standard Name	2000 ACNH	2000 NHHF and WS
I.	Delegation and Subcontracting	X	X
II.	Emergency and Post-Stabilization Care	X	
III.	Care Management/Care Coordination	X	
IV.	Wellness and Prevention	X	
V.	Behavioral Health	X	X
VI.	Member Enrollment and Disenrollment	X	
VII.	Member Services	X	
VIII.	Cultural and Accessibility Considerations	X	
IX.	Grievances and Appeals	X	
X.	Access	X	
XI.	Network Management	X	X
XII.	UM	X	
XIII.	Quality Management	X	
XIV.	SUD	X	X
XV.	Fraud, Waste, and Abuse	X	
XVI.	Financial/Third Party Liability	X	X

HSAG developed checklists to review items that are required in a specific area or a specific document. The SFY 2014 review included all 10 checklists, and no checklists were included in the SFY 2015 and SFY 2018 reviews. HSAG included nine of the checklists in the SFY 2016 and SFY 2017 reviews, and five checklists in the SFY 2019 compliance review. HSAG retired the checklist for Culturally and Linguistically Appropriate Services due to changing requirements in the contract between the MCOs and DHHS. Table B-4 illustrates the 10 checklists included in the New Hampshire compliance reviews from SFY 2014–2019.

Table B-4—Checklists Included in the NHHF and WS Compliance Reviews from SFY 2014–2019

	Checklist	2014	2015*	2016	2017	2018*	2019
1.	Access Standards	X		X			X
2.	Call Center	X			X		
3.	Culturally and Linguistically Appropriate Services**	X					
4.	Provider Directory	X		X			X
5.	Member Handbook	X		X			X
6.	Identification (ID) Cards	X			X		
7.	MCO website	X		X			X
8.	Network Management	X			X		
9.	Notice Requirements	X			X		
10.	Member Rights	X		X			X

* No checklists were included in the SFY 2015 and SFY 2018 compliance reviews.
** Requirements included in this checklist were revised in the contract between the MCOs and DHHS, and the checklist was retired.

The contract executed for the MCM Program between DHHS and the MCOs effective September 1, 2019, included elements that were not listed in the previous compliance tool. HSAG constructed a new tool and additional checklists to ensure that the compliance review contained all the requirements contained in the contract. Since the elements in the checklists were as critical to the operations of the MCOs as the elements in the compliance tool, HSAG began including the scores for the checklists in the total score for the standards and eliminated separate scoring grids for the checklist in SFY 2020. The checklists included in the compliance review for SFY 2020 are shown in Table B-5.

Table B-5—Checklists Included in the ACNH, NHHF, and WS Compliance Reviews in SFY 2020

Standard		Checklist	2020 ACNH	2020 NHHF and WS
III.		Care Management/Care Coordination	X	
V.		Behavioral Health	X	X
VII.		ID Cards	X	
VII.		Member Handbook	X	

Standard	Checklist	2020 ACNH	2020 NHHF and WS
VII.	Member Rights	X	
VII.	Member Welcome Calls	X	
VII.	Provider Directory	X	
VII.	MCO Website	X	
IX.	Appeals	X	
IX.	Notices and Continuation of Benefits	X	
IX.	State Fair Hearings	X	
X.	Access	X	
X.	Access Transitions of Care	X	
XI.	Provider Manual	X	X
XI.	Provider Appeals	X	X
XII.	UM	X	
XIV.	SUD Checklist	X	X
XIV.	SUD Access Checklist	X	X

HSAG included file reviews for grievances, appeals, denials of service, credentialing, and recredentialing in the 2014 compliance review. Five file reviews were dispersed between the compliance review in SFY 2016 and the compliance review in SFY 2017, as shown in Table B-6. No file reviews were included in the SFY 2015 and SFY 2018 compliance reviews; however, the SFY 2019 review included three file reviews. The file reviews included in the compliance reviews from SFY 2014–2019 are shown in Table B-6.

Table B-6—File Reviews Included in the NHHF and WS Compliance Reviews from SFY 2014–2019

	File Reviews	2014	2015*	2016	2017	2018*	2019
1.	Grievances	X		X			X
2.	Appeals	X		X			X
3.	Denials of Service	X		X			X
4.	Credentialing	X			X		
5.	Recredentialing	X			X		

* No file reviews were included in the 2015 and 2018 compliance reviews.

HSAG continued the same file reviews in SFY 2020 and added a file review of the subcontracts with delegated vendors. All file reviews were completed for **ACNH** with the exception of recredentialing because providers must be on the MCO's network for three years before recredentialing occurs. Since the elements in the file reviews were as critical to the operations of the MCOs as the elements in the compliance tool, HSAG began including the scores for the file reviews in the total score for the

standards and eliminated separate scoring grids for the file reviews in SFY 2020. Table B-7 displays the file reviews included in the SFY 2020 compliance reviews for the MCOs.

Table B-7—File Reviews Included in the ACNH, NHHF, and WS Compliance Reviews in SFY 2020

Standard	File Reviews	2020 ACNH	2020 NHHF and WS
I.	Subcontracts	X	X
IX.	Grievances	X	
IX.	Appeals	X	
XI.	Credentialing	X	X
XI.	Recredentialing		X
XII.	Denials of Service	X	

Standards Required by CMS to be Included in EQR Compliance Reviews

DHHS elected to establish a cycle of reviewing one-third of the compliance review standards each fiscal year. The only exception, as noted in this year's **ACNH** review, is when a new MCO joins the MCM Program. The first compliance review conducted for MCOs participating in the MCM Program includes all standards.

CMS established the required activities that must be monitored by EQROs during the review, conducted within the previous three-year period, to determine the MCO's compliance with the standards, and validation of network adequacy (pending the publications of the protocols for that activity). The topics required to be included in the compliance reviews are defined in 42 CFR §438 Subpart D[B-4] and 42 CFR §438.330.[B-5] Those requirements are shown in Table B-8. The table also includes the location of the requirements in the New Hampshire MCM Program compliance tool and the year those requirements are included in the review.

[B-4] U. S. Government Printing Office. (2019). *Title 42 Part 438 Subpart D.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartD_section438.206. Accessed on: Oct 6, 2020.

[B-5] U. S. Government Printing Office. (2019). *U.S. Code of Federal Regulations Title 42 Subpart E.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.330. Accessed on: Oct 6, 2020.

Table B-8—CMS Requirements, Location of Requirements in the MCM Program Compliance Tool, and Year Requirements are Reviewed

CFR	CMS Standard	Standard in New Hampshire MCM Program Compliance Tool	Year the Requirements are Reviewed in New Hampshire		
			Year 1	Year 2	Year 3
438.206	Availability of Services	Standard VIII: Cultural and Accessibility Considerations			X
		Standard X: Access			X
		Standard XI: Network Management	X		
438.207	Assurances of Adequate Capacity and Services	Standard X: Access			X
438.208	Coordination and Continuity of Care	Standard III: Care Management/Care Coordination		X	
		Standard VII: Members Services		X	
		Standard XIII: Quality Management		X	
438.210	Coverage and Authorization of Services	Standard IX: Grievances and Appeals			X
		Standard XII: UM		X	
438.214	Provider Selection	Standard X: Access			X
		Standard XI: Network Management	X		
438.224	Confidentiality	Standard XII: UM		X	
438.228	Grievance and Appeals System	Standard IX: Grievances and Appeals			X
438.230	Subcontractual Relationships and Delegation	Standard I: Delegation and Subcontracting	X		
438.236	Practice Guidelines	Standard XIII: Quality Management		X	
438.242	Health Information Systems	Covered in the tasks for EDV, HEDIS, and PMV	X	X	X
438.330	Quality Assessment and Performance Improvement Program	Standard XIII: Quality Management		X	
		Also covered in the tasks for PIPs, HEDIS, and PMV	X	X	X

PIPs

Validation of PIPs, as set forth in 42 CFR §438.358(b)(1)(i),[B-6] is one of the mandatory EQR activities. HSAG's PIP validation process includes 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

Objectives

The purpose of conducting PIPs, as required in 42 CFR §438.330(b)(1),[B-7] is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR §438.330(d)(2), including:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the HHS CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[B-8]

[B-6] U. S. Government Printing Office. (2019). *Activities related to external quality reviews*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Oct 6, 2020.

[B-7] U.S. Government Printing Office. (2020). U.S. Code of Federal Regulations. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358#title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 3, 2020.

[B-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Nov 30, 2020.

HSAG used a rapid-cycle PIP framework for validation, based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[B-9] For the rapid-cycle PIP framework, HSAG developed four modules with an accompanying reference guide. Prior to issuing each module, HSAG holds technical assistance sessions with the MCOs to educate about the application of each module. The four modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic and narrowed focus description and rationale, supporting baseline data, description of baseline data collection methodology, setting Aims (Global and SMART), and setting up a run chart for the SMART Aim measure.
- **Module 2—Intervention Determination:** In Module 2, the MCO defines the QI activities that have the potential to impact the SMART Aim. The MCO will use a step-by-step process to identify interventions that the MCO will test in Module 3 using PDSA cycle(s).
- **Module 3—Intervention Testing:** In Module 3, the MCO defines the Intervention Plan for the intervention to be tested. The MCO will test interventions using thoughtful, incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, key findings, comparisons of successful and unsuccessful interventions, and outcomes achieved are summarized. The MCO will synthesize all data collection, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement going forward.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the MCOs' module submission forms. Following HSAG's rapid-cycle PIP process, the MCO submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the MCO can seek technical assistance from HSAG. The MCO resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the MCO progressing to the next step of the PIP process.

How Conclusions Were Drawn

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement is related to the QI strategies and activities conducted by the MCO during the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirms that any improvement achieved could be clearly linked to the QI strategies implemented by the MCO.

[B-9] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Nov 30, 2020.

During validation, HSAG determines if criteria for each module are *Achieved*. Any validation criteria not applicable (*N/A*) are not scored. As the PIP progresses, and at the completion of Module 4, HSAG uses the validation findings from modules 1 through 4 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigns a level of confidence and reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = The PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to at least one intervention tested, and the MCO accurately summarized the key findings.
- *Confidence* = The PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to at least one intervention tested; however, the MCO did not accurately summarize the key findings.
- *Low confidence* = The PIP was methodologically sound; however, one the following occurred; the SMART Aim goal was not achieved, or the SMART Aim goal was achieved; however, the demonstrated improvement could not be linked to any of the tested interventions.
- *Reported PIP results were not credible* = The SMART Aim measure and/or approved rapid-cycle PIP process was not followed through the SMART Aim end date.

While the focus of an MCO's PIP may be to improve performance related to healthcare quality and timeliness of care, or access to care, PIP validation activities are designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG can draw conclusions about the quality domain from all PIPs. HSAG may also draw conclusions about the remaining domains of care and services—timeliness and access—depending on the specific PIP topics and interventions selected by the MCOs.

PMV

Validation of performance measures, as set forth in 42 CFR §438.358(b)(1)(ii),[B-10] is one of the mandatory EQR activities. The primary objectives of the PMV process is to:

- Evaluate the accuracy of the performance measures 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.

[B-10] U. S. Government Printing Office. (2019). *Activities related to external quality reviews.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 30, 2020.

Table B-9 presents the 13 state-selected performance measures for the SFY 2020 validation activities in New Hampshire. HSAG completed the reports for this activity in August 2020.

Table B-9—Performance Measures Audited by HSAG for SFY 2020

Performance Measures
CAREMGT.24: Care Management: Comprehensive Assessment Attempts Completed Within 30 Days
CAREMGT.27: Members Identified as High-Risk/High-Need Receiving Care Management
CAREMGT.29: Care Management Outreach to High-Risk/High-Need Members
CAREMGT.37: Members Enrolled in Care Management
CLAIM.27: Claims: Processing Accuracy
MEMCOMM.21: Behavioral Health Crisis Call Results
MHACT.01: Adult Community Mental Health Program (CMHP) Assertive Community Treatment (ACT) Service Utilization
MHREADMIT.01: Readmissions for Mental Health Conditions Within 30 Days
NEMT.22: Family and Friends Program Non-Emergent Medical Transportation (NEMT) Rides
NHHREADMIT.12: ED Visits for Mental Health Preceded by New Hampshire Hospital Stay in Past 30 Days
PHARMQI.09: Safety Monitoring: Prior Authorized Fills for Opioid Prescriptions With Dosage Over 100 mg Morphine Equivalent Dosing (MED)
POLYPHARM.06: Polypharmacy Monitoring: Adults With Five or More Prescriptions in 60 Consecutive Days
SERVICEAUTH.14: Service Authorizations: Denials by Waiver Population

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the HHS CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[B-11]

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) Webex 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.

[B-11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug. 27, 2020.

HSAG validated the MCOs' IS 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-10.

Table B-10—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.

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.

HEDIS

To draw conclusions about the quality and timeliness of care and access to care provided by the MCOs, HSAG assigned each of the HEDIS measures to one or more of these three domains, as depicted in Table B-11. The measures marked N/A relate to utilization of services.

Table B-11—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Prevention			
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total			✔
Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*			✔
Well-Child Visits in the First 15 Months of Life (W15)—Six or More Well-Child Visits	✔		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	✔		
Adolescent Well-Care Visits (AWC)	✔		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	✔		
Childhood Immunization Status (CIS)—Combination 2 and *Combination 10*	✔		
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✔		
Cervical Cancer Screening (CCS)	✔		
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✔		
Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years, and *Total*	✔		
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	✔	✔	✔
Acute and Chronic Care			
Appropriate Testing for Children with Pharyngitis (CWP)—Total	✔		
Appropriate Treatment for Children with Upper Respiratory Infection (URI)—Total	✔		
Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator and *Systemic Corticosteroid*	✔	✔	
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), and *HbA1c Control (<8.0%)*	✔		
Controlling High Blood Pressure (CBP)	✔		
Use of Imaging Studies for Low Back Pain (LBP)	✔		
Asthma Medication Ratio (AMR)—Total	✔		

Performance Measure	Quality	Timeliness	Access
Medication Management for People With Asthma (MMA)— Medication Compliance 75%—Total	✓		
Ambulatory Care (Per 1,000 Member Months)(AMB)—ED Visits	N/A	N/A	N/A
Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	N/A	N/A	N/A
Behavioral Health Measures			
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up and *30-Day Follow-Up*	✓	✓	✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	✓	✓
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	✓	✓	✓
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total	✓		
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment— Total and *Initiation of AOD Treatment—Total*	✓	✓	✓
Identification of Alcohol and Other Drug Services (IAD)—Any Service	N/A	N/A	N/A
Mental Health Utilization (MPT)—Any Service	N/A	N/A	N/A

CMS established the requirements for the states' quality strategies in 42 CFR §438.340. This year's review of the New Hampshire MCM Quality Strategy included information obtained from the comparison of New Hampshire's document to the requirements found in the CFR. Table C-1 provides details of that comparison.

Table C-1—Comparison of the New Hampshire MCM Quality Strategy for SFY 2020 to the CMS Requirements in §438.340

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
§438.340	(a)	27883	1. General Rule ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	Each State contracting with a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) as defined in §438.2 or with a primary care case management (PCCM) entity as described in §438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP or PCCM entity.
HSAG FINDINGS: The New Hampshire MCM Quality Strategy ("Quality Strategy") dated SFY 2020 provided evidence of meeting this requirement.				
§438.340	(b)(1)	27883	2. Clinical Practice Guidelines ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§438.68 and 438.206, and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.
HSAG FINDINGS: Section II, Part B, Goal 1, Objective 1.3 in the Quality Strategy included the requirement to ensure adoption of evidence-based clinical practice guidelines by the MCOs that meet the requirement of this element. The two guidelines noted in the report were the *Bright Futures Pediatric Preventive Health Care from the American Academy of Pediatrics* and the *Immunization Coverage from the Centers for Disease Control and Prevention Vaccines for Children Program.* The Quality Strategy noted that DHHS will ensure compliance by reviewing the NCQA accreditation review results that require adoption of evidence-based clinical practice guidelines, and by reviewing the findings of the EQRO contract compliance review results that include this requirement once every three years in Standard XIII: Quality Management.				
§438.340	(b)(2)	27883	3. Goals and Objectives for Continuous Quality Improvement ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP.

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
HSAG FINDINGS: Section II, Part B, Goal 6—Manage Continuous Performance Improvement met the requirement of this element. The objectives in Goal 6 included ensuring that MCO performance improvement and QI projects demonstrate sustained improvement (Objective 6.1), verifying that the annual EQRO technical report includes MCO recommendations for performance improvement (Objective 6.2), conducting quarterly QAPI meetings between the quality leadership of DHHS and the MCOs (Objective 6.3), ensuring ongoing appropriate use of MCO sanctions that are compliant with 42 CFR §438 Subpart I (Objective 6.4), and requiring transparency by publicly reporting over 200 MCM Program quality measures (Objective 6.5).				
§438.340	(b)(3)(i)	27883 and 27884	4. Quality Metrics and Performance Targets ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include a description of: The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required under §438.10(c)(3).
HSAG FINDINGS: Appendix B of the Quality Strategy defined 227 measures that DHHS uses to evaluate MCO performance. Section II, Part B, Goal 6, Objective 6.5 supported transparency by publicly reporting quality measures on the Medicaid quality website. Appendix B—MCO Performance Measures listed the individual performance measure name, data type, and measurement data period. Goal 1, Objectives 1.1 and 1.2 indicated that the preventive care measure rates and annual treatment measure rates are to be equal to or higher than the 75th percentile of the national Medicaid managed care health plan rates by the end of SFY 2022. Beginning September 1, 2019, the following four preventive care measures and six annual treatment measures will be targeted to produce rates equal to or higher than the national average: PREVENTIVE CARE MEASURES • CMS Adult Core Set/HEDIS (IMA)—*Immunizations for Adolescents—Combination 1* • CMS Adult Core Set/HEDIS (IMA)—*Immunizations for Adolescents—Combination 2* (goal will be the 90th percentile) • CMS Adult Core Set/HEDIS (CHL)—*Chlamydia Screening in Women* • CMS Adult Core Set/HEDIS (PPC)—*Prenatal and Postpartum Care—Postpartum Care* ANNUAL TREATMENT MEASURES • CMS Adult Core Set/HEDIS (SAA)—*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* • CMS Adult Core Set/HEDIS (SSD)—*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • CMS Adult Core Set/HEDIS (ADD)—*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* • CMS Adult Core Set/HEDIS (IET)—*Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • CMS Adult Core Set/HEDIS (APP)—*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* • HEDIS (LBP)—*Use of Imaging Studies for Low Back Pain*				

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	Section	Page	Topic	Requirement
Rates are annually presented to internal stakeholders and the Medicaid Medical Care Advisory Council, as well as included in the EQR Technical Reports and publicly posted to https://medicaidquality.nh.gov.				
§438.340	(b)(3)(ii)	27884	5. Performance Improvement Projects ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include a description of: The performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.
HSAG FINDINGS: Section II, Part B, Goal 6, Objective 6.1 listed the four rapid-cycle PIP topics that must be implemented by the MCOs.				
§438.340	(b)(4)	27884	6. Annual External Independent Review ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in §438.310[c][2]) contract.
HSAG FINDINGS: Section II, Part B, Goal 6, Objective 6.2 required ensuring that the annual EQRO technical report includes MCO recommendations and suggestions for performance improvement to include an assessment of each MCO's strengths and weaknesses with respect to the quality and timeliness of care, and access to healthcare services furnished to Medicaid beneficiaries.				
§438.340	(b)(5)	*27884*	7. Transition of Care Policy ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: A description of the State's transition of care policy required under §438.62(b)(3).
HSAG FINDINGS: Section II, Part B, Goal 1, Objective 1.4 outlined the statewide transition of care policy that meets the requirements of 42 CFR §438.340(b)(5). The Quality Strategy included a link to the DHHS website where Medicaid members could access the Transition of Care policy. The Transition of Care policy accessed on the DHHS website furnished transition information concerning the care of pregnant women, provider terminations, prescription drug transitions, transitional care after discharge, New Hampshire Hospital transitions after discharge, and prior authorizations and transitions of care.				
§438.340	(b)(6)	27884	8. Identifying, Evaluating, and Reducing Health Disparities ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
				whether the individual qualified for Medicaid on the basis of a disability.

HSAG FINDINGS: Section II, Part B, Goal 7, Objective 7.3 discussed ensuring an ongoing process for the identification, evaluation, and reduction of health disparities. The enrollment process included the capture of race, Hispanic ethnicity, primary language spoken, and other disability eligibility information from data feeds through the 834 file. Additionally, MCOs must implement Cultural Competency Plans to assure that providers, individuals, and systems within the MCO effectively furnish services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values; affirms, and respects the worth of the individual members; and protects and preserves the dignity of each member.

| §438.340 | (b)(7) | 27884 | 9. Sanctions
 ☒ Met
 ☐ Partially Met
 ☐ Not Met
 ☐ NA | At a minimum, the State's quality strategy must include the following:

 For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part. |

HSAG FINDINGS: Section II, Part B, Goal 6, Objective 6.4 indicated ongoing appropriate use of MCO sanctions that comply with 42 CFR §438, Subpart I. The New Hampshire MCM Contract included remedies at the State's disposal to address MCO performance concerns, including the enactment of liquidated damages, stratified across four violation levels, and varying financial remedies.

| §438.340 | (b)(8) | 27884 | 10. Assessing Outcomes

 ☐ Met
 ☐ Partially Met
 ☐ Not Met
 ☒ NA | At a minimum, the State's quality strategy must include the following:

 A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity described in §438.310(c)(2). |

HSAG FINDINGS: The New Hampshire MCM Program did not include PCCMs; therefore, this element was not applicable to the New Hampshire MCM Quality Strategy.

| §438.340 | (b)(9) | 27884 | 11. Identification of Persons Needing Long-term Services and Supports and Persons with Special Needs

 ☒ Met
 ☐ Partially Met
 ☐ Not Met
 ☐ NA | At a minimum, the State's quality strategy must include the following:

 The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs). |

HSAG FINDINGS: Section II, Part B, Goal 7, Objective 7.2 acknowledged the responsibility to ensure an ongoing process to identify and inform the MCOs of members with needs or persons with special healthcare needs. The 834 eligibility file is exchanged daily between DHHS and the MCOs to communicate key member details, including flags for members who receive LTSS through one of the Department's Medicaid waivers, and various eligibility categories to identify special healthcare needs.

| §438.340 | (b)(10) | 27884 | 12. Non-duplication of EQR Activities | At a minimum, the State's quality strategy must include the following: |

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
			☒ Met ☐ Partially Met ☐ Not Met ☐ NA	The information required under §438.360(c) (relating to non-duplication of EQR activities)
HSAG FINDINGS: Section II—Medicaid Managed Care Quality Program, Part A—DHHS Managed Care Quality Program Overview indicated that the New Hampshire MCM EQRO activities are not annually duplicated by activities associated with NCQA accreditation.				
§438.340	(b)(11)	27884	13. Definition of Significant Change ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	At a minimum, the State's quality strategy must include the following: The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.
HSAG FINDINGS: Section III—Review of Quality Strategy included the definition of "significant change" as when one of the following actions occurs: re-procurement of the MCM Contract, addition of a new population to the MCM Program, addition of a new group of services to the MCM Program, or a change to the CMS regulations that impacts the New Hampshire MCM Quality Strategy.				
§438.340	(c)(1)(i)	27884	14. Public Comment ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	In drafting or revising its quality strategy, the State must: Make the strategy available for public comment before submitting the strategy to CMS for review, including: Obtaining input from the Medical Care Advisory Committee (established by §431.12 of this chapter), beneficiaries, and other stakeholders.
HSAG FINDINGS: Section III—Review of Quality Strategy emphasized that, in addition to publicly posting the strategy, the current draft Quality Strategy was discussed with New Hampshire's Medicaid Medical Care Advisory Council, the quality leadership of the MCOs, and the MCOs' Member Advisory Councils. Additionally, this section noted that, in addition to input from these committees, the draft Quality Strategy, final Quality Strategy, and supporting reports and documents are available for public review and comment at the New Hampshire Medicaid quality website, located at: https://medicaidquality.nh.gov/care-management-quality-strategy.				
§438.340	(c)(1)(ii)	27884	15. Consulting with Tribes ☐ Met ☐ Partially Met ☐ Not Met ☒ NA	In drafting or revising its quality strategy, the State must: If the State enrolls Indians in the MCO, PIHP, or PAHP, consulting with Tribes in accordance with the State's Tribal consultation policy.
HSAG FINDINGS: Appendix H—Public Comments on NH Medicaid Quality Strategy noted that consultation with tribes did not occur as there are no recognized tribes in the State of New Hampshire.				

| 42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
§438.340	(c)(2)	27884	16. Updating Quality Strategy ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	In drafting or revising its quality strategy, the State must: Review and update the quality strategy as needed, but no less than once every 3 years.
HSAG FINDINGS: Section III—Review of Quality Strategy acknowledged updating the New Hampshire MCM Quality Strategy tri-annually and when there is a significant change to the New Hampshire MCM Program.				
§438.340	(c)(2)(i)	27884	17. Evaluation of the Effectiveness of the Quality Strategy ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.
HSAG FINDINGS: Section III—Review of Quality Strategy, Section B—Quality Strategy Effectiveness Analysis indicated that no less than every three years, DHHS conducts an effectiveness analysis of the current Quality Strategy.				
§438.340	(c)(2)(ii)	27884	18. Quality Strategy Review Posted to Website ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	The State must make the results of the review available on the Website required under §438.10(c)(3).
HSAG FINDINGS: Section III—Review of Quality Strategy supplied a link to the New Hampshire Medicaid quality website that accesses the New Hampshire MCM Quality Strategy dated SFY 2020.				
§438.340	(c)(2)(iii)	27884	19. Recommendations to the Quality Strategy ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	Updates to the quality strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).
HSAG FINDINGS: Section III—Review of Quality Strategy indicated that no less than every three years, DHHS conducts an effectiveness analysis of the current Quality Strategy. The crosswalk of CMS regulations included in Appendix A acknowledged the requirement to ensure that the review takes into consideration the recommendations provided pursuant to 42 CFR §438.364(a)(4).				

42 CFR §438.340—Managed Care State Quality Strategy Evaluation				
Number	**Section**	**Page**	**Topic**	**Requirement**
§438.340	(c)(3)(i)	27884	20. Submitting the Quality Strategy to CMS ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	In drafting or revising its quality strategy, the State must submit to CMS the following: A copy of the initial strategy for CMS comment and feedback prior to adopting it in final.
HSAG FINDINGS: Section III—Review of Quality Strategy, Section D—CMS Review acknowledged that, following public input, the final Quality Strategy is submitted to CMS for feedback prior to finalizing.				
§438.340	(c)(3)(ii)	27884	21. Submitting Revised Quality Strategies to CMS ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	In drafting or revising its quality strategy, the State must submit to CMS the following: A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.
HSAG FINDINGS: Section III—Review of Quality Strategy, Section C—Significant Changes to the Quality Strategy and Section D—CMS Review addressed the triannual update of the New Hampshire MCM Quality Strategy, the circumstances that represent a significant change, and the requirement to submit the final Quality Strategy to CMS for approval following public input.				
§438.340	(d)	27884	22. Availability ☒ Met ☐ Partially Met ☐ Not Met ☐ NA	The State must make the final quality strategy available on the Website required under §438.10(c)(3).
HSAG FINDINGS: Section III, Section A furnished a link to the New Hampshire Medicaid quality website that accesses the New Hampshire MCM Quality Strategy dated SFY 2020.				

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

Figure D-1 displays enrollment in the MCOs since the inception of the MCM Program in New Hampshire.

Figure D-1—Enrollment in the New Hampshire MCM Program by MCO as of December 2, 2019
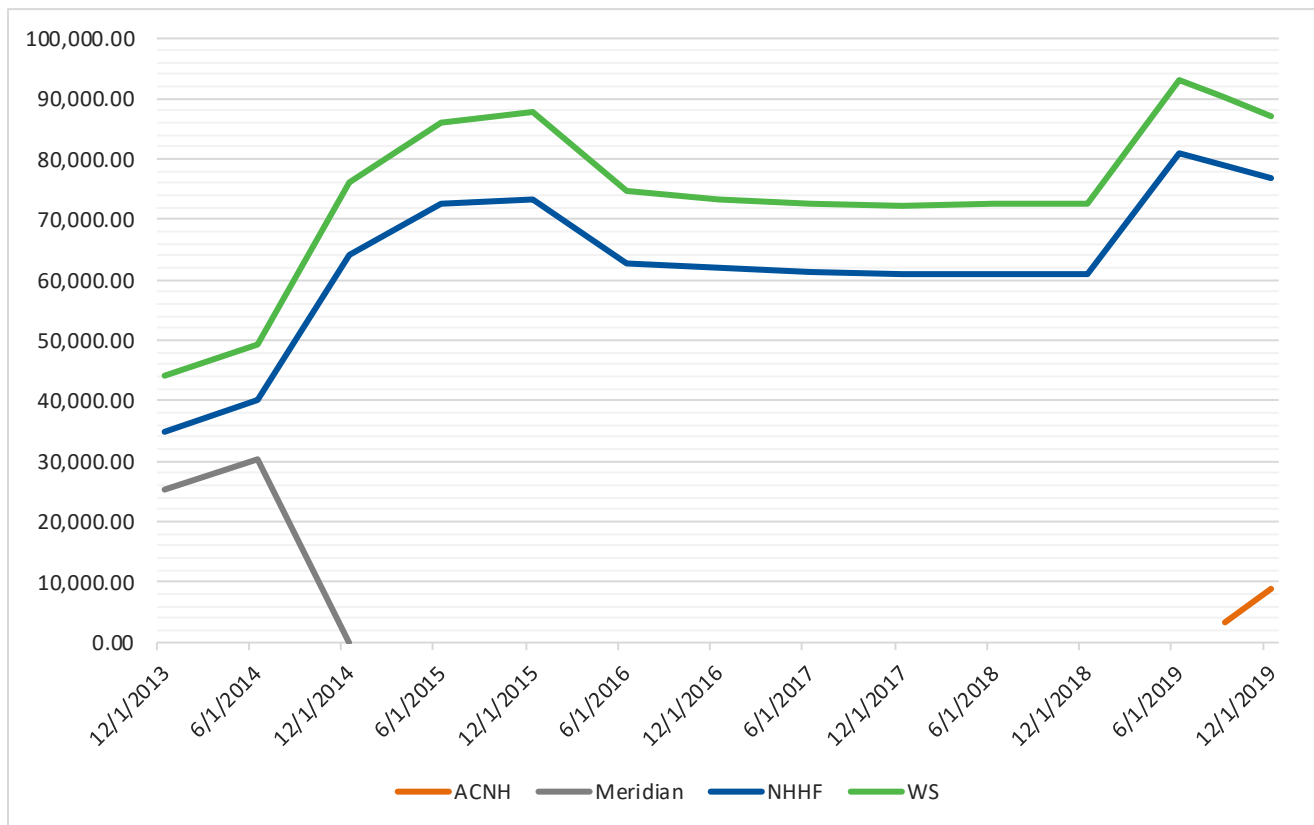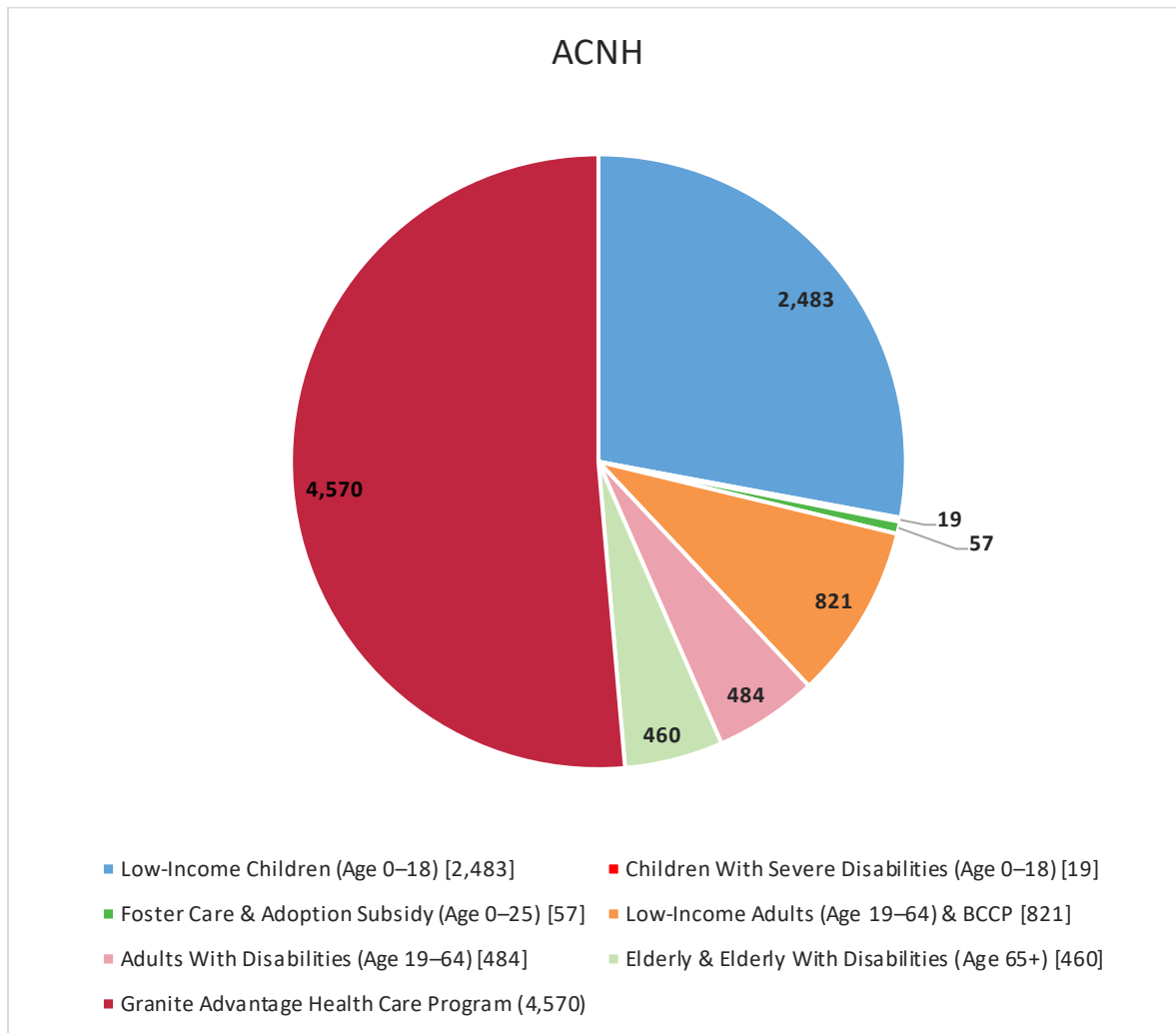

Source: Enterprise Business Intelligence (EBI) Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

Newly enrolled New Hampshire Health Protection Program (NHHPP) members who enrolled after October 1, 2015, were temporarily assigned to a non-MCM benefit plan in anticipation of the Premium Assistance Program (PAP) beginning on January 1, 2016, when they were placed in a Qualified Health Plan (QHP). The NHHPP PAP began January 1, 2016, when members were moved from MCM or non-MCM/PAP to a PAP QHP.

The MCM Program began in December 2013 with three MCOs: Meridian Health Plan (**Meridian**), **NHHF**, and **WS**. In August 2014, **Meridian** exited the MCM Program, and 30,000 beneficiaries were successfully transitioned to the remaining two plans. **NHHF** and **WS** continued to serve the MCM Program population until September 1, 2019, when **ACNH** entered the market. On December 2, 2019, enrollment in the MCM Program was 172,751.

Figure D-2 displays the **ACNH** eligibility categories of MCO members as of December 2, 2019.

Figure D-2—Point-in-Time Eligibility Category for ACNH as of December 2, 2019


ACNH

Legend:
- Low-Income Children (Age 0–18) [2,483]
- Children With Severe Disabilities (Age 0–18) [19]
- Foster Care & Adoption Subsidy (Age 0–25) [57]
- Low-Income Adults (Age 19–64) & BCCP [821]
- Adults With Disabilities (Age 19–64) [484]
- Elderly & Elderly With Disabilities (Age 65+) [460]
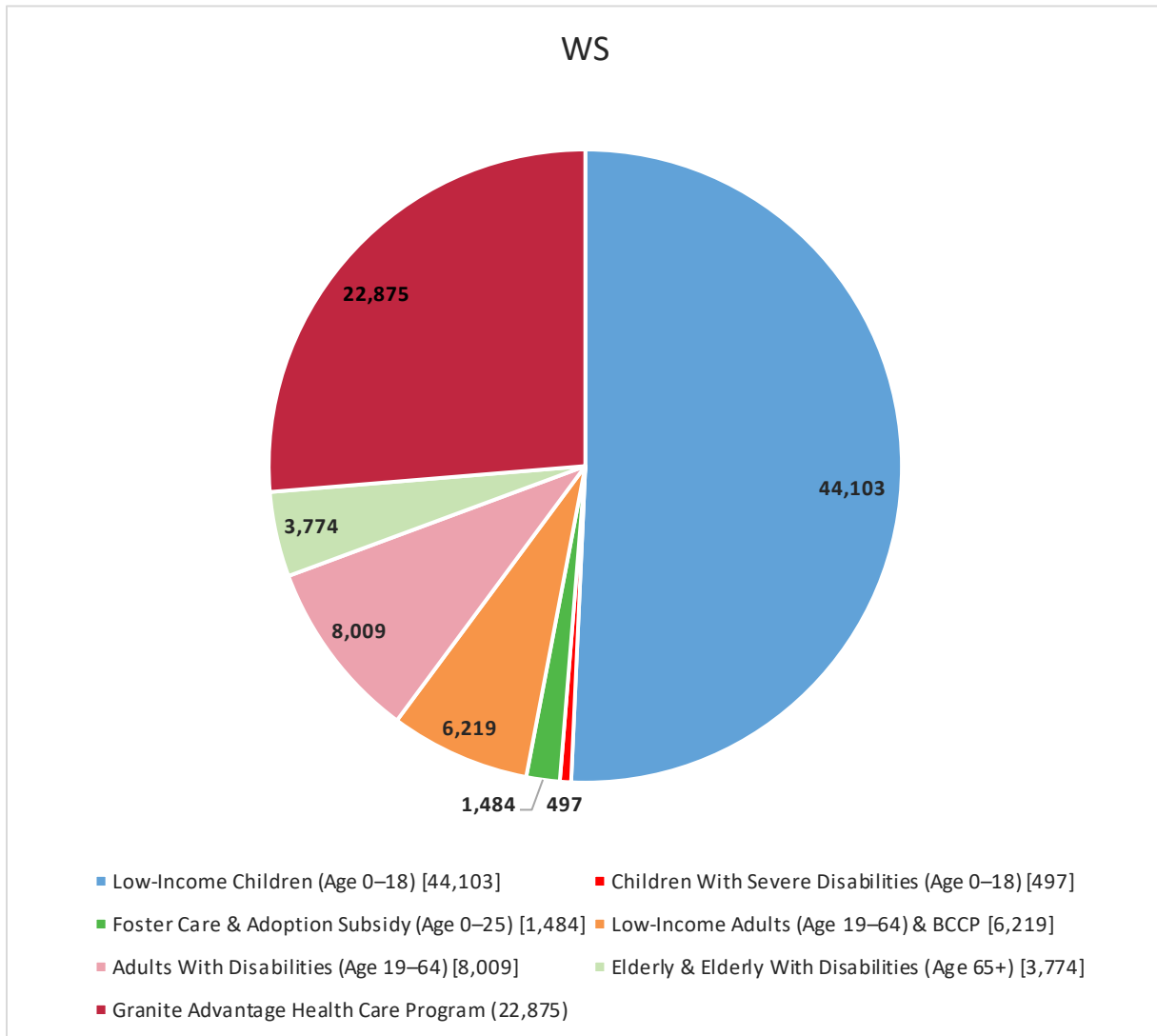- Granite Advantage Health Care Program (4,570)

Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.
Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The largest eligibility category, the Granite Advantage Health Care Program (GAHCP), represented 51.4 percent of **ACNH** members. The smallest eligibility category, children with severe disabilities, represented 0.2 percent of **ACNH** members. Total **ACNH** membership on December 2, 2019, in the seven eligibility categories was 8,894.

Figure D-3 displays the **NHHF** eligibility categories of MCO members as of December 2, 2019.

Figure D-3—Point-in-Time Eligibility Category for NHHF as of December 2, 2019
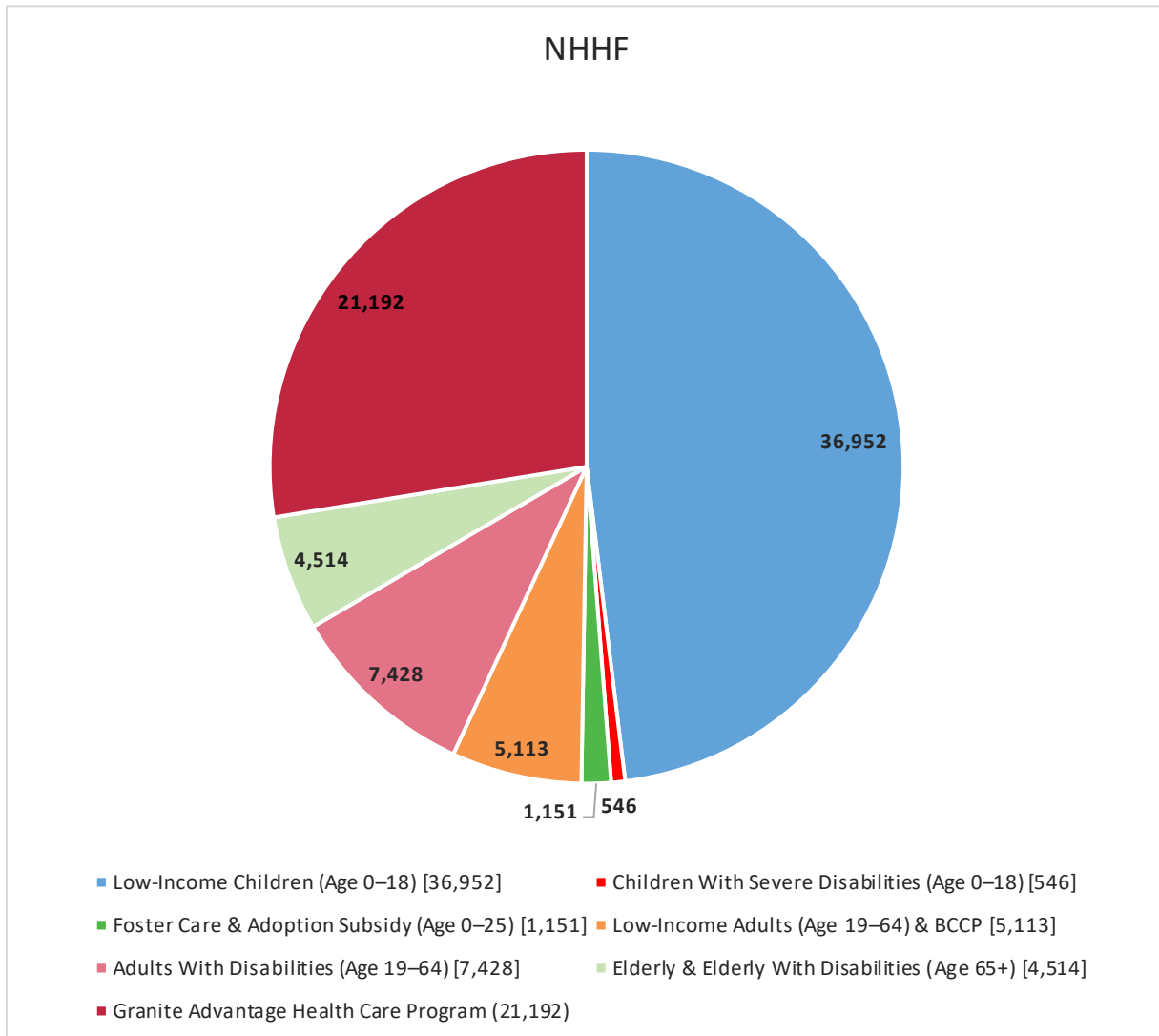

Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The largest eligibility category, low-income children, represented 48.1 percent of **NHHF** members. The smallest eligibility category, children with severe disabilities, represented 0.7 percent of **NHHF** members. Total **NHHF** membership on December 1, 2019, in the seven eligibility categories was 76,896.

Figure D-4 displays the **WS** eligibility categories of MCO members as of December 2, 2019.

Figure D-4—Point-in-Time Eligibility Category for WS as of December 2, 2019

WS

- Low-Income Children (Age 0–18) [44,103]
- Children With Severe Disabilities (Age 0–18) [497]
- Foster Care & Adoption Subsidy (Age 0–25) [1,484]
- Low-Income Adults (Age 19–64) & BCCP [6,219]
- Adults With Disabilities (Age 19–64) [8,009]
- Elderly & Elderly With Disabilities (Age 65+) [3,774]
- Granite Advantage Health Care Program (22,875)

Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.
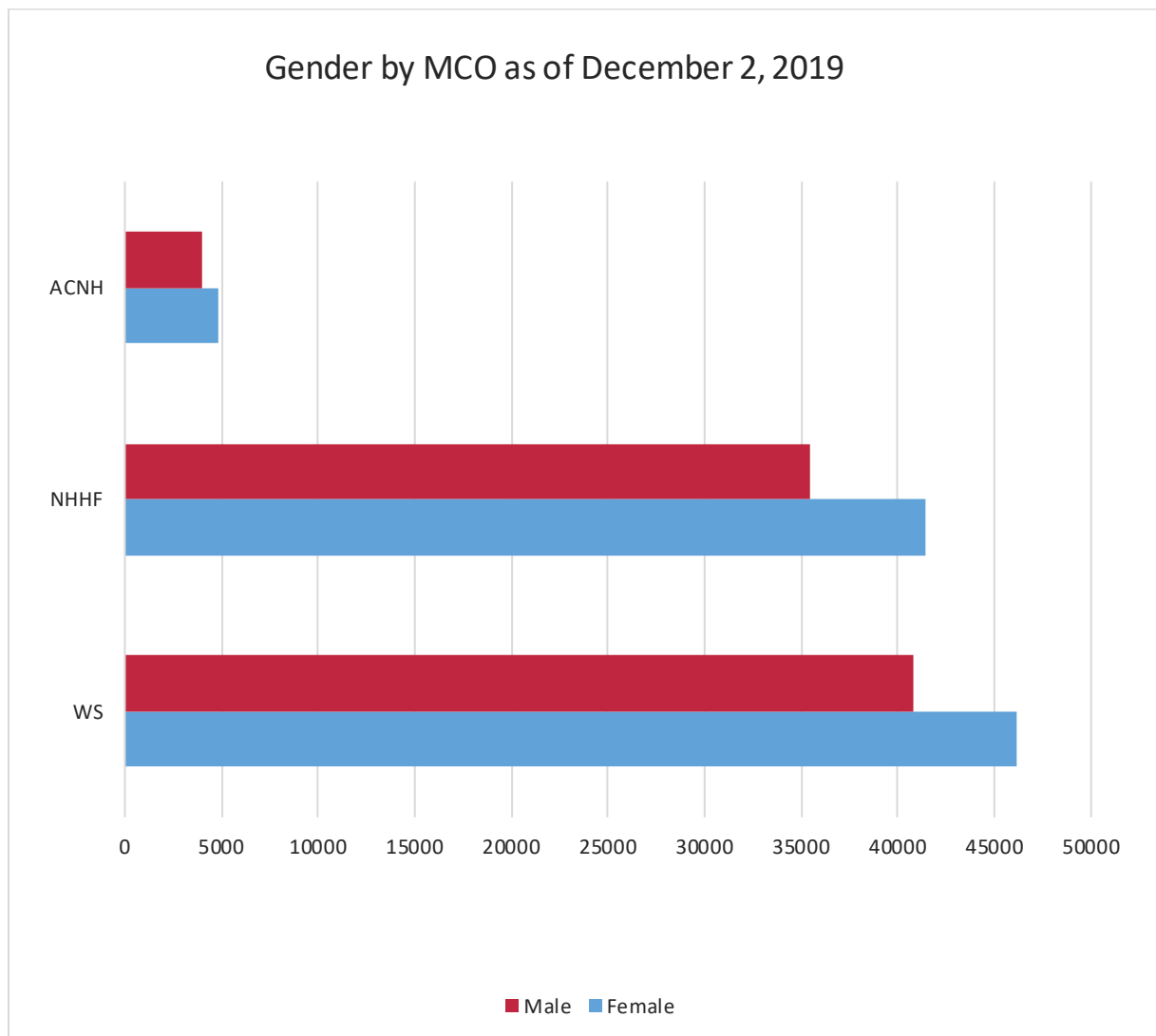*Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.*

The largest eligibility category, low-income children, represented 50.7 percent of **WS** members. The smallest eligibility category, children with severe disabilities, represented 0.6 percent of **WS** members. Total **WS** membership on December 2, 2019, in the seven eligibility categories was 86,961.

Figure D-5 displays information concerning the age groups of the Medicaid members in **ACNH**, **NHHF**, and **WS** as of December 2, 2019.

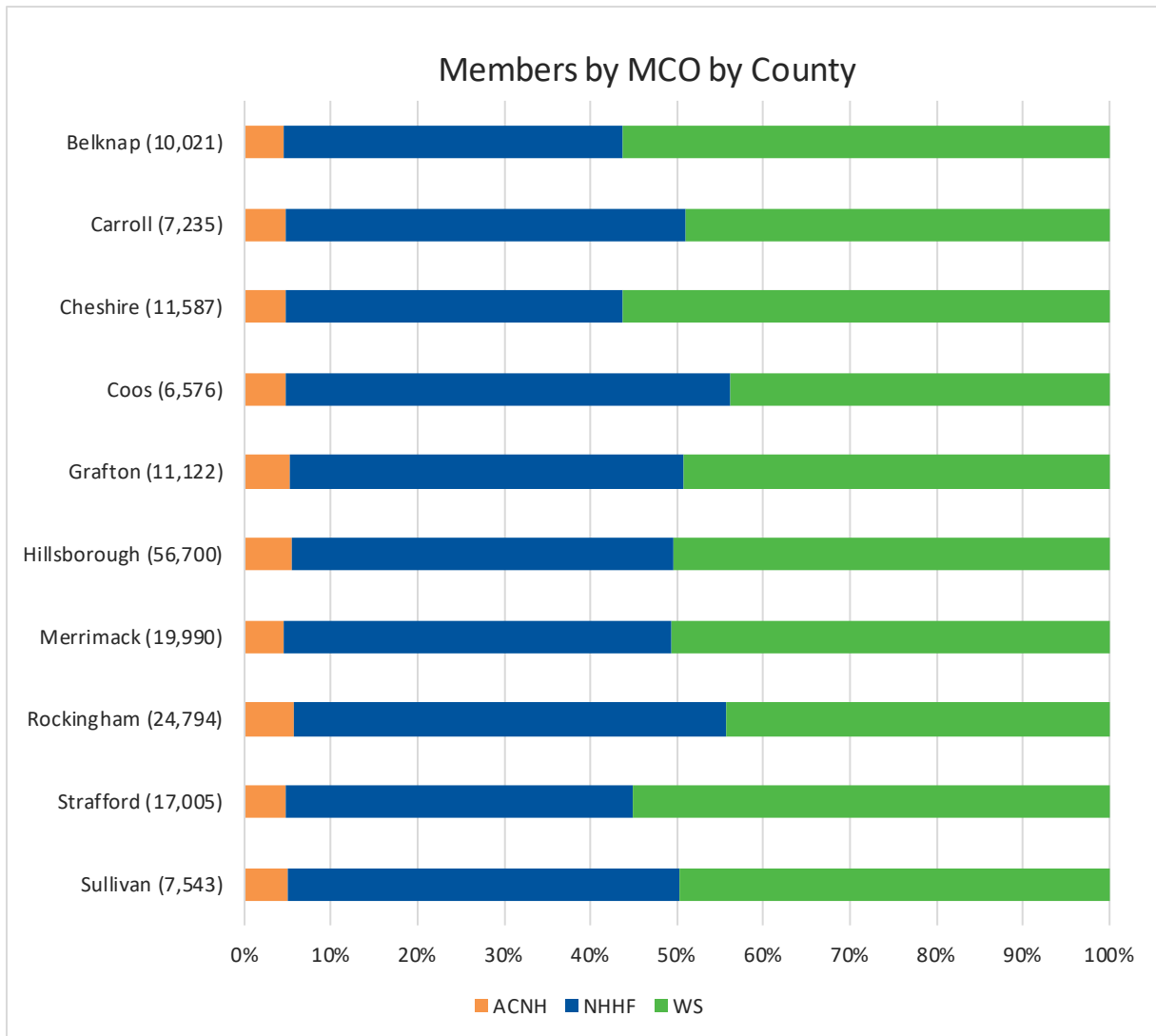**Figure D-5—Point-in-Time Age Groups by MCO as of December 2, 2019**
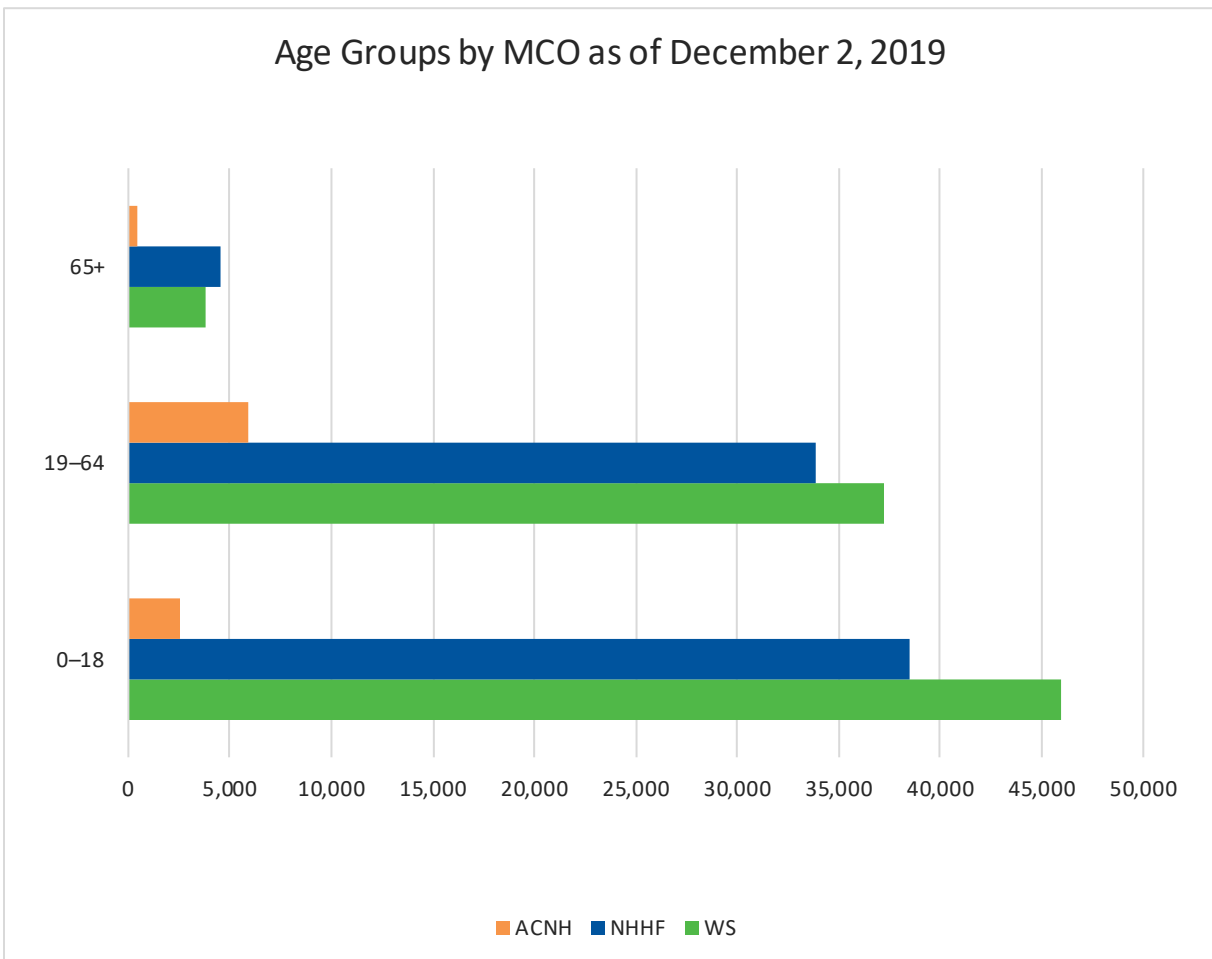
Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The distribution of ages in each MCO on December 2, 2019, was similar for **NHHF** and **WS**; however, the **ACNH** population displayed a very different distribution of ages in the 0–18 year and 19–64 year categories. A total of 28.7 percent of the **ACNH** population, 50.0 percent of the **NHHF** population, and 52.8 percent of the **WS** population were in the 0–18 year category. A total of 66.1 percent of the **ACNH** population, 44.1 percent of the **NHHF** population, and 42.9 percent of the **WS** population were in the 19–64 year category. The 65 years of age and older category totaled 5.2 percent of **ACNH**'s population, 5.9 percent of **NHHF**'s population, and 4.3 percent of **WS**'s population.

Figure D-6 presents the gender distribution of the MCO members as of December 2, 2019.

Figure D-6—Point-in-Time Gender by MCO as of December 2, 2019
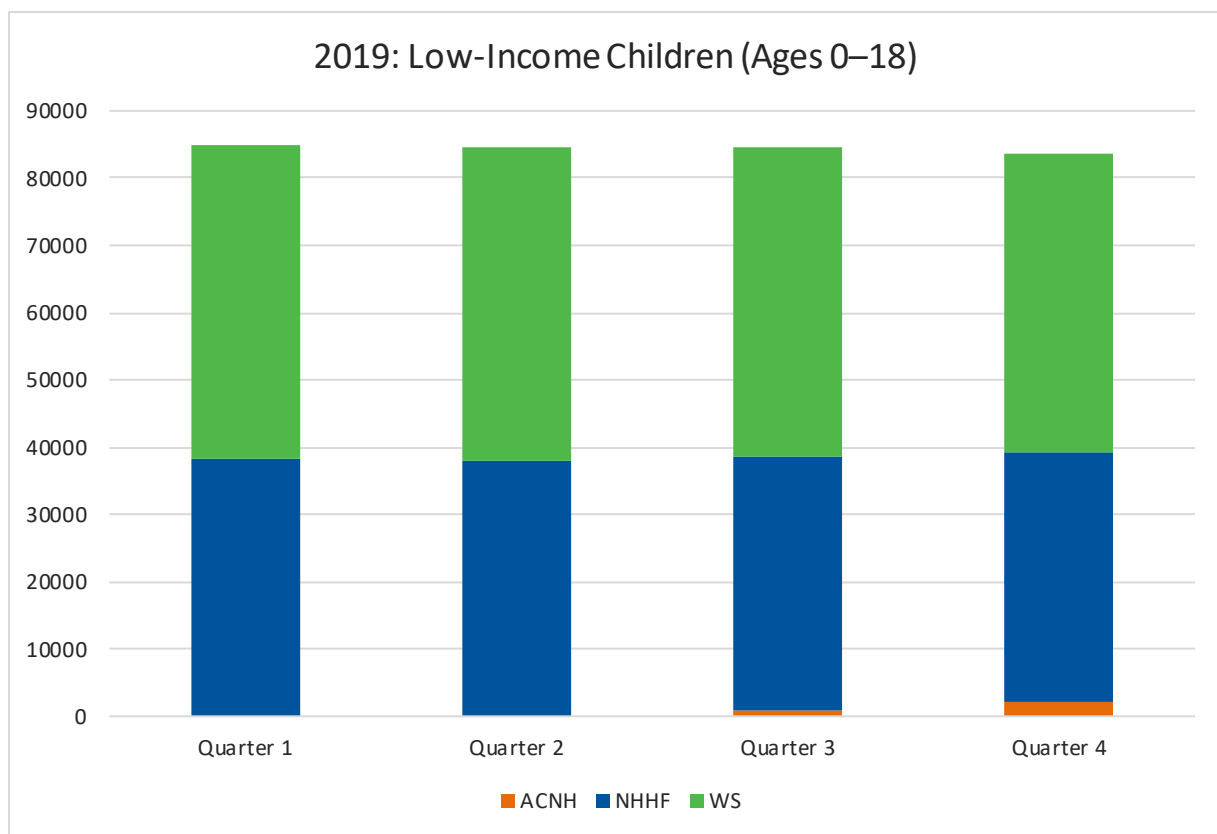

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The gender distribution in all three MCOs is very similar. All three MCOs had between 45.1 percent and 46.9 percent of males in their population, and between 53.1 percent and 54.9 percent of females in their population.

Figure D-7 shows the percentage of membership in the three MCOs for the 10 counties in New Hampshire as of December 2, 2019. The numbers listed next to the county name show the total MCM enrollment by county.

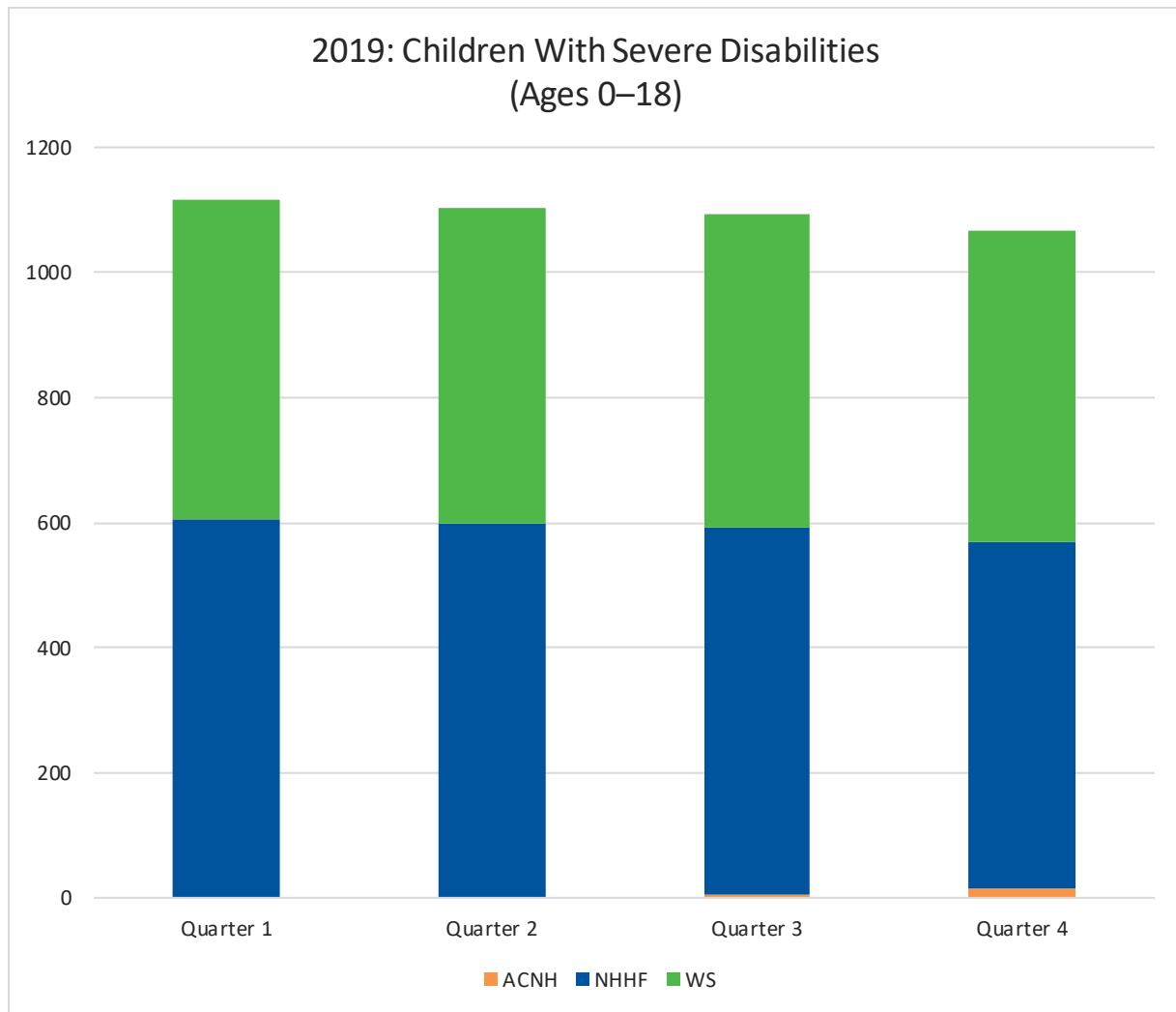**Figure D-7—Point-in-Time County Breakout by MCO as of December 2, 2019**

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The penetration of the MCO population in the New Hampshire counties by **ACNH** was relatively consistent, ranging from a low of 4.5 percent in Belknap County to a high of 5.7 percent in Rockingham County. The range of penetration of the MCO population in the New Hampshire counties by **NHHF** varied between 38.9 percent in Cheshire County to 51.3 percent in Coos County. For **WS**, the range varied from 43.8 percent in Coos County to 56.3 percent in Cheshire and Belknap counties. There also were 178 MCM members who were located out-of-state or had unknown addresses.

Figure D-8 through Figure D-13 provide information concerning the average quarterly MCO enrollment in six eligibility categories during the four quarters of 2019. The six eligibility categories include: low-income children, children with severe disabilities, children in foster care and children with adoption subsidies, low-income adults and adults in the Breast and Cervical Cancer Program (BCCP), adults with disabilities, and the elderly and elderly with disabilities. The figures only include enrollment information for **ACNH** for two quarters because the New Hampshire MCM Contract with **ACNH** began on September 1, 2019.

Figure D-8 shows the average quarterly enrollment for low-income children by MCO during 2019.

Figure D-8—Average Quarterly Enrollment for Low-Income Children (Ages 0–18) by MCO During 2019
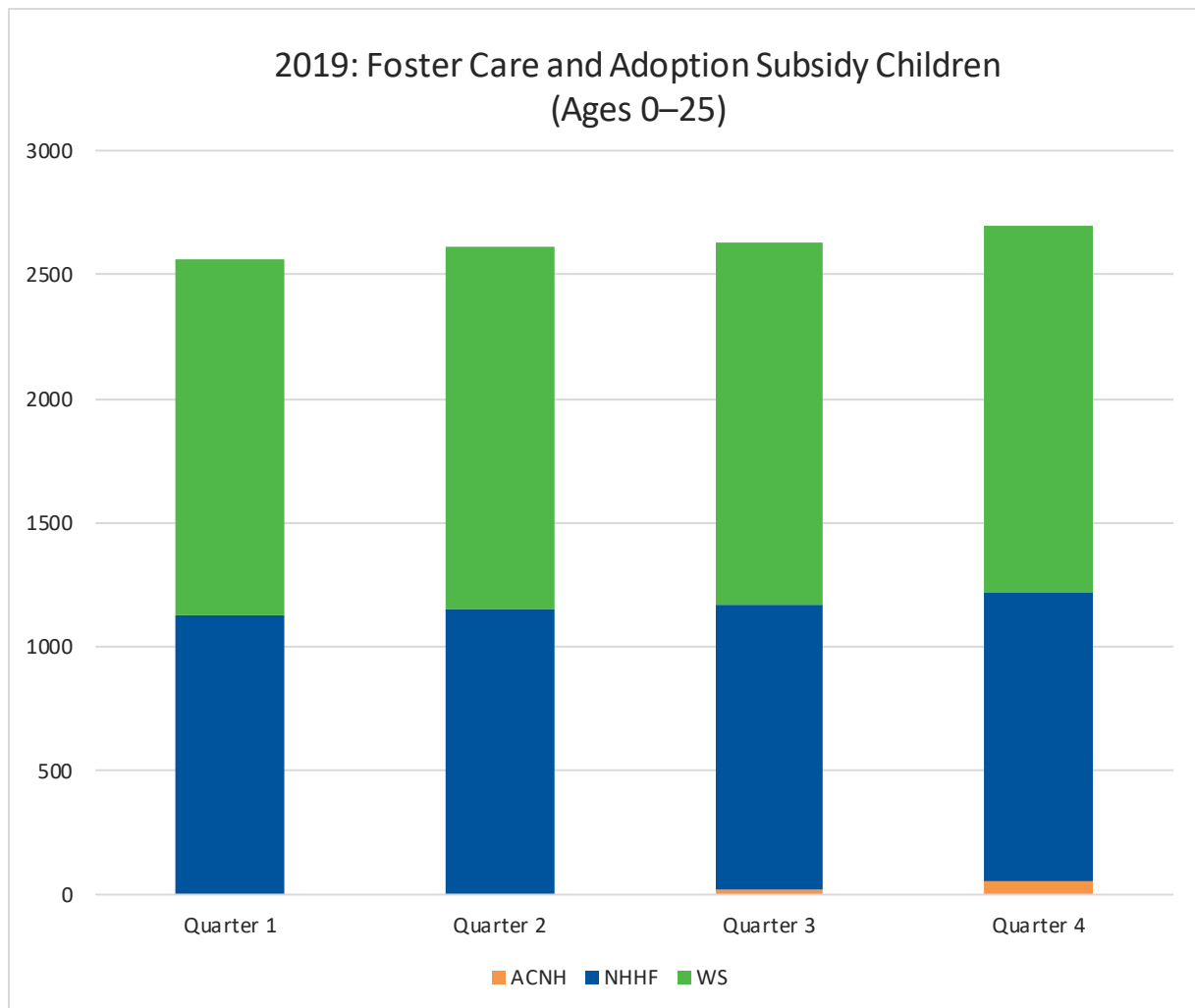

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

NHHF maintained a quarterly average from 44.3 percent to 45.1 percent of the low-income children in the MCM Program during the four quarters of 2019. The average quarterly percentage of low-income children enrolled in **WS** varied from 53.2 percent to 55.0 percent during the year. **ACNH** entered the market in September 2019 with a Quarter 3 average rate of 1.0 percent of the low-income children and increased that percentage to 2.5 percent during Quarter 4.

Figure D-9 displays the average quarterly enrollment for children with severe disabilities by MCO during 2019.

Figure D-9—Average Quarterly Enrollment for Children With Severe Disabilities (Ages 0–18) by MCO During 2019
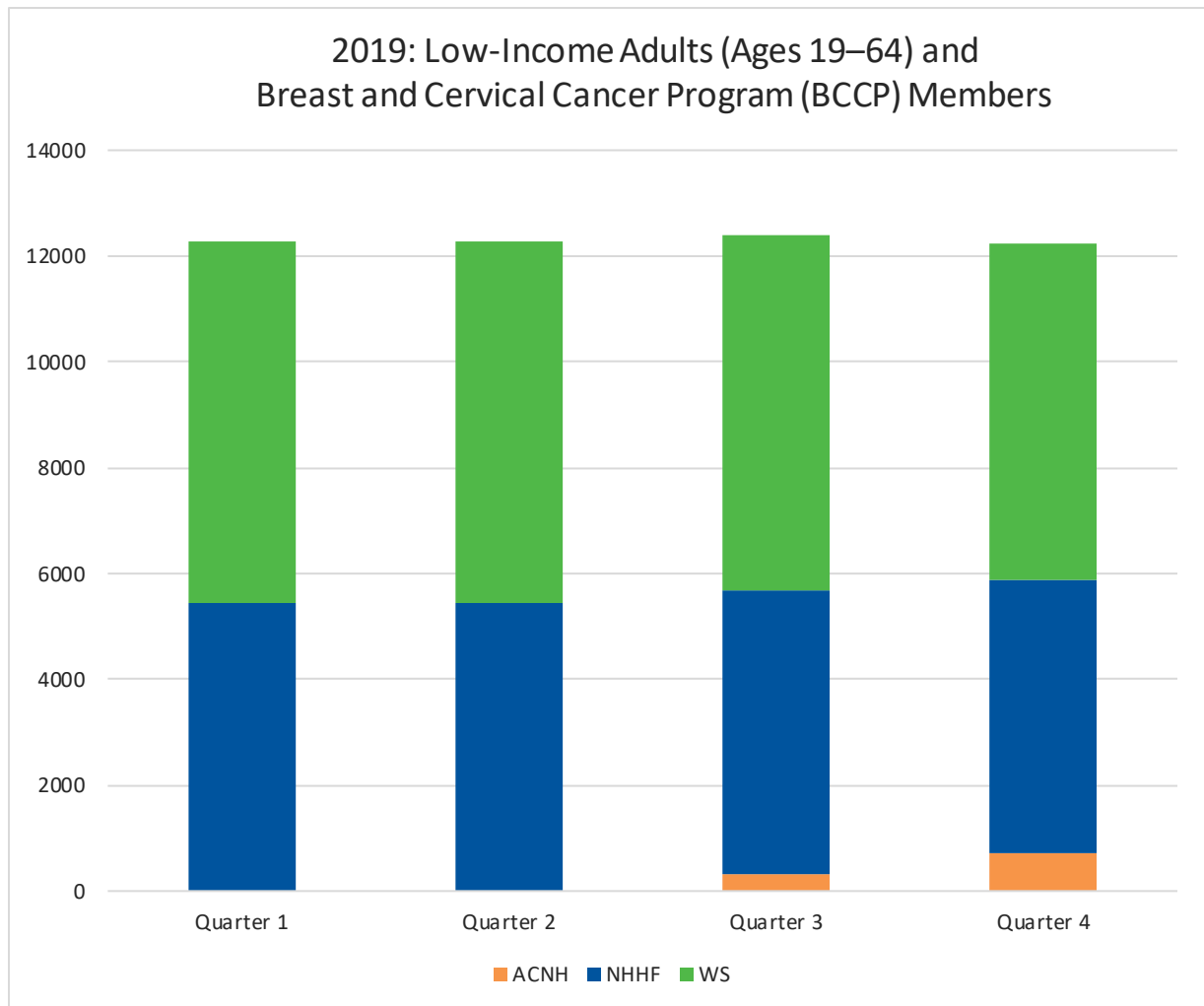

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The average quarterly enrollment of children with severe disabilities in the MCM Program varied by only 49 members from Quarter 1 to Quarter 4 during CY 2019. **NHHF** maintained from 51.8 percent to 54.4 percent of the membership, and **WS** maintained from 45.6 percent to 46.9 percent of the membership in the MCM Program. By Quarter 4 of CY 2019, the **ACNH** average quarterly membership included 1.3 percent of the members who were children with severe disabilities.

Figure D-10 shows the average quarterly enrollment for foster care children and children with adoption subsidies by MCO during 2019.

Figure D-10—Average Quarterly Enrollment for Foster Care and Adoption Subsidy Children (Ages 0–25) by MCO During 2019

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The average quarterly enrollment of foster care and adoption subsidy children in the MCM Program increased by 129 members from Quarter 1 to Quarter 4 in CY 2019. **NHHF** maintained a quarterly average from 43.2 percent to 44.1 percent of the membership, and **WS** maintained a quarterly average from 54.8 percent to 56.2 percent of the membership. **ACNH** entered the market with less than 1 percent of the membership and increased the average membership to 2.1 percent in Quarter 4 of CY 2019.

Figure D-11 displays the average quarterly enrollment for low-income adults and members in the BCCP by MCO during 2019.

Figure D-11—Average Quarterly Enrollment for Low-Income Adults (Ages 19–64) and BCCP Members by MCO During 2019
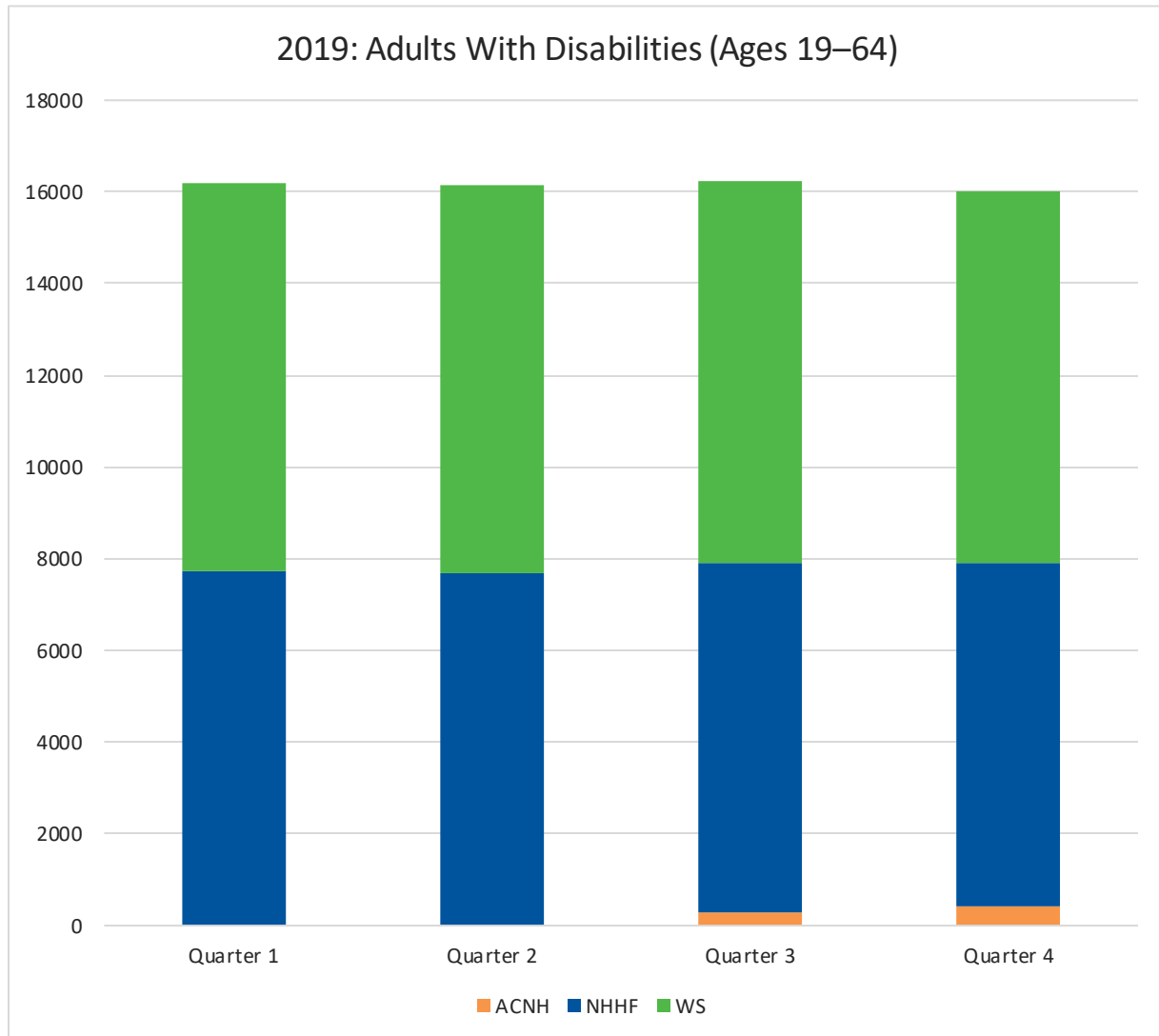

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The average quarterly enrollment of low-income adults and BCCP members in the MCM Program varied from a high in Quarter 3 of 12,385 and a low in Quarter 4 of 12,229. The average quarterly percentage of low-income adults and BCCP members in **NHHF** remained relatively constant from 42.4 percent to 44.3 percent. The average quarterly percentage of members in **WS** varied from 51.8 percent in Quarter 4 to 55.7 percent in Quarters 1 and 2. The average quarterly percentage of members in **ACNH** included 2.7 percent in Quarter 3 to 5.7 percent in Quarter 4.

Figure D-12 shows the average quarterly enrollment for adults with disabilities by MCO during 2019.

Figure D-12—Average Quarterly Enrollment for Adults With Disabilities (Ages 19–64) by MCO During 2019
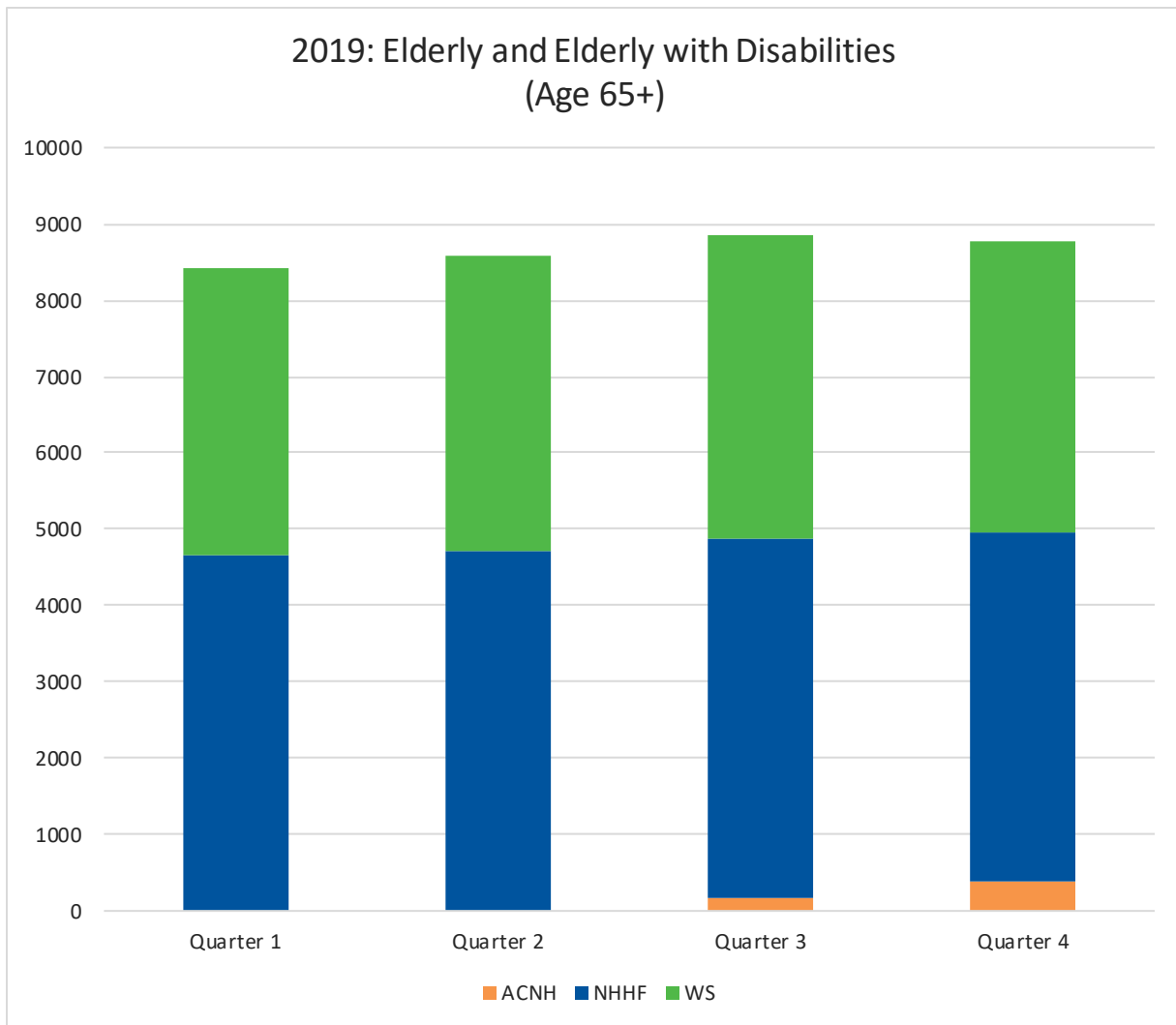

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The highest quarterly average number of adults with disabilities in the MCM Program in CY 2019 was in the Quarter 3 with 16,249 members, and the lowest average number of adults with disabilities in the MCM Program in CY 2019 was in Quarter 4 with 15,995 members. **NHHF**'s membership ranged from a quarterly average of 46.7 percent in Quarter 4 to 47.8 percent in Quarter 1, and **WS**'s average quarterly membership ranged from 50.6 percent in Quarter 4 to 52.4 percent in Quarter 2. **ACNH** entered the market in Quarter 3 with a quarterly average of 1.7 percent of the members and increased that number to 2.7 percent in Quarter 4.

Figure D-13 shows the average quarterly enrollment for the elderly and elderly with disabilities by MCO during 2019.

Figure D-13—Average Quarterly Enrollment for the Elderly and Elderly With Disabilities (Age 65+) by MCO During 2019
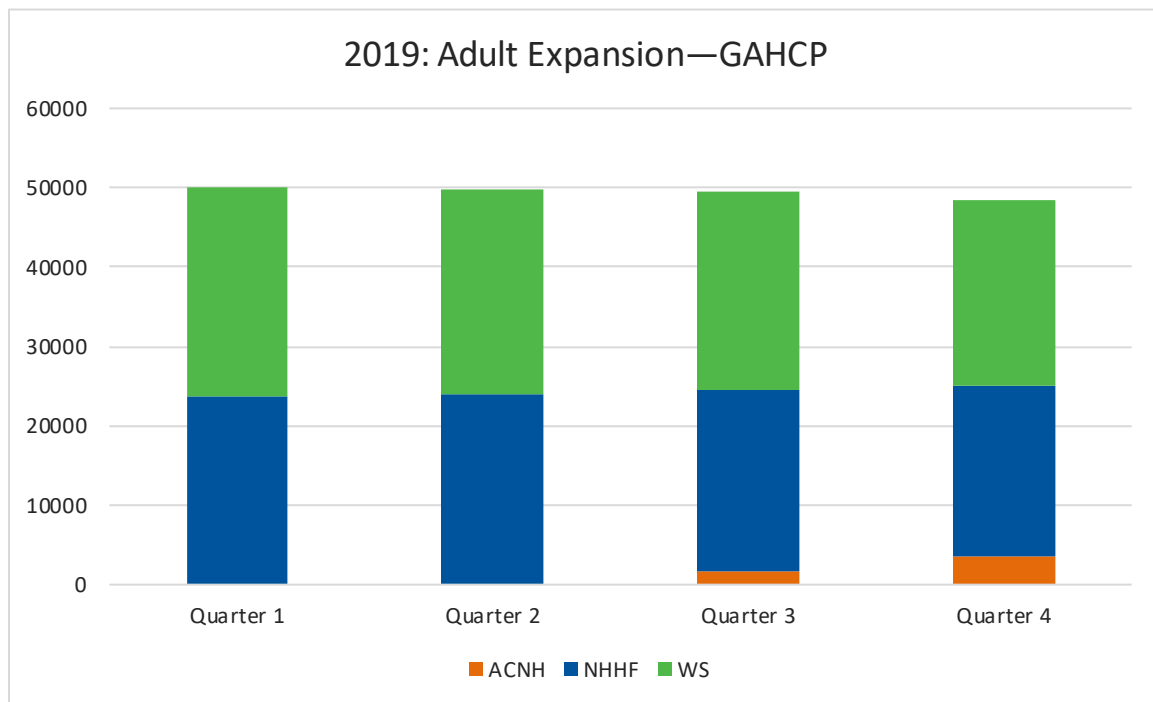

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The number of elderly and elderly with disabilities members age 65 and older in the MCM Program ranged from a quarterly average of 8,430 in Quarter 1 to 8,852 in Quarter 3 of CY 2019. The average quarterly membership of the elderly and elderly with disabilities in **NHHF** ranged from 52.1 percent in Quarter 4 to 55.2 percent in Quarter 1. The **WS** membership ranged from a quarterly average of 43.4 percent in Quarter 4 to 45.3 percent in Quarter 2, and the membership in **ACNH** ranged from 1.8 percent in Quarter 3 to 4.5 percent in Quarter 4.

Senate Bill 313 was signed by the Governor in June 2018, creating the GAHCP to replace the NHHPP. The bill moved the entire Medicaid expansion population from QHPs on the Exchange to Medicaid MCOs. Under NHHPP, expansion individuals were covered either through PAP QHPs, or a medically frail individual could elect to receive coverage through an MCO. The standard benefit plan and alternative benefit plan available under the NHHPP were aligned into one plan under Granite Advantage. Beginning January 1, 2019, Granite Advantage members began receiving healthcare coverage through one of the New Hampshire MCMs' plans. There were approximately 51,000 beneficiaries enrolled in NHHPP when the program changed to Granite Advantage on January 1, 2019. Of the 51,000 approximately 36,000 were enrolled in a PAP QHP and transitioned to managed care.

Figure D-14 shows the average quarterly enrollment for the adult expansion group in the GAHCP.

Figure D-14—Average Enrollment for Adult Expansion—Granite Advantage Health Care Program (GAHCP)

Source: EBI Start of Month Member Tables as of August 13, 2020 (data loaded through end of July 2020) supplemented with MMIS demographics as of August 12, 2020.

The average quarterly number of MCM Program members in the GAHCP decreased from 50,082 in Quarter 1 to 48,484 in Quarter 4. **NHHF**'s membership included quarterly averages from 44.4 percent of the GAHCP members in Quarter 4 to 48.0 percent of the members in Quarter 2. **WS**'s quarterly average membership ranged from 48.0 percent in Quarter 4 to 52.8 percent in Quarter 1. The GAHCP members in **ACNH** ranged from 3.4 percent in Quarter 3 to 7.6 percent of the MCM Program members in Quarter 4.