State of New Hampshire
Department of Health and Human Services

2021 New Hampshire External Quality Review Technical Report

April 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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Health Services Advisory Group, Inc., confirms that no one conducting 2021 external quality review organization activities had a conflict of interest with **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), or **Well Sense Health Plan** (**WS**) health plans.

1. Introduction

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 capitated managed care program. At the end of calendar year (CY) 2020, there were 204,339 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[1-1]

During state fiscal year (SFY) 2021, beneficiaries enrolled in the MCM 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**). All three health plans coordinate and manage their members' care through dedicated staff and a network of qualified providers.

This report is a summative account of a wide variety of activities conducted by Health Services Advisory Group, Inc. (HSAG), New Hampshire's external quality review organization (EQRO). Activities conducted to evaluate the individual MCOs included audits of each MCO's contract compliance, performance improvement projects (PIPs), performance measure validation (PMV), network adequacy validation (NAV), and encounter data validation (EDV). During SFY 2021, HSAG analyzed each MCO's health outcome and beneficiary experience of care data and compared the results to national performance measures in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] survey and the Healthcare Effectiveness Data and Information Set (HEDIS®).[1-3] HSAG also completed a provider satisfaction survey, initiated a secret shopper provider survey, and conducted semi-structured member interviews at the MCM program level.

The SFY 2021 New Hampshire External Quality Review (EQR) Technical Report presents and compares the rates of the three New Hampshire Medicaid health plans (i.e., **ACNH**, **NHHF**, and **WS**) and includes conclusions and recommendations for each MCO in the detailed findings section of this report. That section also contains an explanation of each task conducted in New Hampshire and offers nationally recognized comparison rates, when appropriate. The next section of the report offers a summary of strengths and recommendations for improving the quality, timeliness, and accessibility of healthcare services provided by each health plan. An assessment of the New Hampshire MCM Quality Strategy follows, and the report concludes with information concerning the MCOs' follow-up to the recommendations for improvement included in the SFY 2020 EQR Technical Report. Appendices to this report list abbreviations and acronyms (Appendix A) and the methodology for conducting all activities included in the report (Appendix B).

[1-1] The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of August 24, 2021 (data loaded through end of July 2021).

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

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Table 1-1 through Table 1-3 summarize the areas providing the greatest opportunities for improvement noted in the EQR tasks described in this report for **ACNH**, **NHHF**, and **WS**.

Table 1-1 contains a list of the opportunities for improvement for **ACNH**. Since the MCO completed corrective action plans (CAPs) to remedy the elements not achieving the standard rate for the compliance reviews, targeted improvement activities for **ACNH** should focus on measures that did not meet the standard for NAV, HEDIS, and EDV.

Table 1-1—Opportunities for Improvement for ACNH

EQR Activity	Measure Standard	ACNH's Results	Standard
Contract Compliance Audit	Standard VI: Member Enrollment and Disenrollment	97.1%	100%
	Standard VII: Member Services	99.0%	100%
	Standard XII: Utilization Management (UM)	98.4%	100%
Network Adequacy Validation (NAV)	Providers Found in Directory for Durable Medical Equipment (DME) Suppliers	80.0%	90.0%
	Provider Accommodates Physical Disabilities	89.1%	90.0%
	Non-English Language Speaking Provider (including American Sign Language)	8.6%	90.0%
	Provider Board Certification, if applicable for primary care providers (PCPs) and behavioral health (BH) providers	33.1%	90.0%
	Provider Uniform Resource Locator (URL)	0.0%	90.0%
HEDIS	*Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	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*	Below the 25th Percentile	Equal to or Higher than the National Average
	Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV) and *Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)*	Below the 25th Percentile	Equal to or Higher than the National Average
	Cervical Cancer Screening (CCS)	Below the 25th Percentile	Equal to or Higher than the National Average
	Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years, and *Total*	Below the 25th Percentile	Equal to or Higher than the National Average

EQR Activity	Measure Standard	ACNH's Results	Standard
	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	Below the 25th Percentile	Equal to or Higher than the National Average
	Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)—Bronchodilator	Below the 25th Percentile	Equal to or Higher than the National Average
	Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	**Ongoing Encounter Data Quality Reports**		
	837 Professional (P): Initial Submission Within 14 Days of Claim Payment	98.8%	100%
	837 Institutional (I): Initial Submission Within 14 Days of Claim Payment	99.1%	100%
	Comparative Analysis Between Encounters Submittted to DHHS' Data Warehouse and to HSAG		
	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (P) (Pharmacy); Record Surplus (P) (I); Elements Surplus (P)(I); Element Missing (I); Element Omission (I); Element Accuracy (P)	Rates ranged from 6.4%–98.4%	100%
	Information System Review		
	Dental, vision, and non-emergency medical transportation (NEMT) subcontractors to submit data to **ACNH** on a weekly basis	Monthly submissions	Submit claims within 14 calendar days of claim payment

Table 1-2 contains a list of the opportunities for improvement for **NHHF**. Since the MCO completed CAPs to remedy the elements not achieving the standard rate for the compliance reviews, targeted improvement activities for **NHHF** should focus on measures that did not meet the standard for NAV, HEDIS, and EDV.

Table 1-2—Opportunities for Improvement for NHHF

EQR Activity	Measure Standard	NHHF's Results	Standard
Contract Compliance Audit	Standard VII: Member Services	98.0%	100%
Network Adequacy Validation (NAV)	Providers Found in Directory for PCPs	81.0%	90.0%
	Providers Found in Directory for BH Providers	84.5%	90.0%
	Provider Telephone Number	81.9%	90.0%
	Provider Type/Specialty	89.5%	90.0%
	Provider Accommodates Physical Disabilities	26.2%	90.0%
	Provider Completed Cultural Competency Training	70.0%	90.0%
	Non-English Language Speaking Provider (including American Sign Language)	73.8%	90.0%
	Provider URL	0.0%	90.0%
HEDIS	*Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years, and Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	Below the 25th Percentile	Equal to or Higher than the National Average
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	Below the 25th Percentile	Equal to or Higher than the National Average
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Below the 25th Percentile	Equal to or Higher than the National Average
	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Below the 25th Percentile	Equal to or Higher than the National Average

EQR Activity	Measure Standard	NHHF's Results	Standard
Encounter Data Validation (EDV)	**Ongoing Encounter Data Quality Reports**		
	837(P): Validity of Member Identification Number–Percent Valid	99.8%	100%
	837 Pharmacy: Validity of Member Identification Number–Percent Valid	99.9%	100%
	837(P): Initial Submission Within 14 Days of Claim Payment	99.0%	100%
	837(I): Initial Submission Within 14 Days of Claim Payment	99.6%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	85.5%	100%
	Comparative Analysis Between Encounters Submittted to DHHS' Data Warehouse and to HSAG		
	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (I)(Pharmacy); Elements Surplus (P); Element Missing (I); Element Omissions (I); Element Accuracy (P)(I) (Pharmacy)	Rates ranged from 4.6%—93.8%	100%
	Medical Record Review (MRR)		
	Review reasons for the non-submission of medical records		
	Educate providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472		
	Perform periodic MRRs of submitted claims to verify appropriate coding and data completeness.		

Table 1-3 contains a list of the opportunities for improvement for **WS**. Since the MCO completed CAPs to remedy the elements not achieving the standard rate for the compliance reviews, targeted improvement activities for **WS** should focus on measures that did not meet the standard for NAV, HEDIS, and EDV.

Table 1-3—Opportunities for Improvement for WS

EQR Activity	Measure Standard	WS's Results	Standard
Contract Compliance Audit	Care Management/Care Coordination	88.2%	100%
	Member Enrollment and Disenrollment	94.1%	100%
Performance Measure Validation (PMV)	ACCESSREQ.05–*Requests for Assistance Accessing MCO Designated Primary Care Providers by County*	Not Compliant	Compliant
Network Adequacy Validation (NAV)	Providers Found in Directory for BH Providers	41.2%	90.0%
	Providers Found in Directory for DME Providers	66.7%	90.0%
	Provider's Name	88.2%	90.0%
	Provider Type/Specialty	65.8%	90.0%
	Provider Accommodates Physical Disabilities	88.2%	90.0%
	Provider Completed Cultural Competency Training	20.9%	90.0%
	Non-English Language Speaking Provider (including American Sign Language)	62.0%	90.0%
	Provider Primary Language	62.0%	90.0%
	Provider Board Certification, if applicable for PCPs and BH Providers	71.0%	90.0%
	Provider Office Hours	88.8%	90.0%
	Provider URL	3.2%	90.0%
HEDIS	*Breast Cancer Screening (BCS)*	Below the 25th Percentile	Equal to or Higher than the National Average
	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*	Below the 25th Percentile	Equal to or Higher than the National Average
	Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)	Below the 25th Percentile	Equal to or Higher than the National Average
	Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap), and *Combination 2 (Meningococcal, Tdap, HPV)*	Below the 25th Percentile	Equal to or Higher than the National Average
	Cervical Cancer Screening (CCS)	Below the 25th Percentile	Equal to or Higher than the National Average

EQR Activity	Measure Standard	WS's Results	Standard
	Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years, and *Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal	Below the 25th Percentile	Equal to or Higher than the National Average
	Comprehensive Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%), and *HbA1c Control (<8.0%)*	Below the 25th Percentile	Equal to or Higher than the National Average
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Below the 25th Percentile	Equal to or Higher than the National Average
	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Below the 25th Percentile	Equal to or Higher than the National Average
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Cholesterol Testing—Total and *Blood Glucose and Cholesterol Testing—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Continuation and Maintenance Phase	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	**Ongoing Encounter Data Quality Reports**		
	837(P): Validity of Member Identification Number	99.7%	100%
	837(I): Validity of Member Identification Number	99.6%	100%
	837(P): Initial Submission Within 14 Days of Claim Payment	99.2%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	95.3%	100%
	Comparative Analysis Between Encounters Submittted to DHHS' Data Warehouse and to HSAG		
	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (Pharmacy); Record Surplus (Pharmacy); Elements Missing (P)(I); Element Omission (I); Element Accuracy (I)	Rates ranged from 4.7%–99.4%	100%
	Medical Record Review (MRR)		
	Review reasons for the non-submission of medical records		
	Investigate the relatively high encounter data omission rate for the data element *Procedure Code*		
	Educate providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472		

2. Overview of the MCM Program

The New Hampshire statewide MCM Program is the primary method of service delivery covering 96.5 percent[2-1] of the New Hampshire Medicaid population as of December 1, 2020. At the end of CY 2020, there were 204,339 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[2-2] That number represents an increase of 31,588 beneficiaries from the end of CY 2019 due to the Families First Coronavirus Response Act (FFCRA) that required states not to disenroll Medicaid members during the public health emergency.

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;

[2-1] The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of August 24, 2021 (data loaded through end of July 2021).

[2-2] Ibid.

- Recipients with Retroactive/Presumptive Eligibility Segments (Excluding Auto Eligible Newborns); and
- Veterans Affairs Benefit Recipients.

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 contracted with the following MCOs to provide statewide coverage for the New Hampshire MCM Program in SFY 2021:

- **ACNH**;
- **NHHF**; and
- **WS**.

With the onset of New Hampshire MCM Program, 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 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 Assessment and Performance Improvement (QAPI) program.
- Participating in a program evaluation conducted by the EQRO.

3. Detailed Findings

Overview

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[3-1] HSAG, an EQRO, currently provides EQR services in 18 states and has contracted with DHHS to perform EQR activities for New Hampshire since 2013.

The SFY 2021 New Hampshire EQR Technical Report for the 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 EQR activities conducted during SFY 2021.

The following section of the report presents and compares the rates of the three New Hampshire Medicaid health plans (i.e., **ACNH**, **NHHF**, and **WS**) and includes conclusions and recommendations for each MCO. The section also contains an explanation of each task conducted by the EQRO in New Hampshire and offers nationally recognized comparison rates, when appropriate.

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

This section of the report provides information concerning the New Hampshire EQR tasks conducted by HSAG during SFY 2021. The tasks include MCO contractual compliance, PIPs, PMV, NAV, CAHPS, HEDIS, EDV, semi-structured qualitative interviews, a Secret Shopper Survey, and a Provider Satisfaction Survey.

[3-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 17, 2021.

[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: Nov 17, 2021.

MCO Contractual Compliance

The purpose of the New Hampshire compliance reviews was to determine the MCOs' compliance with 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements included in the New Hampshire Medicaid Care Management Contract.[3-3,3-4,3-5] HSAG followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance With Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019,[3-6] to create the process, tools, and interview questions used for the reviews. New Hampshire elected to review the requirements over a three-year period, and this section of the report contains detailed information concerning the current year's review. For additional information concerning HSAG's compliance reviews from 2017 to the present, see Appendix B Methodologies for Conducting EQR Activities, page B-2.

The complete New Hampshire compliance tool contained 16 standards, and in SFY 2021 HSAG reviewed six of the standards (i.e., approximately one-third of the total standards reviewed during a three-year period):

- 42 CFR §438.208: Coordination and Continuity of Care/Care Management and Care Coordination
- 42 CFR §438.56: Disenrollment/Member Enrollment and Disenrollment
- 42 CFR §438.100: Enrollee Rights/Member Services
- 42 CFR §438.210: Coverage and Authorization of Services/UM
- 42 CFR §438.224, §438.236, and §438.330: Confidentiality, Practice Guidelines, and Quality Assessment and Performance Improvement Program
- Third-Party Liability (TPL)

Those standards included requirements that affect the ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries. To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts

[3-3] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #5 to the Medicaid Care Management Services Contract*. Available at: https://sos.nh.gov/media/p4yppqma/009-gc-agenda-012221.pdf. Accessed on: Nov 17, 2021.

[3-4] Department of Health and Human Services. (2016). 42 CFR §438. Available at: https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-part438.pdf. Accessed on: Nov 17, 2021.

[3-5] Centers for Medicare & Medicaid Services. (2018). Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf. Accessed on: Nov 17, 2021.

[3-6] 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/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Nov 17, 2021.

- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., January 31, 2021)
- Member Handbook and additional documents sent to members
- Provider Manual and other MCO communication sent to providers/subcontractors
- Automated member website
- Automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- Financial and TPL documents
- Denials file review
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG scheduled the three, two-day compliance reviews in April and May 2021. Due to the lingering pandemic from the coronavirus disease 2019 (COVID-19), 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 securely display documents and databases discussed during the review.

Based on the overall score achieved by each MCO, HSAG established a level of confidence rating for this year's compliance review as defined below:

90%–100%: High confidence in the MCO's compliance with State and federal requirements
80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
70%–79%: Low confidence in the MCO's compliance with State and federal requirements
Under 70%: No confidence in the MCO's compliance with State and federal requirements

Table 3-1 displays the comparison rates achieved by the three MCOs for the SFY 2021 compliance review activity and the level of confidence associated with the overall score.

Table 3-1—Rates Achieved by the MCOs for the SFY 2021 Compliance Review

Standard	Standard Name	ACNH	NHHF	WS
III	Care Management/Care Coordination	100%	100%	88.2%
VI	Member Enrollment and Disenrollment	97.1%	100%	94.1%
VII	Member Services	99.0%	98.0%	100%
XII	UM	98.4%	100%	100%
XIII	Quality Management	100%	100%	100%
XVI	TPL	100%	100%	100%
Overall Results		**99.0%**	**99.5%**	**97.4%**
Level of Confidence		**High**	**High**	**High**

All three MCOs demonstrated strengths, with very strong compliance with the federal and State requirements by achieving overall scores of 97.4 percent or higher. The scores for the individual standards ranged from 88.2 percent to 100 percent for the three MCOs.

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.[3-7] HSAG included any element that did not receive a score of *Met* in a CAP document distributed to each MCO. Prior to the completion of the CAP process, which was approved by DHHS, 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 SFY 2022 compliance review to ensure continued compliance with the requirements.

Conclusions and Recommendations for MCO Contractual Compliance

ACNH

HSAG conducted the compliance review for **ACNH** on May 12 and 13, 2021. Table 3-2 details the scores achieved by **ACNH** for the six standards included in the SFY 2021 review.

Table 3-2—Compliance Review Scores for ACNH

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
III	Care Management/Care Coordination	34	34	34	0	0	100%
VI	Member Enrollment and Disenrollment	18	17	16	1	0	97.1%
VII	Member Services	50	50	49	1	0	99.0%
XII	UM	64	64	62	2	0	98.4%
XIII	Quality Management	20	20	20	0	0	100%
XVI	TPL	8	8	8	0	0	100%
Overall Results		**194**	**193**	**189**	**4**	**0**	**99.0%**

* ***Partially Met*** and ***Not Met*** elements were addressed in the CAP completed by **ACNH**.

** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within the standard, after removing non-applicable elements.

[3-7] Ibid.

The ACNH compliance tool included six standards representing 193 applicable elements. ACNH met the requirements for 189 elements and partially met the requirements for four elements. ACNH achieved an overall score of 99.0 percent. Of the six standard areas reviewed, ACNH achieved 100 percent compliance on three standards demonstrating adherence to all requirements:

- Care Management/Care Coordination
- Quality Management
- TPL

ACNH received a score of 97.1 percent or higher but less than 100 percent on the remaining three standards representing areas of relative strength:

- Member Enrollment/Disenrollment
- Member Services
- UM

The six standards included requirements that affect the ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

This year's review included a file review of a random sample of 10 denial files. Of the 10 ACNH files reviewed, one file did not contain evidence of timely decision-making. One other file did not contain evidence of member notification of the denial. All files containing a member notification letter included the reasons for the denial and documented that a qualified clinician made the denial decision.

To improve the standards that scored below 100 percent, ACNH must:

- Ensure that members receive notification of disenrollment rights.
- Send letters to members confirming the member's PCP and providing contact information for that provider.
- Send written notices to members informing them of denied authorization requests as required by federal and State requirements.

NHHF

HSAG conducted the compliance review for NHHF on April 14 and 15, 2021. Table 3-3 details the scores achieved by NHHF for the six standards included in the SFY 2021 review.

Table 3-3—Compliance Review Scores for NHHF

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
III	Care Management/Care Coordination	34	34	34	0	0	100%
VI	Member Enrollment and Disenrollment	18	17	17	0	0	100%

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
VII	Member Services	50	50	48	2	0	98.0%
XII	UM	64	64	64	0	0	100%
XIII	Quality Management	20	20	20	0	0	100%
XVI	TPL	8	8	8	0	0	100%
Overall Results		**194**	**193**	**191**	**2**	**0**	**99.5%**

* ***Partially Met*** and ***Not Met*** elements were addressed in the CAP completed by **NHHF**.
** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing non-applicable elements

The **NHHF** compliance tool included six standards representing 193 applicable elements. **NHHF** met the requirements for 191 elements and partially met the requirements for two elements. **NHHF** achieved an overall score of 99.5 percent. Of the six standard areas reviewed, **NHHF** achieved 100 percent compliance on five standards demonstrating adherence to all requirements:

- Care Management/Care Coordination
- Member Enrollment and Disenrollment
- UM
- Quality Management
- TPL

NHHF received a score of 98 percent on the Member Services standard representing an area of relative strength.

The six standards included requirements that affect the ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

This year's review included a file review of a random sample of 10 denial files. All 10 files presented by **NHHF** contained evidence of timely decisions, and written member and provider notifications. All of the member and provider notifications included the reasons for the denial and documented that a qualified clinician made the denial decision.

To improve the Member Services standard, **NHHF** must include all required information in the new member Welcome Packet.

WS

HSAG conducted the compliance review for WS on May 5 and 6, 2021. Table 3-4 details the scores achieved by WS for the six standards included in the SFY 2021 review.

Table 3-4—Compliance Review Scores for WS

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
III	Care Management/Care Coordination	34	34	28	4	2	88.2%
VI	Member Enrollment and Disenrollment	18	17	16	0	1	94.1%
VII	Member Services	50	50	50	0	0	100%
XII	UM	64	64	64	0	0	100%
XIII	Quality Management	20	20	20	0	0	100%
XVI	TPL	8	8	8	0	0	100%
Overall Results		**194**	**193**	**186**	**4**	**3**	**97.4%**

* ***Partially Met*** and ***Not Met*** elements were addressed in the CAP completed by WS.
** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing non-applicable elements.

The WS compliance tool included six standards representing 193 applicable elements. WS met the requirements for 186 elements, partially met the requirements for four elements, and did not meet the requirements for three elements. WS achieved an overall score of 97.4 percent. Of the six standard areas reviewed, WS achieved 100 percent compliance on four standards demonstrating adherence to all requirements:

- Member Services
- UM
- Quality Management
- TPL

WS received a score of 94.1 percent on the Member Enrollment and Disenrollment standard representing an area of relative strength. WS received a score of 88.2 percent on the Care Management/Care Coordination standard representing an area having multiple opportunities for improvement.

The six standards included requirements that affect the ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

To improve the standards that scored below 100 percent, **WS** must:

- Ensure that care managers sign a conflict-free statement.
- Inform providers of information received about their members on the admission, discharge, transfer (ADT) data files.
- Conduct health risk assessment (HRA) screenings as required by DHHS.
- Submit changes to its risk stratification methodologies to DHHS prior to implementing changes.
- Share results of the comprehensive assessment in writing with the member's local community-based care team.
- Send member status change notifications to DHHS within the required time frame.

This year's review included a file review of a random sample of 10 denial files. All 10 files presented by **WS** contained evidence of timely decisions, and written member and provider notifications. All of the member and provider notifications included the reasons for the denial and documented that a qualified clinician made the denial decision.

For additional information concerning HSAG's methodology for conducting compliance reviews, see Appendix B Methodologies for Conducting EQR Activities, page B-2.

PIPs

In SFY 2020, DHHS decided to implement HSAG's multi-year rapid-cycle PIP approach with its contracted MCOs. 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.

During SFY 2021, the MCOs continued the first two of four required rapid-cycle PIPs, and they will initiate two new PIPs following the completion of the current PIPs. 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 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.*

All three MCOs are using administrative data to determine the rates achieved for each PIP. For both PIP topics, all three MCOs used claims data and applied specific queries to the applicable HEDIS measure to identify the eligible and targeted population for the rolling 12-month measurement period. Using the Specific, Measurable, Attainable, Relevant, and Time-Bound (SMART) Aim denominator, the MCOs ran a query to identify the numerator positive members and displayed the results on a SMART Aim run chart. HSAG used these data and other tools identified throughout this section to validate the MCOs' PIPs.

Based on the modules completed this fiscal year by each MCO, modules 1–3, HSAG established an overall level of confidence for this year's PIP activities as defined below:

- High confidence in reported PIP results: 100 percent of all module evaluation elements were *Achieved* across all steps validated.
- Moderate confidence in reported PIP results: 80 to 99 percent of all module evaluation elements were *Achieved* across all steps validated.
- Low confidence in reported PIP results: 60 to 79 percent of all module evaluation elements were *Achieved* across all steps validated.
- No confidence: Reported PIP results are not credible: Less than 60 percent of all module evaluation elements were *Achieved* across all steps validated.

The MCOs must meet an overall level of high confidence for the validated module prior to moving to the next module.

The confidence levels for **ACNH**'s PIP activities in SFY 2021 are displayed in Table 3-5.

Table 3-5—ACNH's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit additional Module 3 submission forms when a new intervention is initiated.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and	High

PIP Topic	Module	Status	Confidence Level
		submit additional Module 3 submission forms when a new intervention is initiated.	
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.

The confidence levels for **NHHF**'s PIP activities in SFY 2021 are displayed in Table 3-6.

Table 3-6—NHHF's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit additional Module 3 submission forms when a new intervention is initiated.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit additional Module 3 submission forms when a new intervention is initiated.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.

The confidence levels for **WS**'s PIP activities in SFY 2021 are displayed in Table 3-7.

Table 3-7—WS's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit additional Module 3 submission forms when a new intervention is initiated.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.
Continued Engagement of Opioid Abuse or Dependence Treatment	1. PIP Initiation	Completed and achieved all validation criteria.	High
	2. Intervention Determination	Completed and achieved all validation criteria.	High
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit additional Module 3 submission forms when a new intervention is initiated.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.

For additional information concerning HSAG's methodology for validating PIPs, see Appendix B Methodologies for Conducting EQR Activities, page B-14.

ACNH

Table 3-8 through Table 3-12 present a summary of the SFY 2021 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 2021, the New Hampshire MCOs progressed through Module 3—Intervention Testing. The MCOs will continue testing interventions and completing new Module 3s for each new intervention through the specific, measurable, attainable, relevant, and time-bound (SMART) Aim end date of June 30, 2022. The final outcomes and PIP validation status for each PIP will be reported in the SFY 2022 EQR Technical Report.

Table 3-8 presents the PIP title and the 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.

Table 3-8—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 67.4% to goal of 88.0%.
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 26.5% to 42.6%.

* In April 2021, DHHS determined that due to COVID-19, the SMART Aim end date for the current PIPs will be extended until June 30, 2022.

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, **ACNH** chose to focus improvement efforts on 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 on eligible adult members who initiated SUD treatment during an acute inpatient stay.

In SFY 2019–2020, **ACNH** completed a process map and failure modes and effects analysis (FMEA) to determine and prioritize the opportunities for improvement within the current processes. Using these quality improvement (QI) tools helped the MCO determine interventions to test that had the potential for impacting the SMART Aim goal and desired outcomes for the improvement project.

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP, the intervention submitted in Module 3 for validation involved testing telephonic outreach conducted by designated **ACNH** staff to the prescribing providers to schedule or complete the metabolic screening test (blood glucose or HbA1c). The goal of this intervention is to increase the number of providers ordering the required metabolic screening following the outreach.

For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, the intervention submitted in Module 3 for validation involved testing the facilitation of timely communication between the **ACNH** transition of care (TOC) coordinator and the hospital discharge planner. The goal of this intervention is to increase the number of targeted inpatient members who had the follow-up visit scheduled prior to being discharged.

Table 3-9 lists the interventions discussed above that **ACNH** tested during SFY 2021.

Table 3-9—ACNH Interventions by PIP Topic

PIP Title	Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Telephonic outreach to prescribing providers
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	• Facilitation of timely communication between the ACNH transition care coordinator and the hospital discharge planner

The interventions addressed processes to improve ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

ACNH passed the Module 3s submitted for each of these interventions and achieved all validation criteria for both PIP topics. **ACNH** will conclude its intervention testing on or before June 30, 2022.

NHHF

In SFY 2021, **NHHF** completed Module 3 of the rapid-cycle PIP process. Table 3-10 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 3-10—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 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%.

* In April 2021, DHHS determined that due to COVID-19, the SMART Aim end date for the current PIPs will be extended until June 30, 2022.

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 percent to 90.0 percent. 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.

In SFY 2020, **NHHF** completed a process map and FMEA to determine and prioritize the opportunities for improvement within the current processes. Using these QI tools helped the MCO determine interventions to test that had the potential for impacting the SMART Aim goal and desired outcomes for each improvement project.

The first intervention tested for the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP involved testing reminder calls to prescribing providers for targeted members. A monthly report is generated using pharmacy claims to identify the most recent prescribers of antipsychotic medications to members who have not been screened for diabetes within a 12-month period. The goal of this intervention is to increase the number of prescribers who order the required lab test following the reminder call. The second intervention tested for this PIP involved testing telephonic outreach to noncompliant members to remind them about the lab work required to monitor their medication. The goal of this intervention is to increase member compliance for completing the ordered diabetic screening lab test.

For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, the first intervention submitted was testing the use of a notification of AOD diagnosis and/or referral (NDR) form. The goal of this intervention is to have an increase in the number of providers completing and submitting the NDR form within 48 hours of diagnosis. The second intervention involved testing MCO faxed outreach to PCPs after the member's acute care ADT for AOD dependence diagnosis to support treatment engagement. The goal of this intervention was to increase the number of targeted members engaged in treatment following an acute care event that included AOD diagnoses.

Table 3-11 lists the interventions discussed above that **NHHF** tested during SFY 2021.

Table 3-11—NHHF Interventions by PIP Topic

PIP Title	Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Telephonic reminder calls to prescribing providers for targeted members • Telephonic outreach to noncompliant members
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	• Use of a notification of AOD diagnosis and/or referral form • Fax outreach to PCPs after the member's acute care ADT for AOD dependence diagnosis to support treatment engagement

The interventions addressed processes to improve ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

NHHF passed the Module 3s submitted for each tested intervention and achieved all validation criteria for both PIP topics. **NHHF** will conclude its intervention testing on or before June 30, 2022.

WS

In SFY 2021, **WS** completed Module 3 of the rapid-cycle PIP process. Table 3-12 presents the PIP title and SMART Aim statement defined by **WS** for each PIP. The SMART Aim statement defines the focus for improvement efforts and sets a quantitative goal for improvement.

Table 3-12—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%.

* In April 2021, DHHS determined that due to COVID-19, the SMART Aim end date for the current PIPs will be extended until June 30, 2022.

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.

In SFY 2019–2020, **WS** completed a process map and FMEA to determine and prioritize the opportunities for improvement within the current processes. Using these QI tools helped the MCO determine interventions to test that had the potential for impacting the SMART Aim goal and desired outcomes for each improvement project.

The intervention tested for the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* PIP involved testing the mailing of a cobranded educational letter (e.g., cobranded with the member's PHO) to members that prompts them to contact the provider for an appointment, attend the appointment, and complete the needed HbA1c screening within 30 days of receiving the letter. The goal of this intervention is to decrease the number of noncompliant members on the provider's/MCO's monthly care gap report following the mailing of the

letter. However, WS indicated that the cobranded letter intervention could not be launched for testing due to a recent drop in the number of administrative-level staff at both systems to cobrand letters/materials. The MCO developed a new intervention that involved member outreach calls to inform and prompt those members who have not had a diabetic screening to contact their provider for an appointment for a glucose or HbA1c lab test.

For the *Continued Engagement of Opioid Abuse or Dependence Treatment* PIP, the first intervention submitted was a provider education intervention wherein the MCO would email targeted providers an educational resource guide. The goal of this intervention was to increase the number of providers who had knowledge of SUD treatment options and resources and were able to connect members to an appropriate treatment after receiving the resource guide through email. The second intervention submitted was a provider-focused intervention wherein the MCO sent an email to targeted providers educating them on available telehealth services. The goal of this intervention was to increase the number of providers who are aware of and use the available telehealth capabilities, including those specific to SUD.

Table 3-13 lists the interventions discussed above that WS tested during SFY 2021.

Table 3-13—WS Interventions by PIP Topic

PIP Title	Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Telephonic reminder calls to inform or prompt members who have not had a diabetic screening to contact their provider for an appointment for a HbA1c test • Telephonic outreach to noncompliant members
Continued Engagement of Opioid Abuse or Dependence Treatment	• Email campaign to targeted providers containing an educational resource guide • Email campaign to targeted providers educating them on available telehealth services

The interventions addressed processes to improve ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries.

WS passed the Module 3s submitted for each tested intervention and achieved all validation criteria for both PIP topics. WS will conclude its intervention testing on or before June 30, 2022.

PMV

The following section of the report describes the results of HSAG's SFY 2021 EQR activities specific to validation of performance measures. This section provides conclusions as to the strengths and areas of opportunity related to the ***timeliness of care***, ***access to care***, and ***quality of care*** provided by the New Hampshire Medicaid MCOs. During SFY 2021, each MCO submitted rates for 14 state-specific measures that were validated during PMV. HSAG offered recommendations to each MCO to facilitate continued QI in the Medicaid program.

Based on the acceptable level achieved by the MCO per measure, HSAG established an overall level of confidence for this year's performance validation review based on each MCO following state-specific measure guidelines as defined below:

0 measures determined to be not acceptable: High confidence in the MCO's ability to comply with New Hampshire's technical specifications for this year's measures.

1–2 measures determined to be not acceptable: Moderate confidence in the MCO's ability to comply with New Hampshire's technical specifications for this year's measures.

3–4 measures determined to be not acceptable: Low confidence in the MCO's ability to comply with New Hampshire's technical specifications for this year's measures.

5 or more measures determined to be not acceptable: No confidence in the MCO's ability to comply with New Hampshire's technical specifications for this year's measures.

Table 3-14 displays the findings from the PMV activities conducted for each MCO in SFY 2021. HSAG found **WS** non-compliant with one measure (e.g., ACCESSREQ.05) included in three audit elements. HSAG determines the level of confidence based on the number of non-compliant measures, not the number of audit elements used to evaluate the measures.

Table 3-14—SFY 2021 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
Appropriate provider data systems and processing	Acceptable	Acceptable	13 of 14 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	13 of 14 Acceptable*
Required measures received a "Reportable" designation	Acceptable	Acceptable	13 of 14 Acceptable*
Level of Confidence	**High Confidence**	**High Confidence**	**Moderate Confidence**

ACNH

ACNH used a variety of methods for producing the measures under review and had staff members 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 virtual review. HSAG had no concerns with the measure production for any measure under review this year.

HSAG recommends that **ACNH** conduct internal audits of the INPASC.04 measure to ensure ongoing compliance with the measure specifications.

HSAG also recommends that **ACNH** deploy a robust testing plan for future new measures or revisions to existing measures, which should include primary source verification (PSV) of measure-level detailed data in alignment with the source systems. **ACNH** should conduct additional reviews of its performance measure detailed data in comparison to the DHHS performance measure specifications to ensure all source code has resulted in appropriate identification of claims, members, and other relevant performance measure information.

NHHF

NHHF used a variety of methods for producing the measures under review and had staff members 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 PSV 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. No adjustments or data reconsiderations required 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 measures under review and had staff members dedicated to quality reporting. **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 PSV without issue for 13 of 14 measures under review.

WS completed all measures without issue during the reporting period except ACCESSREQ.05.

HSAG recommends that **WS** enhance its internal quality assurance processes to conduct ongoing PSV of the detailed data reported in support of the DHHS performance measures, in comparison to its applicable source systems. This PSV should include performing user acceptance testing (UAT) on all

newly implemented reporting to ensure 100 percent compliance with the DHHS performance measure specifications. **WS** should conduct additional reviews of its performance measure detailed data in comparison to the DHHS performance measure specifications to ensure all source code appropriately identifies claims, members, and other relevant performance measure information. **WS** should consider conducting this review at least prior to each submission of performance measure data to DHHS to ensure the data are accurate.

WS should also complete a full root cause analysis to determine the necessary corrections required to ensure both ACCESSREQ.05 and TIMELYCRED.01 are able to be reported in future reporting periods. While TIMELYCRED.01 was *Reportable* due to manual data corrections made by **WS** which resulted in updated, reportable rates, the source code was not producing accurate data. Although manual reporting is acceptable, it can result in a higher risk of error due to data entry mistakes made by the individuals documenting the data. The ACCESSREQ.05 performance measure will require **WS** to complete corrective action to further revise its source code to ensure the code includes only member requests for assistance in accessing PCPs.

For additional information concerning the measures reviewed and HSAG's methodology for validating performance measures, see Appendix B Methodologies for Conducting EQR Activities, page B-18.

NAV

The NAV task for SFY 2021 included a review of the MCOs' online provider directory. The provider directory validation (PDV) activity included three main tasks: collecting MCOs' Provider Data Structure Questionnaire responses; conducting a directory review of sampled PCP, BH, and DME providers from each MCO; and conducting an assessment of the overall adherence to federal and State regulations of each MCO's online directory.

Within its questionnaire responses, each MCO reported delegating selected services. For example, all MCOs reported delegating vision services while **WS** also reported delegating pharmacy, BH services, and DME supplies. Additionally, **NHHF** reported delegating selected pharmacy services. Information obtained from the MCOs' questionnaire responses was self-reported, and HSAG did not validate the responses for accuracy.

Each MCO reported in the questionnaire that it may not update its provider data unless a provider requests a change or changes are identified as a result of routine credentialing processes, suggesting that MCOs may not be proactively evaluating their provider data for accuracy and making necessary updates. HSAG's directory case review findings supported this conclusion, as HSAG's reviewers identified notable discrepancies when comparing the MCOs' provider data to their online provider directories among the 861 randomly selected provider locations (i.e., "cases" among the three MCOs). Table 3-15 summarizes directory review findings among the sampled cases, by MCO.

Table 3-15—Summary of Sampled Cases Found in Online Directories, by MCO and Provider Category

MCO and Provider Category	Number of Sampled Provider Locations (Cases)*	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count of Cases	% of Cases	Count of Cases	% of Cases	Count of Cases	% of Cases
All MCOs	**861**	**691**	**80.3**	**126**	**14.6**	**44**	**5.1**
ACNH	277	267	96.4	6	2.2	4	1.4
NHHF	286	237	82.9	38	13.3	11	3.8
WS	298	187	62.8	82	27.5	29	9.7

Table 3-16 displays, by MCO and indicator, the percentage of sampled provider locations (cases) identified in the online directories with exact matches between the MCOs' provider data files and the online provider directory information. Cases with unmatched results may include spelling discrepancies, incomplete information, or information not listed in the directory (e.g., the MCO's provider data included a data value for an indicator, but the online provider directory did not include a data value for the indicator).

Table 3-16—Percentage of Cases With Exact Matches, by MCO and Indicator

Indicator	ACNH		NHHF		WS		All MCOs	
	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*
Provider's Name	267	100.0	237	92.0	187	88.2	**691**	**94.1**
Provider Street Address	267	100.0	237	100.0	187	96.3	**691**	**99.0**
Provider Address: Suite Number	267	100.0	237	99.6	187	95.2	**691**	**98.6**
Provider City	267	100.0	237	100.0	187	99.5	**691**	**99.9**
Provider State	267	100.0	237	100.0	187	100.0	**691**	**100.0**
Provider Zip Code	267	100.0	237	100.0	187	98.9	**691**	**99.7**
Provider Telephone Number	267	99.3	237	81.9	187	96.8	**691**	**92.6**
Provider Type/Specialty	267	97.8	237	89.5	187	65.8	**691**	**86.3**
Provider Gender	263	99.6	228	96.1	183	97.3	**674**	**97.8**

Indicator	ACNH		NHHF		WS		All MCOs	
	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*	Count of Cases Matching Between Data Sources	% of Cases Matching Between Data Sources*
Provider Accepting New Patients	267	95.9	237	90.3	187	94.1	**691**	**93.5**
Provider Accommodates Physical Disabilities	267	89.1	237	26.2	187	88.2	**691**	**67.3**
Provider Completed Cultural Competency Training	267	98.9	237	70.0	187	20.9	**691**	**67.9**
Non-English Language Speaking Provider (including American Sign Language)	267	8.6	237	73.8	187	62.0	**691**	**45.4**
Provider Primary Language	267	100.0	237	97.0	187	62.0	**691**	**88.7**

* The denominator for each indicator includes the number of cases in which the provider location was found in the directory and relevant to the provider; the numerator is shown above as the count of cases matching between the MCO's provider data file and the MCO's online directory information (i.e., the Count of Cases Matching Between Data Sources).

HSAG evaluated selected indicators as present or absent for each case, and Table 3-17 displays, by MCO, the percentage of sampled providers found in the online directories with information present for each indicator.

Table 3-17—Percentage of Cases With Information Present, by MCO and Indicator

Indicator	ACNH		NHHF		WS		All MCOs	
	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*
Provider Board Certification, if applicable for PCPs and BH Providers	263	33.1	228	93.9	183	71.0	**674**	**63.9**

Indicator	ACNH		NHHF		WS		All MCOs	
	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*	Count of Cases With Directory Data Present	% of Cases With Directory Data Present*
Provider Office Hours	267	99.6	237	97.0	187	88.8	**691**	**95.8**
Provider URL	267	0.0	237	0.0	187	3.2	**691**	**0.9**

* The denominator for each indicator includes the number of cases in which the provider location was found in the directory and relevant to the provider category; the numerator is shown above as the count of cases in which the MCO's online directory contained information for the indicator (i.e., the Count of Cases With Directory Data Present).

As part of the PDV, HSAG compared the key indicators published in each online provider directory with the data in the MCO's provider file, and HSAG confirmed whether each MCO's website contained the fields stipulated in §42 CFR 438.10(h) and the MCM Program Services Contract, Amendment #5 §4.4.1.5.[3-8] All MCOs met the federal requirements and MCM contract requirements except **WS**'s DME supplier directory.[3-9] HSAG located all MCOs' provider directories via a Web portal except **WS**'s DME suppliers, which linked to a portable document format (PDF) document with a static table containing a limited number of indicators. None of the MCOs displayed both a toll-free number and email address that an individual could use to report an inaccuracy in the provider directory information to the MCO. While not required under the MCM contract, such information is a best practice to allow directory users to assist the MCOs in identifying potential provider data concerns.

Due to the nature of the PDV methodology, the full PDV Report includes limitations to consider when generalizing results across providers contracted with each New Hampshire Medicaid MCO. Based on the findings detailed in the report and the accompanying case-level directory review data files submitted to DHHS, HSAG offered recommendations to evaluate and address potential MCO provider data quality and/or access to care concerns.

Each MCO submitted provider data files to HSAG during January 2021, and HSAG's reviewers compared data values for each sampled case between the MCOs' provider data files and the MCOs' online provider directories during February and March 2021. Because MCOs continually receive updates from their providers that may affect current updates to the online provider directory, HSAG used, and DHHS approved, a standard of 90 percent compliance for items evaluated in this study.

[3-8] State of New Hampshire Department of Health and Human Services. (2020). *Medicaid Care Management Services Contract, Amendment #5.* Available at: https://sos.nh.gov/media/p4yppqma/009-gc-agenda-012221.pdf. Accessed on: Nov 17, 2021.

[3-9] MCM Contract Requirements represent additional data fields beyond those outlined in federal regulations. HSAG assessed data fields required by the MCM contract as informational findings only.

HSAG recommends that the MCOs conduct PDV studies to ensure that the directories contain complete and accurate information. DHHS could develop a methodology that MCOs could use to ensure consistency in collecting the information. By requiring the MCOs to use the same methodology, the rates could be compared across plans and QI efforts tracked to assist in the MCOs' ongoing QI efforts.

ACNH

ACNH fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory.

HSAG's reviewers evaluated 277 randomly sampled directory review cases by comparing provider data submitted to HSAG by **ACNH** against **ACNH**'s online provider directory. Table 3-18 summarizes the count and percentage of **ACNH**'s cases found in the directory, by provider category; indicator-level results for **ACNH** are presented in Table 3-16 and Table 3-17 above.

Table 3-18—Summary of Providers Present in Directory, by Provider Category—ACNH

Provider Category	Number of Sampled Provider Locations (Cases)	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count of Cases	% of Cases	Count of Cases	% of Cases	Count of Cases	% of Cases
PCPs	157	152	96.8	4	2.5	1	0.6
BH Providers	115	111	96.5	2	1.7	2	1.7
DME Suppliers	5	4	80.0	0	0.0	1	20.0
Total	**277**	**267**	**96.4**	**6**	**2.2**	**4**	**1.4**

A key factor contributing to the extremely low match rates for the *Non-English Language Speaking Provider* indicator displayed in Table 3-10 was that the data supplied by **ACNH** listed this information as "missing per MCO" when this information was displayed in the directory for providers reported to speak a non-English language.

ACNH's "Not Present" result for 100.0 percent of cases for the *Provider URL* indicator displayed in Table 3-11 was attributed to the directory showing "http://No Response" in every surveyed provider profile. Overall, **ACNH**'s provider directory appeared to contain static information across all provider profiles surveyed. Those fields included the following findings:

- The office hours listed for providers showed 8:00 AM to 5:00 PM.
- The website URL showed "http://No Response" for all providers.
- The Cultural Competency field listed "No Response."

HSAG identified the following recommendations to improve the data included in **ACNH**'s provider directories to positively affect the ***timeliness of care*** and ***access to care*** for New Hampshire Medicaid beneficiaries:

- MCOs should use a variety of strategies to improve the accuracy of their provider data, including outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports.
- MCOs should routinely validate vendor data and update information included in the corresponding online provider directory.
- MCOs should evaluate the end user experience for their online provider directories among members using the MCO's online provider directory from a desktop computer, laptop computer, tablet, and from a variety of available mobile devices.

NHHF

NHHF fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory.

HSAG's reviewers evaluated 286 randomly sampled directory review cases by comparing provider data submitted to HSAG by **NHHF** against **NHHF**'s online provider directory. Table 3-19 summarizes the count and percentage of **NHHF**'s cases found in the directory by provider category; indicator-level results for **NHHF** are presented in Table 3-16 and Table 3-17 above.

Table 3-19—Summary of Providers Present in Directory, by Provider Category—NHHF

Provider Category	Number of Sampled Provider Locations (Cases)	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count of Cases	% of Cases	Count of Cases	% of Cases	Count of Cases	% of Cases
PCPs	147	119	81.0	23	15.6	5	3.4
BH Providers	129	109	84.5	14	10.9	6	4.7
DME Suppliers	10	9	90.0	1	10.0	0	0.0
Total	**286**	**237**	**82.9**	**38**	**13.3**	**11**	**3.8**

NHHF changed its online directory structure during the SFY 2021 PDV directory reviews, leading to a more cumbersome review process that required clicking on additional weblinks to obtain provider information on office hours, more contact information, therapy modalities such as play therapy or family therapy, board certification details, accessibility information, and disorders treated. Additionally, these structural updates resulted in adding a red "x" mark or a green "check" mark next to the *Accepting New Patients*, *In Network*, *Primary Care Provider*, and *Office Hours* indicator fields for the member to

identify whether the provider is accepting new patients, not accepting new patients, etc. This type of graphic may be confusing for users, as it relies on color-coded icons without accompanying text definitions.

However, the structural updates also added functionality that allows provider searches by BH services offered (e.g., treatment of specific BH conditions). While HSAG scored applicable cases as exact matches, the specialties listed in **NHHF**'s provider data were not shown in the disorder list (i.e., bipolar, schizophrenia, depression, anxiety, etc.) within the provider's profile.

HSAG's reviewers found a high percentage of matching data between **NHHF**'s provider data file and the sampled cases found in the online directory records for the *Provider Primary Language* indicator as displayed in Table 3-10. However, these cases were determined to have matching information because the **NHHF** directory showed "*None*" for an additional provider language; however, **NHHF**'s provider data file indicated that these records were missing data concerning additional provider languages. Additionally, when the **NHHF** provider data contained a "No" value for the additional provider language field, these sampled cases also appeared in the directory, with "None" listed for an additional provider language. This could confuse members, as selected provider profiles listed a data value of "English" as the additional practitioner language, but other provider profiles showed a value of "None." This approach to the data values assumes that all providers speak English if "None" is listed in the additional provider language field. An explanation for this information may be needed to confirm the extent to which all providers speak English to ensure that members are able to accurately identify providers who speak a language that facilitates culturally competent healthcare.

HSAG identified the following recommendations to improve the data included in **NHHF**'s provider directories to positively affect the ***timeliness of care*** and ***access to care*** for New Hampshire Medicaid beneficiaries:

- MCOs should use a variety of strategies to improve the accuracy of their provider data, including outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports.
- MCOs should routinely validate vendor data and update information included in the corresponding online provider directory.
- MCOs should evaluate the end user experience for their online provider directories among members using the MCO's online provider directory from a desktop computer, laptop computer, tablet, and from a variety of available mobile devices.

WS

WS fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory, except the DME supplier directory.

As part of the PDV, HSAG compared the key indicators published in each online provider directory with the data in the MCO's provider file, and HSAG confirmed whether each MCO's website met the federal requirements as stipulated in §42 CFR 438.10(h) and the MCM Program Services Contract,

Amendment #5 §4.4.1.5.[3-10] Additionally, HSAG reviewed each MCO's provider directory website to ensure compliance with federal requirements and MCM contract requirements. All MCOs met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory except **WS**'s DME supplier directory.

As a directory for its DME suppliers, **WS** offered an Internet hyperlink to a PDF document that contained a static table listing DME suppliers and a limited number of additional indicators. HSAG's reviewers evaluated 298 randomly sampled directory review cases by comparing provider data submitted to HSAG by **WS** against **WS**'s online provider directory. Table 3-20 summarizes the count and percentage of **WS**'s cases found in the directory, by provider category; indicator-level results for **WS** are presented in Table 3-16 and Table 3-17 above.

Table 3-20—Summary of Providers Present in Directory, by Provider Category—WS

Provider Category	Number of Sampled Provider Locations (Cases)	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count of Cases	% of Cases	Count of Cases	% of Cases	Count of Cases	% of Cases
PCPs	122	113	92.6	9	7.4	0	0.0
BH Providers	170	70	41.2	73	42.9	27	15.9
DME Suppliers	6	4	66.7	0	0.0	2	33.3
Total	**298**	**187**	**62.8**	**82**	**27.5**	**29**	**9.7**

Overall, **WS** had low match rates for the *Provider Completed Cultural Competency Training* indicator as displayed in Table 3-10 among PCP and BH providers. This is because during the directory reviews, the provider profile showed an "N/A" in the provider directory; however, the data value submitted by **WS** was "No," indicating that the provider had not completed cultural competency training. HSAG's reviewers identified the same scenario for the *Non-English Language Speaking Provider* indicator.

WS's BH provider directory was available on the website of **WS**'s delegated entity, Beacon Health Strategies, and this directory had findings not seen in **WS**'s directory for PCPs and physical health service providers, including the following specific findings:

- When searching for a BH provider, HSAG's reviewers were required to answer a security challenge used to distinguish between a computer bot and a human user. This can burden members who may have limited Internet service availability or difficulty understanding the security challenge.
- The **WS** BH provider directory demonstrated instances in which individual directory information could not be confirmed from the search page. For example, when searching for a provider name that

[3-10] State of New Hampshire Department of Health and Human Services. (2020). *Medicaid Care Management Services Contract, Amendment #5.* Available at: https://sos.nh.gov/media/p4yppqma/009-gc-agenda-012221.pdf. Accessed on: Nov 17, 2021.

is part of a clinic or hospital affiliation, the search results only showed the facility name in the results. The member would have to then click on each search result to locate the provider's individual profile.

- **WS** had a low match rate for the *Provider Type/Specialty* indicator among BH providers. The provider specialty in the data supplied by **WS** only showed one of the services offered for each provider. For example, the data showed "post-traumatic stress disorder" (PTSD) as the provider type/specialty, while the directory showed "Psychologist," with PTSD listed as one of the provider's types of services offered. However, the directory allowed the user to search by the types of service offered, a useful option for BH providers who may offer a range of psychological services (e.g., offering treatment for mood disorders or SUD).

HSAG identified the following recommendations to improve the data included in **WS**'s provider directories to positively affect the ***timeliness of care*** and ***access to care*** for New Hampshire Medicaid beneficiaries:

- MCOs should use a variety of strategies to improve the accuracy of their provider data, including outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports.
- MCOs should routinely validate vendor data and update information included in the corresponding online provider directory.
- MCOs should evaluate the end user experience for their online provider directories among members using the MCO's online provider directory from a desktop computer, laptop computer, tablet, and from a variety of available mobile devices.

For additional information concerning HSAG's methodology for validating network adequacy, see Appendix B Methodologies for Conducting EQR Activities, page B-20.

CAHPS

In October 2020, the Agency for Healthcare Research and Quality (AHRQ) released the 5.1 versions of the Adult and Child Health Plan Surveys. These surveys acknowledged for the first time that members could receive care in person, by phone, or by video. Based on the CAHPS 5.1 versions developed by AHRQ, NCQA introduced new HEDIS versions of the Health Plan Surveys, entitled the CAHPS 5.1H Health Plan Surveys.[3-11]

The CAHPS 5.1H Surveys identified a set of standardized items including four global ratings and four composite scores.[3-12] The global ratings reflected patients' overall experience with their personal doctor,

[3-11] National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2020.

[3-12] For this report, the 2021 Adult and Child Medicaid CAHPS results presented for **ACNH**, **NHHF**, and **WS** are limited to the four CAHPS global ratings and four CAHPS composite measures evaluated through the CAHPS 5.1H 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).

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, HSAG calculated the percentage of respondents who chose a positive experience rating on a scale of 0 to 10. The definition of a positive response for the global ratings included a value of 8, 9, or 10. For each of the four composite scores, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composites included responses of "Usually" or "Always."

HSAG compared each measure rate to the NCQA national average and identified a statistically significant difference by using the confidence interval for each measure rate. HSAG used arrows to denote statistically significant differences in Table 3-21 and Table 3-22. An upward **green** arrow (↑) denotes if the lower limit of the confidence interval was higher than the national average. A downward **red** arrow (↓) denotes if the upper limit of the confidence interval was lower than the national average. The table displays a **dash** (—) if the national average was within the confidence interval indicating that there was no significant difference in the rates.

Table 3-21 contains the results from the adult Medicaid CAHPS positive rates calculated for **ACNH**, **NHHF**, and **WS** and comparisons to the NCQA national averages.

Table 3-21—ACNH, NHHF, and WS Adult Medicaid CAHPS Results

CAHPS Measure	2021 Adult Medicaid Positive Rates	2020 National Average Comparison*	2021 Adult Medicaid Positive Rates	2020 National Average Comparison*	2021 Adult Medicaid Positive Rates	2020 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**73.8%**	—	**79.1%**	—	**82.0%**	—
Rating of All Health Care	**77.7%**	—	**76.0%**	—	**77.7%**	—
Rating of Personal Doctor	**80.9%**	—	**81.2%**	—	**82.8%**	—
Rating of Specialist Seen Most Often	**79.4%**	—	**86.9%**	—	**83.9%**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**86.5%**	—	**85.2%**	—	**88.0%**	↑
Getting Care Quickly	**86.3%**	—	**86.0%**	—	**83.8%**	—
How Well Doctors Communicate	**93.8%**	—	**95.6%**	↑	**93.2%**	—
Customer Service	**92.5%**	—	**88.7%+**	—	**90.8%**	—

* The 2020 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 3-22 contains the results from the general child CAHPS positive rates calculated for **ACNH**, **NHHF**, and **WS** and comparisons to NCQA national averages.

Table 3-22—ACNH, NHHF, and WS Child Medicaid CAHPS Results

CAHPS Measure	2021 Child Medicaid Positive Rates	2020 National Average Comparison*	2021 Child Medicaid Positive Rates	2020 National Average Comparison*	2021 Child Medicaid Positive Rates	2020 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**82.0%**	—	**88.2%**	—	**87.3%**	—
Rating of All Health Care	**89.3%**	—	**84.5%**	—	**90.1%**	—
Rating of Personal Doctor	**86.8%**	—	**87.3%**	—	**90.9%**	—
Rating of Specialist Seen Most Often	**86.8%+**	—	**82.1%+**	—	**86.4%+**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**89.2%+**	—	**90.5%**	↑	**85.2%**	—
Getting Care Quickly	**86.6%+**	—	**88.8%**	—	**92.5%**	—
How Well Doctors Communicate	**95.7%**	—	**96.3%**	—	**96.1%**	—
Customer Service	**84.0%+**	—	**90.7%+**	—	**88.6%+**	—

* The 2020 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.

ACNH

ACNH surveyed 2,025 adult Medicaid members in 2021, and members returned 208 completed surveys. After excluding ineligible members, the response rate was 13.9 percent. In 2021, the **ACNH** adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 16.3 percent. Figure 3-1 and Figure 3-2 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2020 national averages for the global ratings and composite measures, respectively, for **ACNH**'s adult Medicaid population.

Figure 3-1—ACNH Adult Medicaid CAHPS Results: Global Ratings

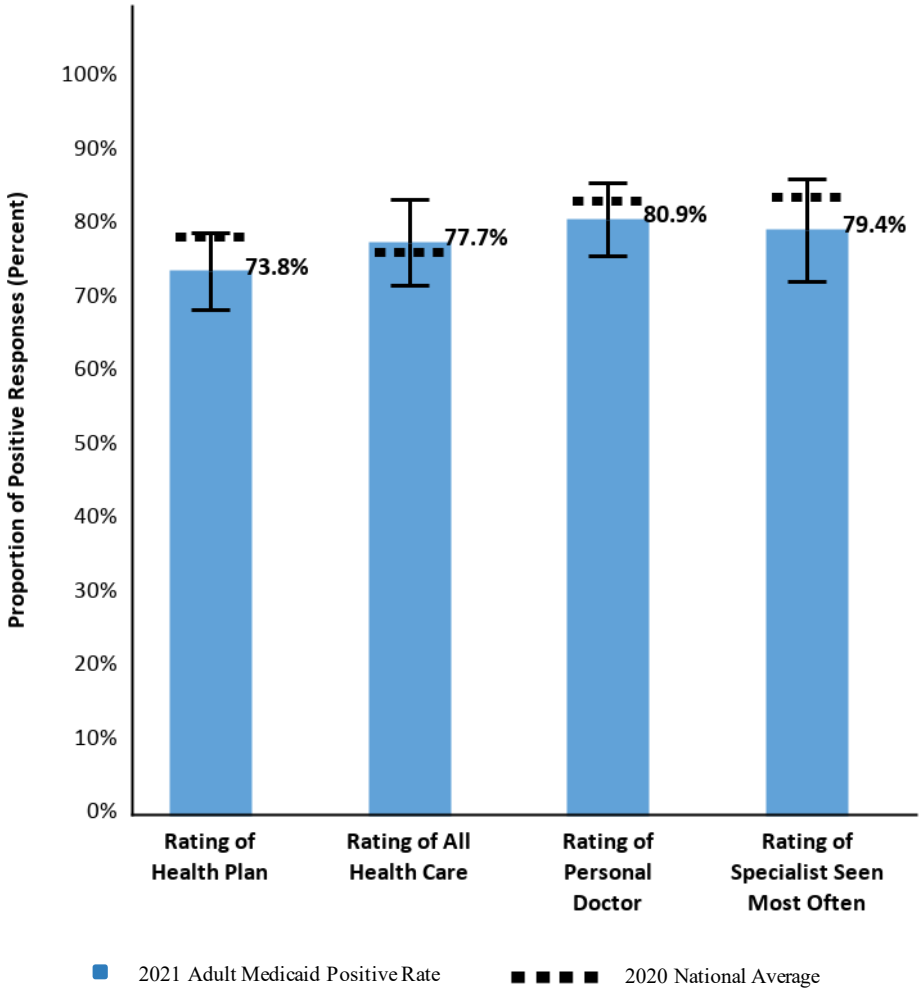
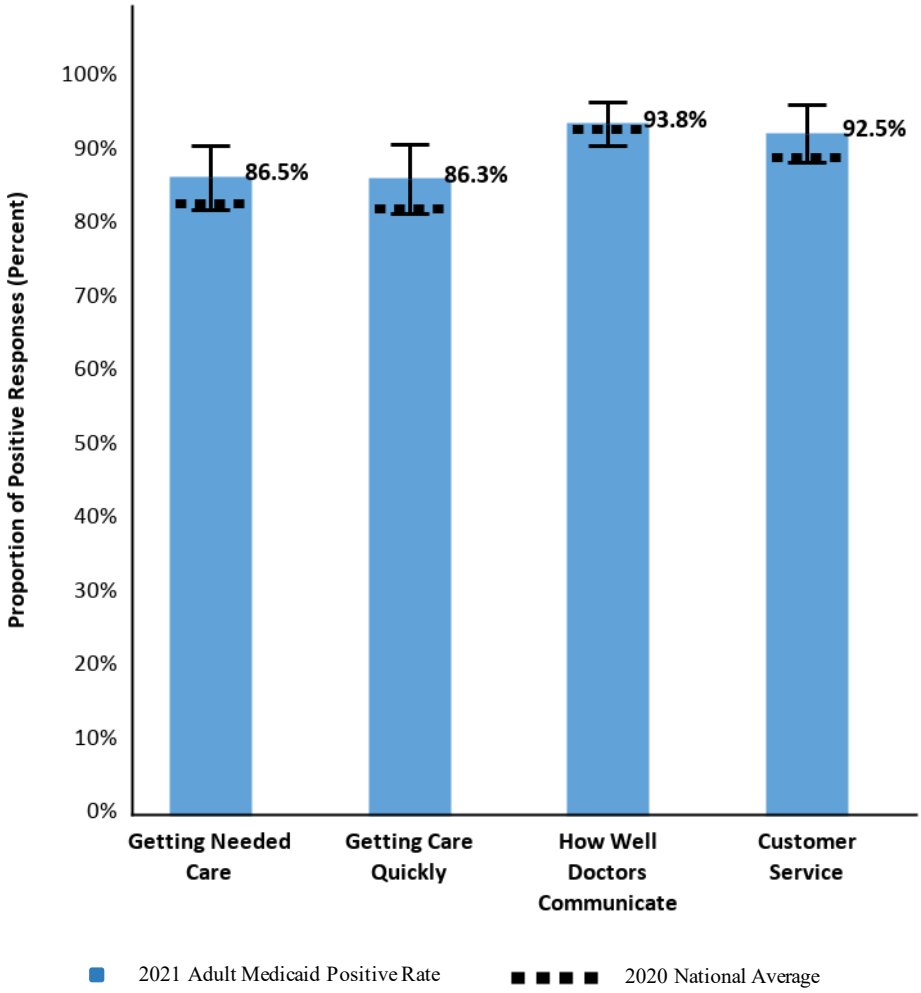


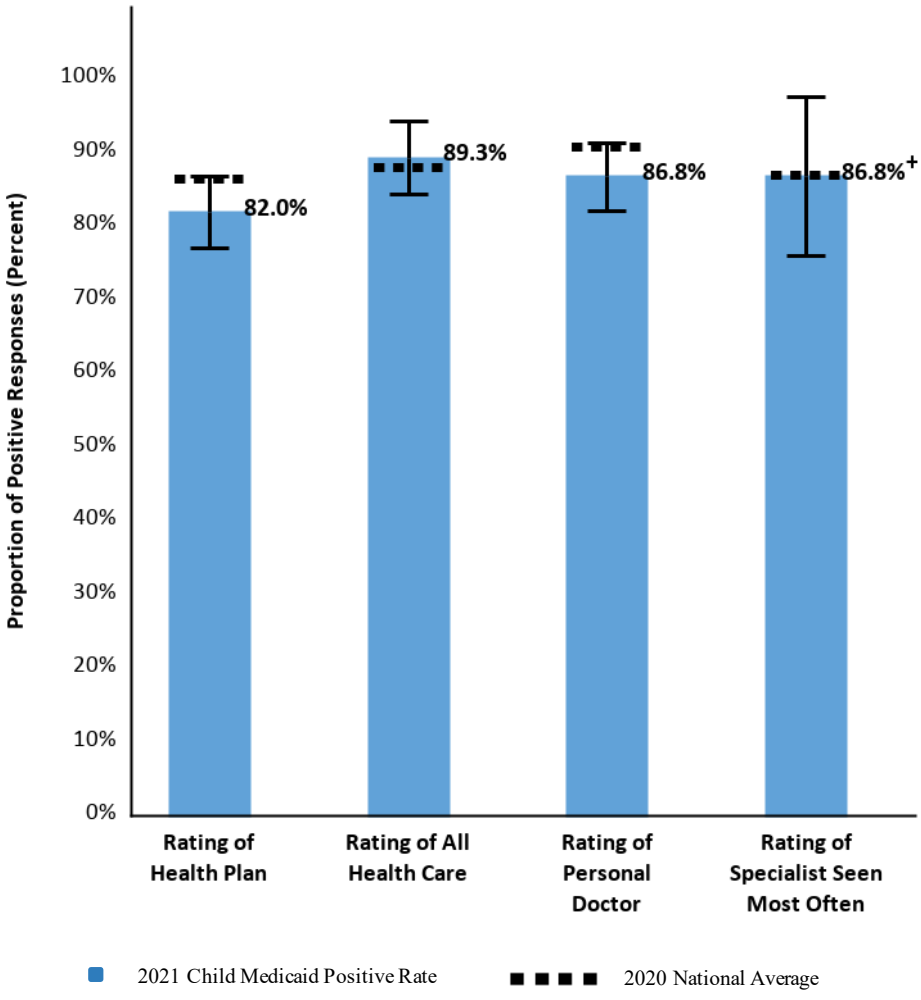
Figure 3-2—ACNH Adult Medicaid CAHPS Results: Composite Measures



For **ACNH**'s adult Medicaid population, five rates, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2020 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

ACNH surveyed 2,426 general child Medicaid members in 2021, and parents/caretakers of child members returned 247 completed surveys. After excluding ineligible members, the response rate was 10.3 percent. In 2021, the **ACNH** general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set, which was 13.1 percent.[3-13] Figure 3-3 and Figure 3-4 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2020 national averages for the global ratings and composite measures, respectively, for **ACNH**'s general child Medicaid population.[3-14]

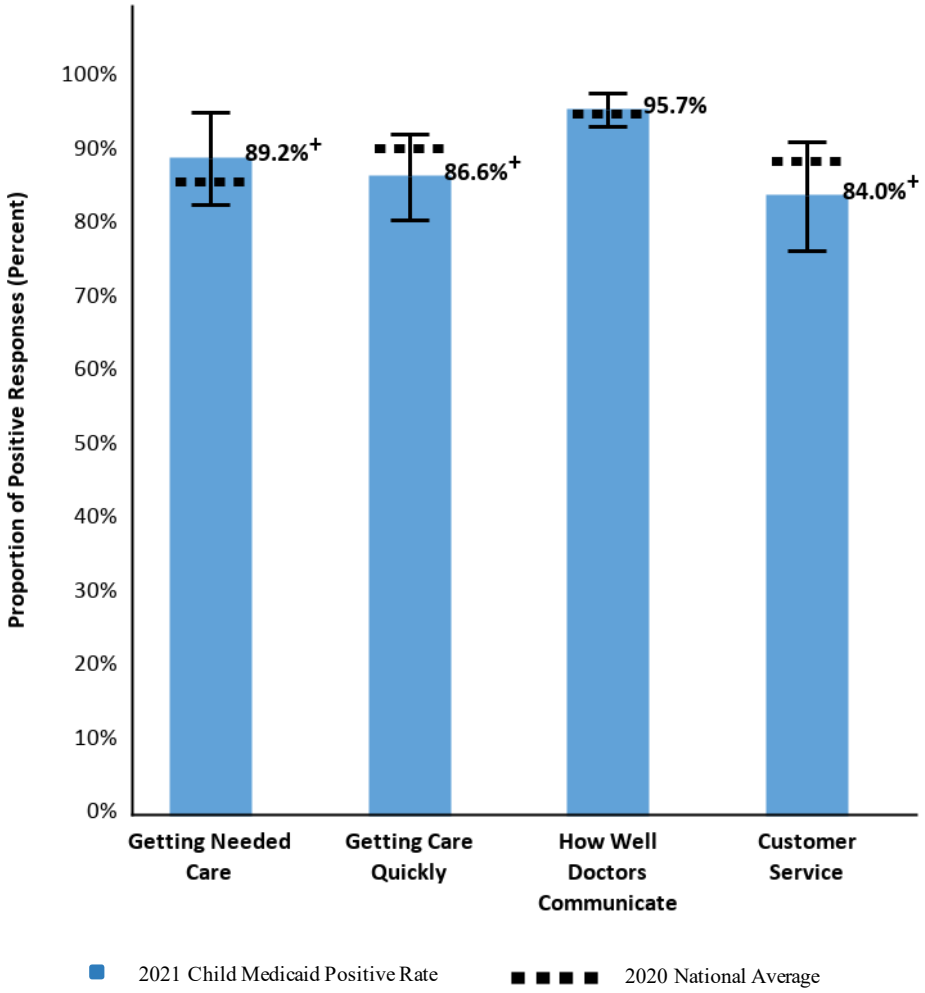
Figure 3-3—ACNH Child Medicaid CAHPS Results: Global Ratings



[3-13] 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).

[3-14] The 2021 child Medicaid CAHPS results presented in Figure 3-3 and Figure 3-4 for **ACNH** are based on results of the general child population only.

Figure 3-4—ACNH Child Medicaid CAHPS Results: Composite Measures



For **ACNH**'s general child Medicaid population, three rates, *Rating of All Health Care*, *Getting Needed Care*, and *How Well Doctors Communicate*, exceeded NCQA's 2020 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

Conclusions and Recommendations for Improvement

HSAG compared the adult and child Medicaid populations' 2021 CAHPS survey results to the 2020 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2021 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2020 NCQA Medicaid national averages, HSAG recommends that **ACNH** focus ***quality of care*** improvement efforts on the *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* measures for the adult population as these rates fell below the national averages. In addition, HSAG recommends that **ACNH** focus ***timeliness of care***, ***access to care***, and ***quality of care*** improvement efforts on the *Rating of Health Plan*,

Rating of Personal Doctor, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, and *Customer Service* measures for the child population as these rates also fell below the national averages.

The rates for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by frequently including information about the ratings from the CAHPS survey in provider communications during the year. **ACNH** 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. Improvement in these areas will positively impact ***quality of care***. **ACNH** could 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 *Getting Care Quickly* could be improved by evaluating the process of care delivery and identifying if there are any operational issues contributing to access to care barriers for members. **ACNH** could explore ways to channel members to useful and reliable sources of information on the Internet by expanding its website to include health information and relevant tools, as well as links to related information. Benefits of Internet access to health information and advice will include improved ***timeliness of care***, ***access to care***, ***quality of care***, and efficiency. Furthermore, **ACNH** could consider implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems, such as a 24-hour nurse hotline and web- or telemedicine-based diagnosis and treatment of minor conditions.

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. **ACNH** could further promote the use of existing after-hours customer service to improve customer service results. Calls to **ACNH**'s customer services department may include information about providers or benefits, and improving that rate will positively impact ***timeliness of care***, ***access to care***, and ***quality of care.*** The MCO's Member Advisory Board could be used to better understand what constitutes high-quality services from the perspective of its members. **ACNH** could appoint workgroups from call center staff members to refine existing service standards to clearly inform staff members what is expected of them during interactions with members.

NHHF

NHHF surveyed 2,376 adult Medicaid members in 2021, and members returned 342 completed surveys. After excluding ineligible members, the response rate was 14.5 percent. In 2021, the NHHF adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 16.3 percent. Figure 3-5 and Figure 3-6 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2020 national averages for the global ratings and composite measures, respectively, for NHHF's adult Medicaid population.

Figure 3-5—NHHF Adult Medicaid CAHPS Results: Global Ratings

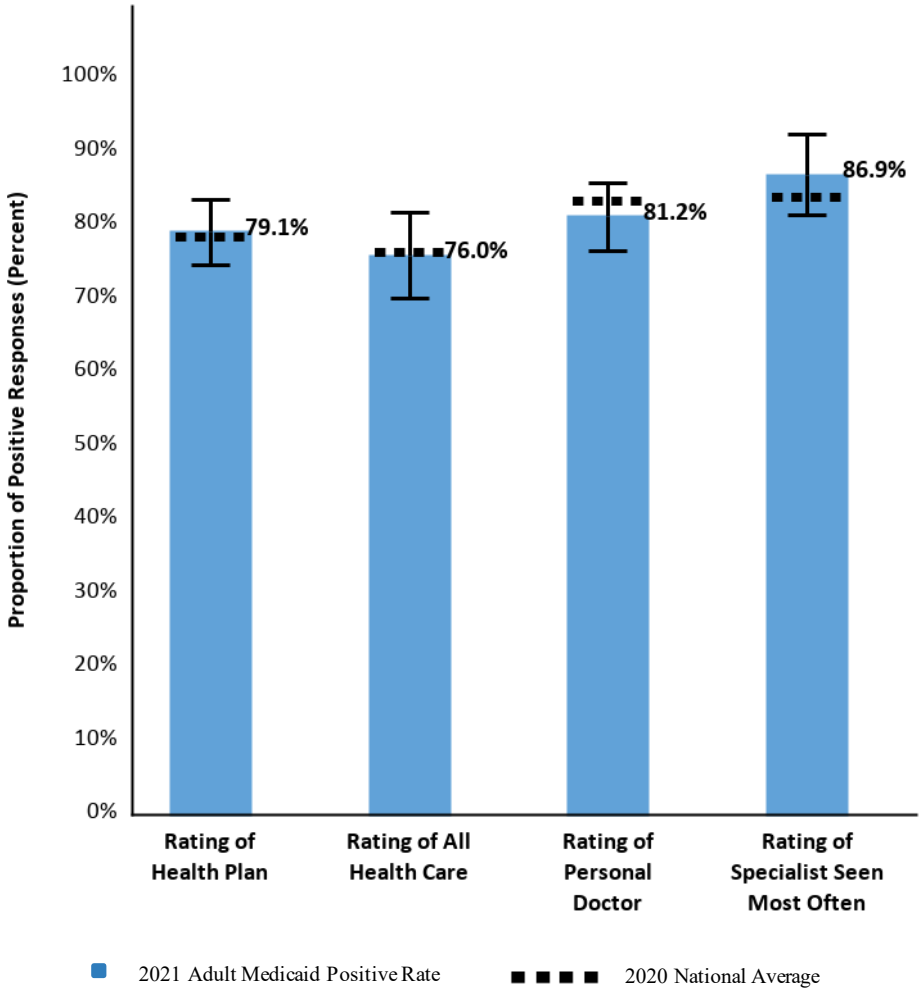
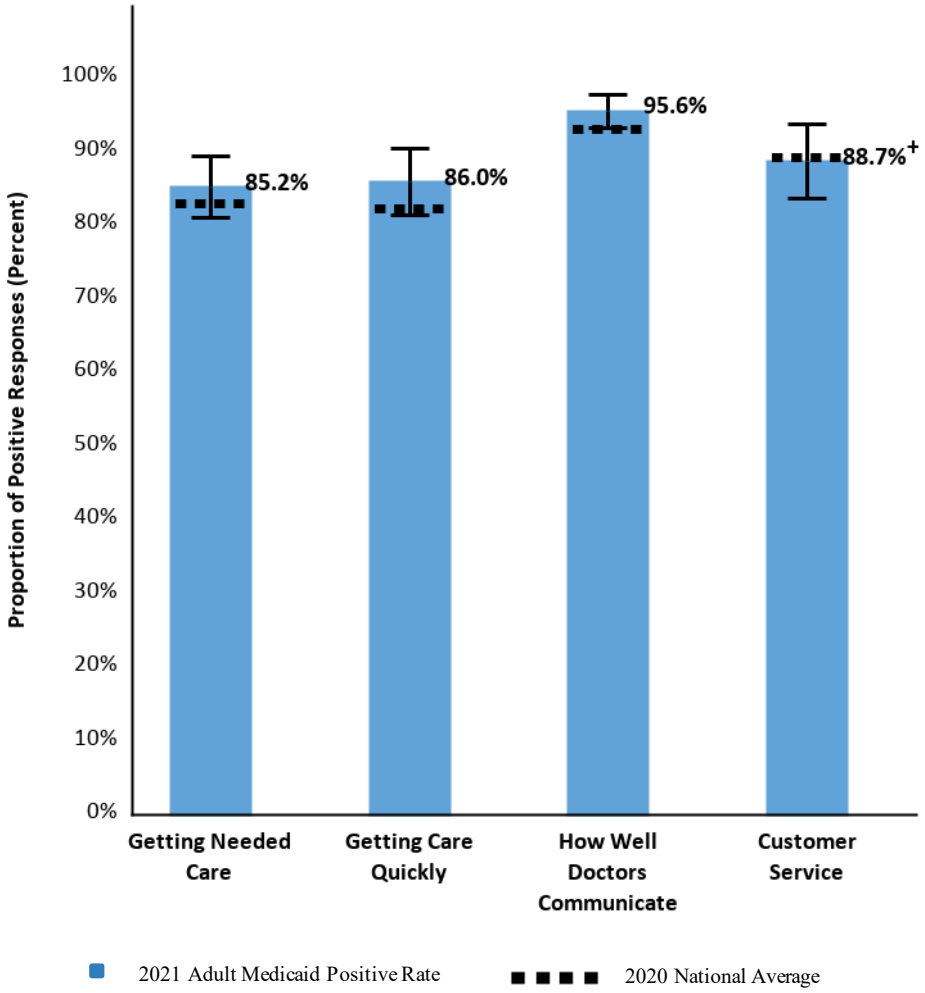


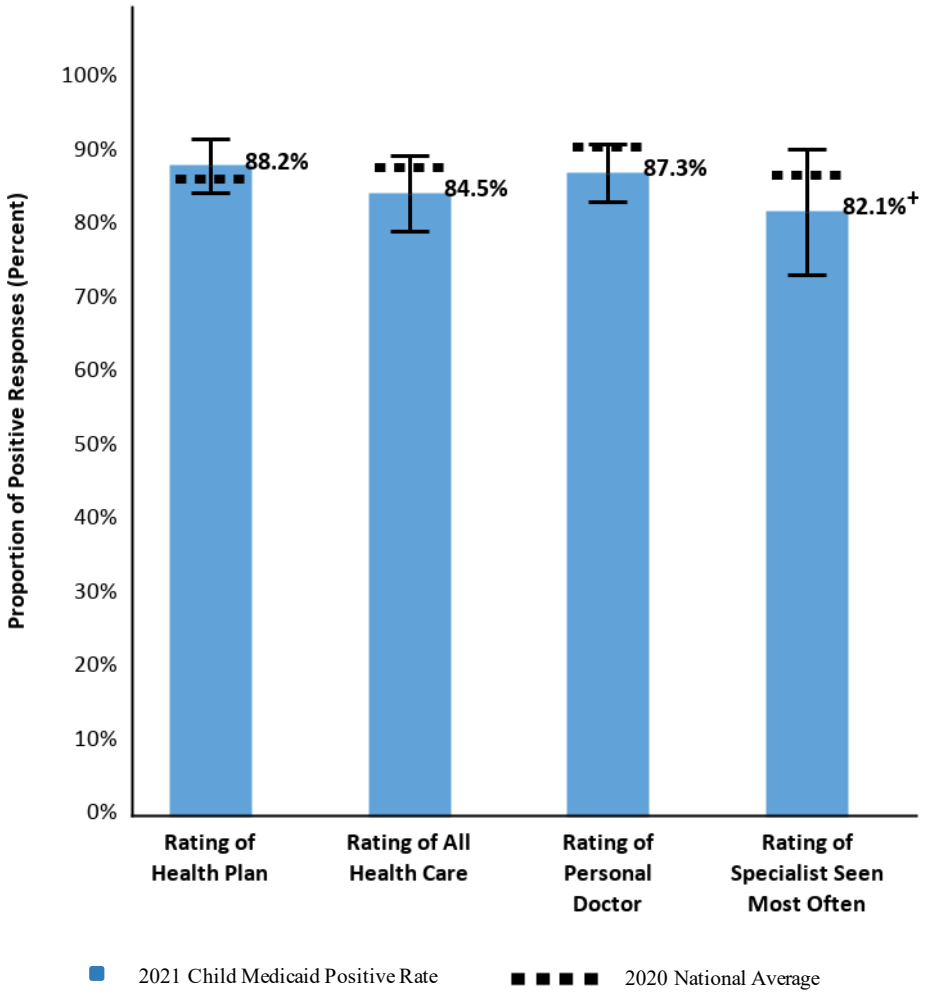
Figure 3-6—NHHF Adult Medicaid CAHPS Results: Composite Measures



For **NHHF**'s adult Medicaid population, five rates, *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*, exceeded NCQA's 2020 Medicaid national averages. The measure rate for *How Well Doctors Communicate* was statistically significantly higher than the national average.

NHHF surveyed 2,640 general child Medicaid members in 2021, and parents/caretakers of child members returned 309 completed surveys. After excluding ineligible members, the response rate was 11.8 percent. In 2021, the NHHF general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, which was 13.1 percent.[3-15] Figure 3-7 and Figure 3-8 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2020 national averages for the global ratings and composite measures, respectively, for NHHF's general child Medicaid population.[3-16]

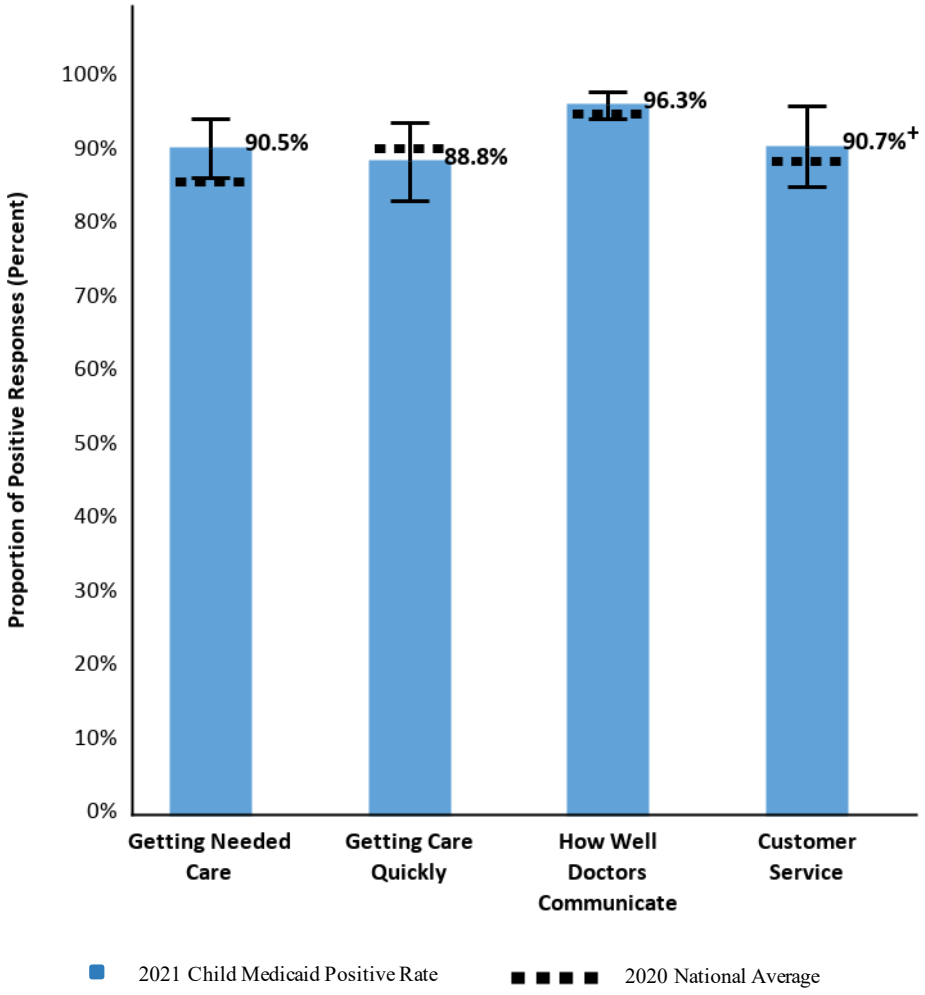
Figure 3-7—NHHF Child Medicaid CAHPS Results: Global Ratings



[3-15] 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).

[3-16] The 2021 child Medicaid CAHPS results presented in Figure 3-7 and Figure 3-8 for NHHF are based on results of the general child population only.

Figure 3-8—NHHF Child Medicaid CAHPS Results: Composite Measures



For **NHHF**'s general child Medicaid population, four rates, *Rating of Health Plan*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2020 Medicaid national averages. The rate for *Getting Needed Care* was statistically significantly higher than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and child Medicaid populations' 2021 CAHPS survey results to the 2020 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2021 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2020 NCQA Medicaid national averages, HSAG recommends that **NHHF** focus ***timeliness of care***, ***access to care***, and ***quality of care*** improvement efforts on *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service* for the adult population as these rates fell below the national averages. In addition, HSAG recommends that **NHHF** focus ***access to care***

and ***quality of care*** improvement efforts on the *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Getting Care Quickly* for the child population as these rates fell below the national averages.

The rates for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **NHHF** could include reminders about the importance of improving communication 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. Improvement in these areas will positively impact ***quality of care***. **NHHF** could 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 *Getting Care Quickly* could be improved by evaluating the process of care delivery and identifying if there are any operational issues contributing to access to care barriers for members. **NHHF** could explore ways to channel members to useful and reliable sources of information on the Internet by expanding its website to include health information and relevant tools, as well as links to related information. Benefits of Internet access to health information and advice may include improved ***timeliness of care***, ***access to care***, ***quality of care***, and efficiency. Furthermore, **NHHF** could consider implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems, such as a 24-hour nurse hotline and web- or telemedicine-based diagnosis and treatment of minor conditions.

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. **NHHF** could further promote the use of existing after-hours customer service to improve customer service results. Calls to **NHHF**'s customer services department may include information about providers or benefits, and improving that rate will positively affect ***timeliness of care***, ***access to care***, and ***quality of care***. The MCO's Member Advisory Board could be used to better understand what constitutes high-quality services from the perspective of its members. **NHHF** could appoint workgroups from call center staff members to refine existing service standards to clearly inform staff members what is expected of them during interactions with members.

WS

WS surveyed 2,835 adult Medicaid members in 2021, and members returned 370 completed surveys. After excluding ineligible members, the response rate was 13.2 percent. In 2021, the WS adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 16.3 percent. Figure 3-9 and Figure 3-10 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2021 national averages for the global ratings and composite measures, respectively, for WS's adult Medicaid population.

Figure 3-9—WS Adult Medicaid CAHPS Results: Global Ratings

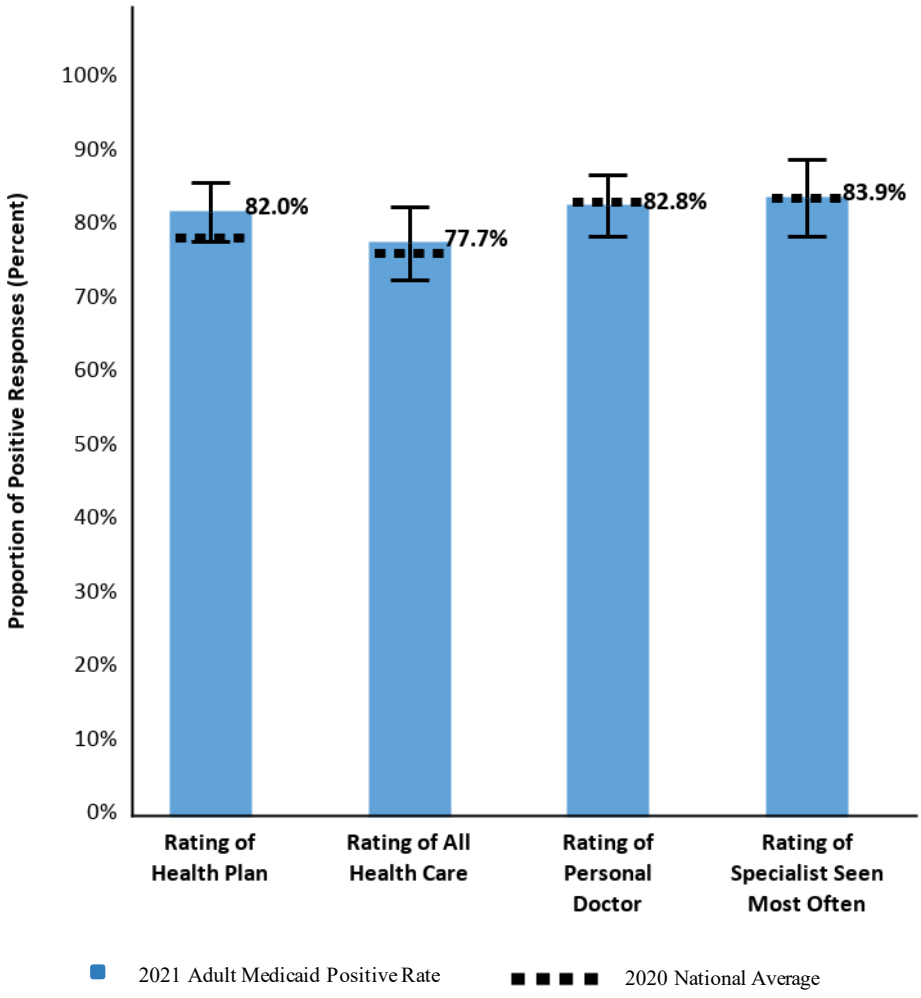
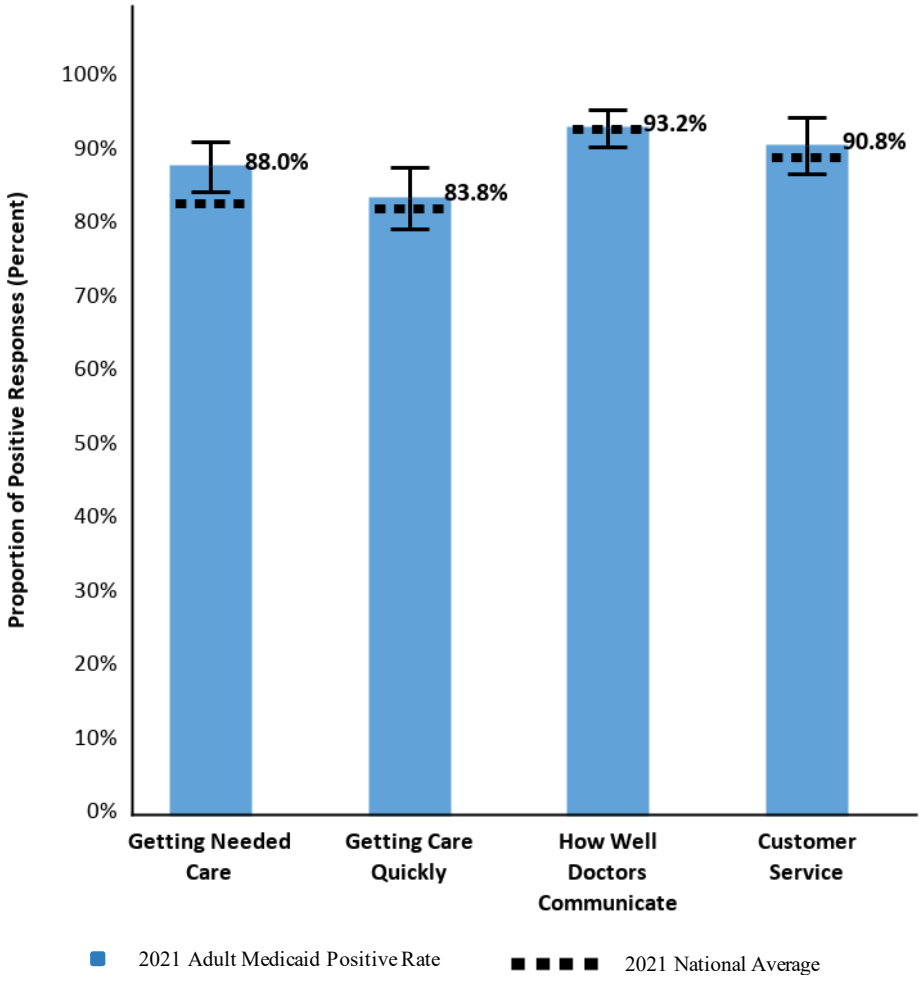


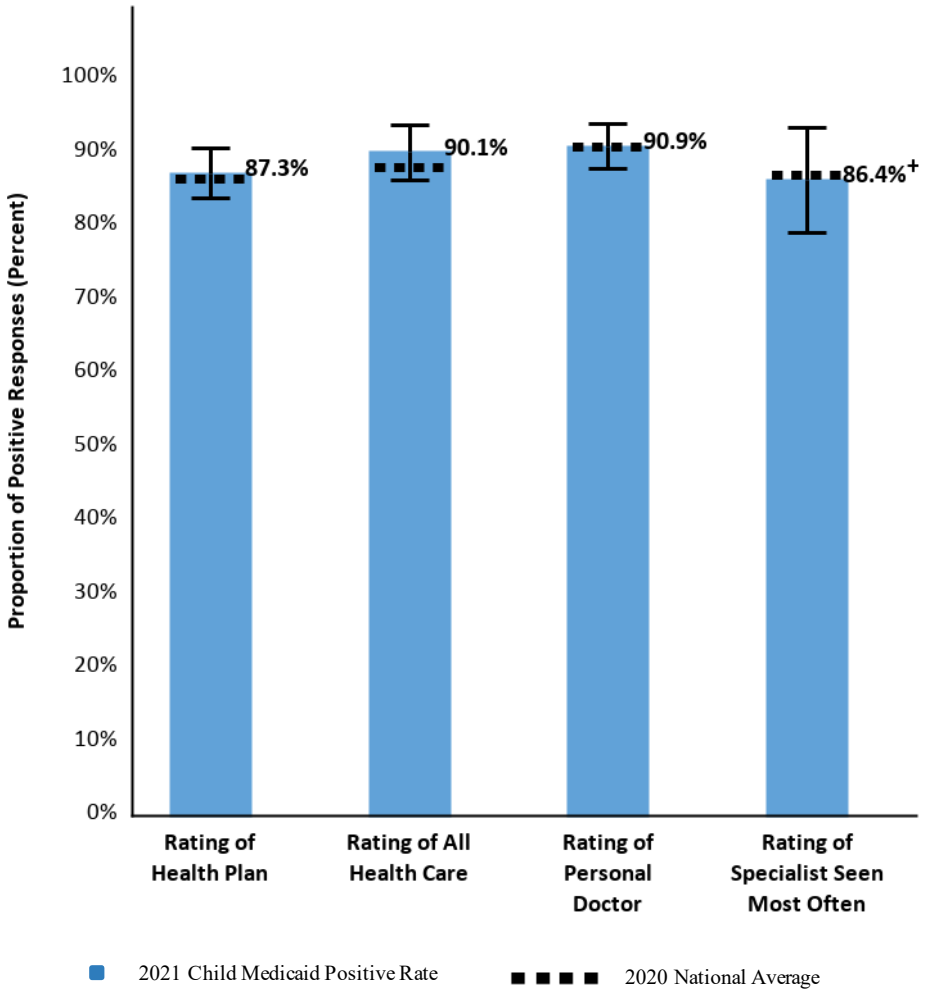
Figure 3-10—WS Adult Medicaid CAHPS Results: Composite Measures



For **WS**'s adult Medicaid population, all rates were higher than NCQA's 2020 Medicaid national averages, except for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. The measure rate for *Getting Needed Care* was statistically significantly higher than NCQA's 2020 Medicaid national average.

WS surveyed 2,888 general child Medicaid members in 2021, and parents/caretakers of child members returned 382 completed surveys. After excluding ineligible members, the response rate was 13.3 percent. In 2021, the WS general child Medicaid response rate was higher than the average NCQA response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, which was 13.1 percent.[3-17] Figure 3-11 and Figure 3-12 show the 2021 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2020 national averages for the global ratings and composite measures, respectively, for WS's general child Medicaid population.[3-18]

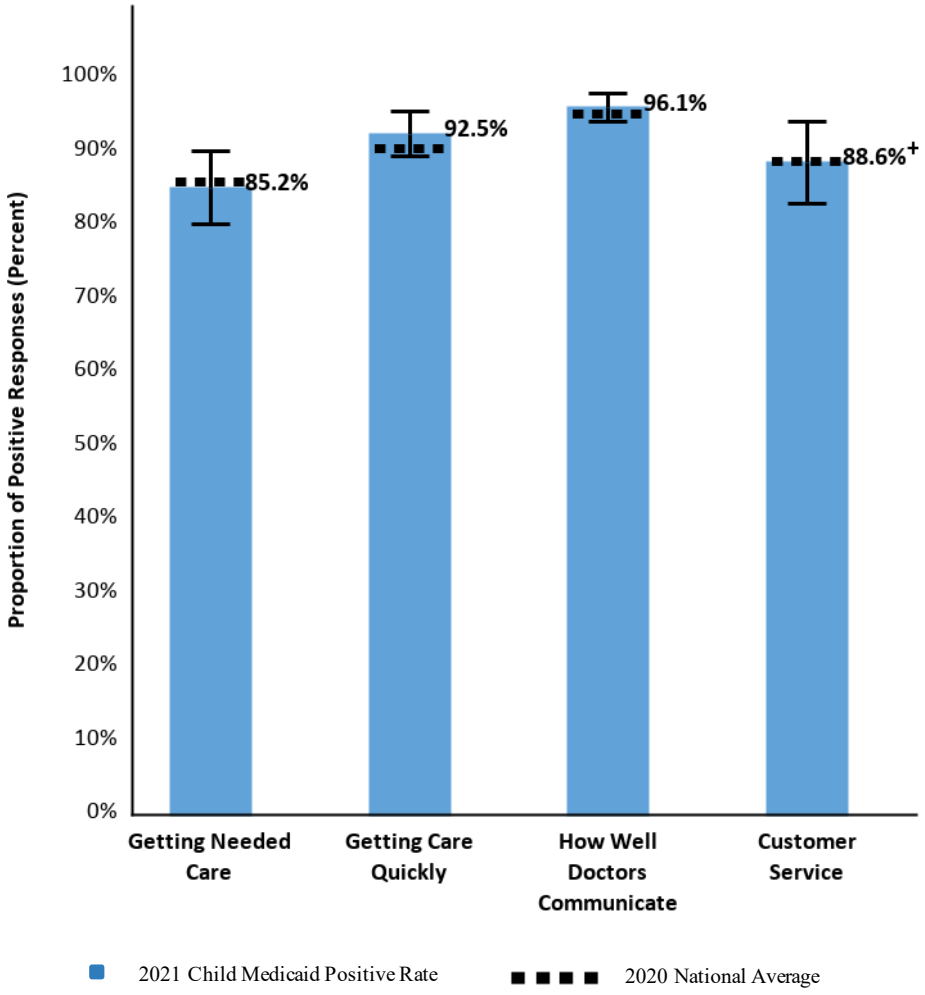
Figure 3-11—WS Child Medicaid CAHPS Results: Global Ratings



[3-17] 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).

[3-18] The 2021 child Medicaid CAHPS results presented in Figure 3-11 and Figure 3-12 for WS are based on results of the general child population only.

Figure 3-12—WS Child Medicaid CAHPS Results: Composite Measures



For **WS**'s general child Medicaid population, five rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*, were higher than NCQA's 2020 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

Conclusions and Recommendations for Improvement

HSAG performed a comparison of the adult and child Medicaid populations' 2021 CAHPS survey results to the 2020 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2021 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2020 NCQA Medicaid national averages, HSAG recommends that **WS** focus on ***quality of care*** improvement efforts on the *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures for the adult population, since these rates fell below the national averages. In addition, HSAG recommends that **WS** focus on ***timeliness of care***,

access to care, and ***quality of care*** improvement efforts on the *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* measures, since these rates fell below the national averages for the child population.

To improve CAHPS rates, **WS** could consider involving MCO staff members at every level to assist in improving *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* rates. To improve the rate for *Rating of Personal Doctor* and *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** could 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** could 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. Improving these rates will positively affect ***timeliness of care***, ***access to care***, and ***quality of care.***

The rates for *Getting Needed Care* could be improved by evaluating the process of care delivery and identifying if there are any operational issues contributing to access to care barriers for members. **WS** could explore ways to channel members to useful and reliable sources of information on the Internet by expanding their website to include health information and relevant tools, as well as links to related information. Benefits of Internet access to health information and advice may include improved quality of care, timeliness, and efficiency. Furthermore, **WS** could consider enhancing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to nonurgent health conditions and problems, such as its web- or telemedicine-based services. Improving these rates will demonstrate a positive impact on ***timeliness of care*** and ***access to care***.

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 workgroups from call center staff members to refine existing service standards to clearly inform staff members what is expected of them during interactions with members. Calls to **WS**'s customer services department may include information about providers or benefits. Improving these rates will positively affect ***timeliness of care***, ***access to care***, and ***quality of care***.

For additional information concerning HSAG's methodology for evaluating CAHPS results, see Appendix B Methodologies for Conducting EQR Activities, page B-22.

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.[3-19] **ACNH**, **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, all 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).

The information system (IS) review for **ACNH**, **NHHF**, and **WS** included the assessment standards shown below.

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.

[3-19] 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 20, 2021.

- 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—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—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

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

ACNH, **NHHF**, and **WS** were found to be fully compliant with all applicable IS assessment standards.

MCO HEDIS Rates With Statewide Averages

HSAG compared the measurement year (MY) 2020 HEDIS rates for the three MCOs and provided a statewide average. For some rates, comparisons to percentiles were not made due to changes in the technical specifications or the first year reporting for measures to include the following:

- *Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months-Six or More Visits* and *15 months to 30 months—Two or More Visits*
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years, 12–17 years, 18–21 Years,* and *Total*

- *Controlling High Blood Pressure (CBP)*
- *Identification of Alcohol and Other Drug Services (IAD)*

For three measures, *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), Comprehensive Diabetes Care—HbA1c Poor Control (CDC),* and *Ambulatory Care—ED Visits—Total (AMB)*, a lower rate indicates better performance.

To evaluate the performance of the statewide average rate, 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

HSAG compared the statewide average MY 2020 rates to national benchmarks that are based on NCQA's Quality Compass[3-20] national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2020 representing MY 2019.

Table 3-23 displays the HEDIS 2021 rates representing MY 2020 rates for the MCOs, the statewide average rate, and the HEDIS MY 2020 statewide average percentile ranking.

Table 3-23—HEDIS MY 2020 Health Plan Comparison Table

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Prevention					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total	74.64%	78.42%	78.87%	78.23%	25th–49th Percentile
Breast Cancer Screening (BCS)					
Breast Cancer Screening [1]	NA	53.73%	50.09%	52.48%	<25th Percentile

[3-20] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	43.21%	54.92%	55.33%	54.86%	NC
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	NA	81.91%	79.86%	80.67%	NC
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years[2]	54.34%	63.67%	62.49%	62.70%	NC
12–17 Years[2]	44.71%	54.20%	52.78%	53.21%	NC
18–21 Years[2]	23.75%	33.20%	31.08%	31.73%	NC
Total[2]	45.58%	55.76%	55.53%	55.28%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile–Total[1]	55.47%	72.75%	57.11%	63.92%	<25th Percentile
Counseling for Nutrition—Total[1]	61.31%	70.80%	62.11%	65.90%	25th–49th Percentile
Counseling for Physical Activity—Total[1]	55.23%	66.18%	55.79%	60.33%	25th–49th Percentile
Childhood Immunization Status (CIS)					
Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)	58.54%	78.10%	55.47%	65.38%	<25th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	24.39%	51.58%	33.58%	41.32%	50th–74th Percentile
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	NA	76.89%	72.26%	74.30%	<25th Percentile

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Combination 2 (Meningococcal, Tdap, HPV)	NA	34.55%	28.71%	31.40%	25th–49th Percentile
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening[1]	36.98%	59.37%	52.66%	54.04%	<25th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.32%	0.17%	0.18%	0.18%	75th–89th Percentile
Chlamydia Screening in Women (CHL)					
16–20 Years	43.64%	43.16%	43.26%	43.22%	<25th Percentile
21–24 Years	50.89%	52.38%	53.97%	52.88%	<25th Percentile
Total	48.21%	46.13%	46.54%	46.45%	<25th Percentile
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care[1]	80.94%	81.75%	72.02%	77.13%	<25th Percentile
Postpartum Care[1]	75.25%	74.21%	71.53%	73.12%	25th–49th Percentile
Acute and Chronic Care					
Appropriate Testing for Children with Pharyngitis (CWP)					
Total[1]	78.05%	84.11%	83.99%	83.89%	75th–89th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)					
Appropriate Treatment for Upper Respiratory Infection	93.78%	93.70%	93.66%	93.68%	≥90th Percentile

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Bronchodilator	72.73%	86.49%	85.39%	84.52%	25th–49th Percentile
Systemic Corticosteroid	72.73%	70.81%	79.78%	74.94%	50th–74th Percentile
Comprehensive Diabetes Care (CDC)					
Hemoglobin A1c (HbA1c) Testing	87.14%	85.40%	82.24%	84.10%	<25th Percentile
HbA1c Poor Control (>9.0%),[1]*	44.00%	38.93%	59.37%	48.55%	<25th Percentile
HbA1c Control (<8.0%)	44.86%	51.34%	33.58%	42.82%	<25th Percentile
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure[2]	52.90%	58.88%	45.99%	52.70%	NC
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain	80.16%	75.51%	76.73%	76.48%	50th–74th Percentile
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	16.49%	10.91%	10.71%	10.94%	25th–49th Percentile
Asthma Medication Ratio (AMR)					
Total	NA	59.89%	61.50%	60.78%	25th–49th Percentile
Ambulatory Care—Total (AMB)					
*Emergency Department (ED) Visits—Total**	42.99	34.87	37.12	36.78	≥90th Percentile

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Antibiotic Utilization—Total (ABX)					
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	34.48%	35.23%	35.03%	35.06%	75th–89th Percentile
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total[1]	51.47%	62.28%	58.15%	59.01%	≥90th Percentile
30-Day Follow-Up—Total[1]	68.14%	76.78%	73.30%	74.08%	≥90th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***	80.00%	76.62%	75.14%	76.15%	<25th Percentile
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People with Diabetes and Schizophrenia	NA	61.82%	58.33%	59.63%	<25th Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.85%	77.70%	68.51%	72.63%	≥90th Percentile

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose Testing—Total	NA	53.19%	51.66%	52.45%	25th–49th Percentile
Cholesterol Testing—Total	NA	34.66%	28.48%	31.34%	<25th Percentile
Blood Glucose and Cholesterol Testing—Total	NA	33.86%	27.32%	30.28%	25th–49th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
Total	NA	66.45%	60.10%	62.37%	25th–49th Percentile
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	74.66%	63.53%	57.79%	61.03%	75th–89th Percentile
Effective Continuation Phase Treatment	64.38%	48.17%	43.06%	46.24%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase[1]	NA	55.99%	42.36%	48.26%	75th–89th Percentile
Continuation and Maintenance Phase[1]	NA	67.34%	44.10%	53.59%	25th–49th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment[2]*—Total*	59.03%	53.16%	46.14%	50.77%	75th–89th Percentile
Engagement of AOD Treatment[2]*—Total***	29.74%	22.83%	20.91%	22.91%	75th–89th Percentile

Performance Measure HEDIS MY 2020	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2020 Statewide Average Percentile
Identification of Alcohol and Other Drug Services (IAD)					
Any Service—Total[2]	17.86%	9.14%	11.10%	10.97%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total[1]	71.51%	72.41%	68.80%	70.55%	≥90th Percentile
30-Day Follow-Up—Total[1]	78.21%	80.77%	76.16%	78.23%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
7-Day Follow-Up—Total[2]	36.92%	23.92%	31.05%	29.51%	≥90th Percentile
30-Day Follow-Up—Total[2]	50.54%	37.52%	45.13%	43.33%	≥90th Percentile

* For this indicator, a lower rate indicates better performance.

**This measure is also a PIP topic for the three MCOs.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

Table 3-24 displays a summary of the New Hampshire statewide MCM Program rates and the comparisons to national benchmarks based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019.

Table 3-24—Summary of the NH MCM Program Statewide Scores for MY 2020 HEDIS Measures With National Benchmarks

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	0	1	1	5	9	**16**
Acute and Chronic Care	2	2	2	3	3	**12**
Behavioral Health	7	5	0	4	3	**19**
All Domains	**9**	**8**	**3**	**12**	**15**	**47**
Percentage	**19.15%**	**17.02%**	**6.38%**	**25.53%**	**31.92%**	**100%**

The New Hampshire statewide Medicaid rates ranked at or above the 50th percentile for 20 measures (42.55 percent), with nine of these measures (19.15 percent) meeting or exceeding the 90th percentile. A total of 27 measures (57.45 percent) fell below the 50th percentile.

The following statewide average rates met or exceeded the HEDIS MY 2020 Statewide Average 90th percentile:

- Two Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Ambulatory Care—Total (AMB)—ED Visits—Total*
- Seven Behavioral Health measure indicator rates: *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), Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

The following statewide average rates fell below the HEDIS MY 2020 Statewide Average 25th percentile:

- Nine Prevention measure indicator rates: *Breast Cancer Screening (BCS); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total; Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV); Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap); Cervical Cancer Screening (CCS); Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- Three Acute and Chronic Care measure indicator rates: *Comprehensive Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%),* and *HbA1c Control (<8.0%)*
- Three Behavioral Health measure indicator rates: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), Diabetes Monitoring for*

People with Diabetes and Schizophrenia (SMD), and *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Cholesterol Testing—Total*

ACNH

Table 3-25 below contains **ACNH**'s HEDIS MY 2020 performance measure rates and **ACNH**'s HEDIS MY 2020 percentile ranking as compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing measurement year (MY) 2019. **ACNH** operations in New Hampshire began September 1, 2019; therefore, no HEDIS data were available prior to MY 2020. Additionally, due to specification changes in HEDIS MY 2020, comparisons to percentiles are not appropriate for some measures as indicated below.

Table 3-25—ACNH HEDIS MY 2020 Rates and Percentile Rankings

ACNH HEDIS Rates	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Ranking
Prevention		
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total	74.64%	<25th Percentile
Breast Cancer Screening (BCS)		
Breast Cancer Screening[1]	NA	NC
Well-Child Visits in the First 30 Months of Life (W30)		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	43.21%	NC
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	NA	NC
Child and Adolescent Well-Care Visits (WCV)		
3–11 Years[2]	54.34%	NC
12–17 Years[2]	44.71%	NC
18–21 Years[2]	23.75%	NC
Total[2]	45.58%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		
BMI Percentile–Total[1]	55.47%	<25th Percentile
Counseling for Nutrition—Total[1]	61.31%	<25th Percentile
Counseling for Physical Activity—Total[1]	55.23%	<25th Percentile

ACNH HEDIS Rates	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Ranking
Childhood Immunization Status (CIS)		
Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)	58.54%	<25th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	24.39%	<25th Percentile
Immunizations for Adolescents (IMA)		
Combination 1 (Meningococcal, Tdap)	NA	NC
Combination 2 (Meningococcal, Tdap, HPV)	NA	NC
Cervical Cancer Screening (CCS)		
Cervical Cancer Screening[1]	36.98%	<25th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)		
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.32%	75th–89th Percentile
Chlamydia Screening in Women (CHL)		
16–20 Years	43.64%	<25th Percentile
21–24 Years	50.89%	<25th Percentile
Total	48.21%	<25th Percentile
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care[1]	80.94%	<25th Percentile
Postpartum Care[1]	75.25%	25th–49th Percentile
Acute and Chronic Care		
Appropriate Testing for Children with Pharyngitis (CWP)		
Total[1]	78.05%	50th–74th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)		
Appropriate Treatment for Upper Respiratory Infection	93.78%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Bronchodilator	72.73%	<25th Percentile

ACNH HEDIS Rates	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Ranking
Systemic Corticosteroid	72.73%	50th–74th Percentile
Comprehensive Diabetes Care (CDC)		
Hemoglobin A1c (HbA1c) Testing	87.14%	25th–49th Percentile
HbA1c Poor Control (>9.0%),[1]*	44.00%	25th–49th Percentile
HbA1c Control (<8.0%)	44.86%	25th–49th Percentile
Controlling High Blood Pressure (CBP)		
Controlling High Blood Pressure[2]	52.90%	NC
Use of Imaging Studies for Low Back Pain (LBP)		
Use of Imaging Studies for Low Back Pain	80.16%	75th–89th Percentile
Plan All-Cause Readmissions (PCR)		
Observed Readmissions—Total	16.49%	<25th Percentile
Asthma Medication Ratio (AMR)		
Total	NA	NC
Ambulatory Care—Total (AMB)		
*ED Visits—Total**	42.99	75th–89th Percentile
Antibiotic Utilization—Total (ABX)		
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	34.48%	75th–89th Percentile
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness (FUH)		
7-Day Follow-Up—Total[1]	51.47%	75th–89th Percentile
30-Day Follow-Up—Total[1]	68.14%	75th–89th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)		
*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***	80.00%	25th–49th Percentile

ACNH HEDIS Rates	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Ranking
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		
Diabetes Monitoring for People with Diabetes and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.85%	50th–74th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)		
Blood Glucose Testing—Total	NA	NC
Cholesterol Testing—Total	NA	NC
Blood Glucose and Cholesterol Testing—Total	NA	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)		
Total	NA	NC
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	74.66%	≥90th Percentile
Effective Continuation Phase Treatment	64.38%	≥90th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)		
Initiation Phase[1]	NA	NC
Continuation and Maintenance Phase[1]	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)		
Initiation of AOD Treatment[2]*—Total*	59.03%	≥90th Percentile
Engagement of AOD Treatment[2]*—Total***	29.74%	≥90th Percentile
Identification of Alcohol and Other Drug Services (IAD)		
Any Service—Total	17.86%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)		
7-Day Follow-Up—Total[1]	71.51%	≥90th Percentile
30-Day Follow-Up—Total[1]	78.21%	≥90th Percentile

ACNH HEDIS Rates	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Ranking
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)		
7-Day Follow-Up—Total[2]	36.92%	≥90th Percentile
30-Day Follow-Up—Total[2]	50.54%	≥90th Percentile

* For this indicator, a lower rate indicates better performance.
**This measure is also a PIP topic for the three MCOs.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
NA indicates that a rate could not be reported due to a small denominator.
NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

Conclusions

ACNH was fully compliant with all NCQA-defined IS standards for HEDIS MY 2020.

The HEDIS audits confirmed that **ACNH** 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. **ACNH** demonstrated the accuracy and completeness of its primary databases, which contained claims and encounters, membership and enrollment, and provider credentialing data. **ACNH** also demonstrated the ability to appropriately store data used for HEDIS reporting.

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

- One Acute and Chronic Care measure rate: *Appropriate Treatment for Upper Respiratory Infection (URI)*
- Eight Behavioral Health measure indicator rates: *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*, *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Eleven Prevention measure indicator rates: *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total; 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 (DTaP, IPV, MMR, HIB, HepB, VZV)* and *Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza); Cervical Cancer Screening (CCS); Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- Two Acute and Chronic Care measure rates: *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*

Recommendations

With 18 of 36 rates (50.00 percent) falling below the 50th percentile, **ACNH** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care, timely prenatal and postpartum care, comprehensive diabetes care, pharmacotherapy management of COPD exacerbation using bronchodilators, and cervical cancer screening. **ACNH** also should focus on ensuring young women are appropriately screened for chlamydia. Weight assessment and counseling for BMI/nutrition/physical activity for children and adolescents, immunizations for children, plan all-cause readmissions, and diabetes screenings for people with schizophrenia or bipolar disorder who are using antipsychotic medications are additional areas of focus for **ACNH**. Improving these rates will impact ***timeliness of care***, ***access to care***, and ***quality of care*** for **ACNH**'s members in the New Hampshire MCM Program.

NHHF

Table 3-26 displays **NHHF**'s HEDIS MY 2018, HEDIS MY 2019, and HEDIS MY 2020 performance measure rates and **NHHF**'s HEDIS MY 2020 percentile ranking. HEDIS MY 2020 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019. Additionally, due to specification changes in HEDIS MY 2020, comparisons to percentiles are not appropriate for some measures as indicated below.

Table 3-26—NHHF HEDIS MY 2018, MY 2019, MY 2020 Rates and MY 2020 Percentile Rankings

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	89.11%	81.56%	78.42%	25th–49th Percentile

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Breast Cancer Screening (BCS)				
Breast Cancer Screening[1]	59.77%	58.74%	53.73%	25th–49th Percentile
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	54.92%	NC
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	81.91%	NC
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years[2]	—	—	63.67%	NC
12–17 Years[2]	—	—	54.20%	NC
18–21 Years[2]	—	—	33.20%	NC
Total[2]	—	—	55.76%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile–Total[1]	78.59%	75.67%	72.75%	25th–49th Percentile
Counseling for Nutrition—Total[1]	75.67%	72.75%	70.80%	25th–49th Percentile
Counseling for Physical Activity—Total[1]	71.78%	67.88%	66.18%	25th–49th Percentile
Childhood Immunization Status (CIS)				
Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)	79.56%	75.67%	78.10%	75th–89th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	47.20%	48.18%	51.58%	75th–89th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	77.62%	78.10%	76.89%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	32.36%	32.36%	34.55%	25th–49th Percentile

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening[1]	64.48%	54.99%	59.37%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.12%	0.13%	0.17%	75th–89th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	44.48%	47.99%	43.16%	<25th Percentile
21–24 Years	51.11%	51.63%	52.38%	<25th Percentile
Total	45.55%	49.10%	46.13%	<25th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care[1]	—	88.56%	81.75%	<25th Percentile
Postpartum Care[1]	—	82.00%	74.21%	25th–49th Percentile
Acute and Chronic Care				
Appropriate Testing for Children with Pharyngitis (CWP)				
Total[1]	—	86.14%	84.11%	75th–89th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Appropriate Treatment for Upper Respiratory Infection	—	93.33%	93.70%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	86.50%	85.85%	86.49%	50th–74th Percentile
Systemic Corticosteroid	83.50%	81.76%	70.81%	25th–49th Percentile
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	91.73%	92.21%	85.40%	<25th Percentile

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
HbA1c Poor Control (>9.0%),[1]*	25.79%	31.14%	38.93%	25th–49th Percentile
HbA1c Control (<8.0%)	59.37%	53.77%	51.34%	25th–49th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure[2]	—	—	58.88%	NC
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain	70.00%	74.59%	75.51%	50th–74th Percentile
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	—	11.26%	10.91%	25th–49th Percentile
Asthma Medication Ratio (AMR)				
Total	70.35%	67.24%	59.89%	25th–49th Percentile
Ambulatory Care—Total (AMB)				
*ED Visits—Total**	44.68	45.76	34.87	≥90th Percentile
Antibiotic Utilization—Total (ABX)				
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	36.76%	36.29%	35.23%	75th–89th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total[1]	64.62%	55.38%	62.28%	≥90th Percentile
30-Day Follow-Up—Total[1]	78.02%	75.13%	76.78%	≥90th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***	79.23%	82.61%	76.62%	<25th Percentile

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	71.74%	68.75%	61.82%	<25th Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	82.19%	78.01%	77.70%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	—	56.12%	53.19%	25th–49th Percentile
Cholesterol Testing—Total	—	37.64%	34.66%	25th–49th Percentile
Blood Glucose and Cholesterol Testing—Total	29.65%	36.53%	33.86%	25th–49th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	78.00%	74.07%	66.45%	50th–74th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	52.81%	61.92%	63.53%	75th–89th Percentile
Effective Continuation Phase Treatment	39.20%	45.90%	48.17%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase[1]	59.96%	53.77%	55.99%	≥90th Percentile
Continuation and Maintenance Phase[1]	69.15%	58.74%	67.34%	75th–89th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment[2]*—Total*	37.89%	48.65%	53.16%	≥90th Percentile

NHHF HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
*Engagement of AOD Treatment[2]—Total***	13.68%	18.86%	22.83%	75th–89th Percentile
Identification of Alcohol and Other Drug Services (IAD)				
Any Service—Total[2]	6.64%	10.11%	9.14%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total[1]	77.98%	74.34%	72.41%	≥90th Percentile
30-Day Follow-Up—Total[1]	85.71%	81.45%	80.77%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total[2]	21.03%	26.03%	23.92%	75th–89th Percentile
30-Day Follow-Up—Total[2]	30.63%	37.06%	37.52%	≥90th Percentile

* For this indicator, a lower rate indicates better performance.

**This measure is also a PIP topic for the three MCOs.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

Conclusions

NHHF was fully compliant with all NCQA-defined IS standards for HEDIS MY 2020.

The HEDIS audits confirmed that **NHHF** 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 **NHHF** demonstrated the accuracy and completeness of their primary databases, which contained claims and encounters, membership and enrollment, and provider credentialing data. **NHHF** also demonstrated the ability to appropriately store data used for HEDIS reporting.

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

- Two Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Ambulatory Care—Total (AMB)—ED Visits—Total*
- Eight Behavioral Health measure rates: *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), Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total, Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—30-Day Follow-Up—Total*

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

- Four Prevention measure rates: *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- One Acute and Chronic Care measure indicator rate: *Comprehensive Diabetes Care (CDC)—HbA1c Testing*
- Two Behavioral Health measure rates: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*

Recommendations

With 24 of 47 rates (51.06 percent) falling below the 50th percentile, **NHHF** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care, plan all-cause readmissions, screening for breast and cervical cancer, timely prenatal and postpartum care, pharmacotherapy management of COPD exacerbation using systemic corticosteroids, and comprehensive diabetes care. **NHHF** also should focus on ensuring that members are appropriately screened for chlamydia, weight assessment and counseling for BMI/nutrition/physical activity, immunizations for adolescents, and asthma medication ratio. The focus for improving BH measures should be on diabetes monitoring for people with diabetes and schizophrenia, diabetes screenings for people with schizophrenia or bipolar disorder who are using antipsychotic medications, and metabolic monitoring for children and adolescents on antipsychotics. Improving these rates will impact ***timeliness of care***, ***access to care***, and ***quality of care*** for **NHHF**'s members in the New Hampshire MCM Program.

WS

Table 3-27 displays **WS**'s HEDIS MY 2018, HEDIS MY 2019, and HEDIS MY 2020 performance measure rates and **WS**'s HEDIS MY 2020 percentile ranking. HEDIS MY 2020 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019. Additionally, due to specification changes in HEDIS MY 2020, comparisons to percentiles are not appropriate for some measures as indicated below.

Table 3-27—WS HEDIS MY 2018, MY 2019, MY 2020 Rates and MY 2020 Percentile Rankings

WS HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	88.69%	80.78%	78.87%	25th–49th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening[1]	54.13%	54.70%	50.09%	<25th Percentile
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	55.33%	NC
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	—	79.86%	NC
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years[2]	—	—	62.49%	NC
12–17 Years[2]	—	—	52.78%	NC
18–21 Years[2]	—	—	31.08%	NC
Total[2]	—	—	55.53%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile–Total[1]	67.68%	67.68%	57.11%	<25th Percentile
Counseling for Nutrition—Total[1]	66.16%	66.16%	62.11%	<25th Percentile
Counseling for Physical Activity—Total[1]	64.63%	64.63%	55.79%	<25th Percentile
Childhood Immunization Status (CIS)				
Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)	75.18%	75.18%	55.47%	<25th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza))	41.61%	41.61%	33.58%	25th–49th Percentile

WS HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.35%	78.35%	72.26%	<25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	33.82%	33.82%	28.71%	<25th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening[1]	60.94%	60.94%	52.66%	<25th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.20%	0.10%	0.18%	75th–89th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	44.90%	48.16%	43.26%	<25th Percentile
21–24 Years	58.70%	57.63%	53.97%	<25th Percentile
Total	47.38%	51.09%	46.54%	<25th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care[1]	—	86.62%	72.02%	<25th Percentile
Postpartum Care[1]	—	76.40%	71.53%	25th–49th Percentile
Acute and Chronic Care				
Appropriate Testing for Children with Pharyngitis (CWP)				
Total[1]	—	84.98%	83.99%	75th–89th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Appropriate Treatment for Upper Respiratory Infection	—	93.52%	93.66%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	95.02%	92.48%	85.39%	50th–74th Percentile
Systemic Corticosteroid	87.06%	86.73%	79.78%	75th–89th Percentile

WS HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	89.54%	89.54%	82.24%	<25th Percentile
HbA1c Poor Control (>9.0%),[1]*	40.39%	40.39%	59.37%	<25th Percentile
HbA1c Control (<8.0%)	49.39%	49.39%	33.58%	<25th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure[2]	—	—	45.99%	NC
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain	67.85%	76.31%	76.73%	50th–74th Percentile
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	—	12.79%	10.71%	25th–49th Percentile
Asthma Medication Ratio (AMR)				
Total	63.77%	63.18%	61.50%	25th–49th Percentile
Ambulatory Care—Total (AMB)				
*ED Visits—Total**	48.62	49.13	37.12	≥90th Percentile
Antibiotic Utilization—Total (ABX)				
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	36.07%	36.54%	35.03%	75th–89th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total[1]	54.72%	52.04%	58.15%	≥90th Percentile
30-Day Follow-Up—Total[1]	71.24%	71.14%	73.30%	≥90th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***	81.45%	82.80%	75.14%	<25th Percentile

WS HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	65.85%	68.09%	58.33%	<25th Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	79.65%	75.17%	68.51%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	—	56.77%	51.66%	25th–49th Percentile
Cholesterol Testing—Total	—	34.80%	28.48%	<25th Percentile
Blood Glucose and Cholesterol Testing—Total	32.53%	33.74%	27.32%	<25th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	64.62%	76.58%	60.10%	25th–49th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	56.26%	59.89%	57.79%	50th–74th Percentile
Effective Continuation Phase Treatment	43.31%	46.74%	43.06%	50th–74th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase[1]	39.12%	44.35%	42.36%	25th–49th Percentile
Continuation and Maintenance Phase[1]	48.59%	52.14%	44.10%	<25th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment[2]*—Total*	44.00%	48.87%	46.14%	50th–74th Percentile

WS HEDIS Rates	HEDIS 2019 (MY 2018) Rate	HEDIS 2020 (MY 2019) Rate	HEDIS MY 2020 Rate	HEDIS MY 2020 Percentile Rankings
*Engagement of AOD Treatment[2]—Total***	20.95%	24.55%	20.91%	75th–89th Percentile
Identification of Alcohol and Other Drug Services (IAD)				
Any Service—Total[2]	9.81%	12.35%	11.10%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total[1]	73.58%	71.12%	68.80%	≥90th Percentile
30-Day Follow-Up—Total[1]	82.55%	80.95%	76.16%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total[2]	20.50%	26.81%	31.05%	≥90th Percentile
30-Day Follow-Up—Total[2]	34.17%	42.07%	45.13%	≥90th Percentile

* For this indicator, a lower rate indicates better performance.

**This measure is also a PIP topic for the three MCOs.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported

Conclusions

WS was fully compliant with all NCQA-defined IS standards for HEDIS MY 2020.

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

- Two Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Ambulatory Care—Total (AMB)—ED Visits—Total*
- Six Behavioral Health measure rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Twelve Prevention measure indicator rates: *Breast Cancer Screening (BCS*); *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 (DTaP, IPV, MMR, HIB, HepB, VZV); 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;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- Three Acute and Chronic Care measure indicator rates: *Comprehensive Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%),* and *HbA1c Control (<8.0%)*
- Five Behavioral Health measure indicator rates: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total,* and *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*

Recommendations

With 28 of 47 rates (59.57 percent) falling below the 50th percentile, **WS** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care, plan all-cause readmissions, screening for breast and cervical cancer, comprehensive diabetes care, asthma medication ratio, and timely prenatal and postpartum care. **WS** should also focus on ensuring that members are appropriately screened for chlamydia, weight assessment and counseling for BMI/nutrition/physical activity, follow-up care for children prescribed ADHD medications, immunizations for children and adolescents, metabolic monitoring for children and adolescents on antipsychotics, and use of first-line psychosocial care for children and adolescents on antipsychotics. **WS** could improve additional BH rates by focusing efforts on diabetes screenings for people with schizophrenia or bipolar disorder who are using antipsychotic medications, and diabetes monitoring for people with diabetes and schizophrenia. Improving these rates will impact ***timeliness of care***, ***access to care***, and ***quality of care*** for **WS**'s members in the New Hampshire MCM Program.

For additional information concerning HSAG's methodology for evaluating HEDIS results, see Appendix B Methodologies for Conducting EQR Activities, page B-25.

EDV

During SFY 2021, HSAG conducted the following two EDV activities:

- Ongoing encounter data quality reports—assess completeness, accuracy, and timeliness of MCOs' encounter data files submitted to DHHS each month/quarter.

- Comparative analysis—analysis of DHHS' electronic encounter data completeness and accuracy by comparing DHHS' electronic encounter data to the data extracted from the MCOs' data systems.

While the ongoing encounter data quality reports evaluated encounters submitted to DHHS between July 1, 2020, and June 30, 2021, HSAG included encounter data with dates of service between July 1, 2019, and June 30, 2020, in the comparative analysis.

The following two EDV activities were in progress at the time the SFY 2020 New Hampshire EQR Technical Report was written. As a result, these activities are shown in this year's technical report:

- IS review for **ACNH**—assessment of DHHS' and/or MCO's IS and processes. Of note, HSAG conducted this activity for **ACNH** only in SFY 2020 because HSAG conducted the IS review activity for **NHHF** and **WS** during SFY 2018.
- MRR for **NHHF** and **WS**—analysis of DHHS' electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period. HSAG used data with dates of service between July 1, 2018, and June 30, 2019, for the MCOs' MRR activity. **ACNH** was not included in the MRR because that MCO did not begin operating in the New Hampshire MCM Program until September 2019.

Ongoing Encounter Data Quality Reports

Health Plan Comparisons

Through the monthly and quarterly reports, HSAG evaluated encounter data in four areas: (1) encounter submission accuracy and completeness, (2) encounter data completeness, (3) encounter data accuracy, and (4) encounter data timeliness. While the ongoing reports are produced monthly and quarterly, Table 3-28 displays aggregate compliance rates for each MCO in relation to the standards noted within Exhibit A of the MCO contract. The aggregate results are for encounters submitted to DHHS between July 1, 2020, and June 30, 2021. Values in **green font** indicate rates meeting the corresponding standards, and values in **red font** indicate rates that fell 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. In addition, values in **green shaded** cells indicate rates that improved from the SFY 2020 EDV study by more than 10 percentage points.

Table 3-28—Aggregate Rates for Encounter Data Submission and Quality Standards

Evaluation Area	Standard	MCO	837P (Professional) Encounters		837I (Institutional) Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
Percentage of 837 Professional/Institutional (P/I) Files Confirmed by Reconciliation Files from MCOs	NA	ACNH	98.3%		97.0%		NA	
		NHHF	95.7%		100.0%		NA	
		WS	71.8%		88.6%		NA	

Evaluation Area	Standard	MCO	837P (Professional) Encounters		837I (Institutional) Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
X12 EDI Compliance Edits	98.0%	ACNH	100.0%		100.0%		NA	
		NHHF	100.0%		100.0%		NA	
		WS	100.0%		100.0%		NA	
Validity of Member Identification Number	100.0%	ACNH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		NHHF	100.0%	99.8%	100.0%	100.0%	100.0%	99.9%
		WS	100.0%	99.7%	100.0%	99.6%	100.0%	100.0%
Validity of Billing Provider Information	98.0%	ACNH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		NHHF	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		WS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Validity of Servicing Provider Information	98.0%	ACNH	100.0%	100.0%	100.0%	100.0%	NA	
		NHHF	100.0%	100.0%	100.0%	100.0%	NA	
		WS	100.0%	100.0%	100.0%	100.0%	NA	
Initial Submission Within 14 Days of Claim Payment	100.0%	ACNH	98.8%		99.1%		100.0%	
		NHHF	99.0%		99.6%		85.5%	
		WS	99.2%		100.0%		95.3%	

NA indicates that a standard is not applicable to an encounter type.

The only rate that was below the standard by more than 10.0 percentage points was from **NHHF**'s pharmacy encounters for the timely submission standard. The remaining noncompliant rates were all above 95.0 percent. Compared to the results in the SFY 2020 EDV study, all MCOs improved their results for some of the measures.

The list below includes the findings for each measure:

- **837P/I Files Confirmed by Reconciliation Files**: For **ACNH** and **NHHF**, the percentage of 837P/I files confirmed by the reconciliation files was at least 95.7 percent. However, the rates for **WS** were relatively lower. In addition, all MCOs improved their rates from the SFY 2020 EDV study.
- **X12 EDI Compliance Edits:** All three MCOs met the submission standard regarding the 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:** All MCOs populated all submitted encounters with member identification numbers for all three encounter types. However, when these values were assessed, all MCOs either met the standard of 100 percent or fell slightly below the standard by no more than 0.4 percentage points. Compared to the results in the SFY 2020 EDV study, nearly all results were the same or better for all MCOs.
- **Billing Provider Information:** All 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. Compared to the results in the SFY 2020 EDV study, all results were the same or better for all MCOs.

- **Servicing Provider Information:** All MCOs populated all submitted encounters with servicing provider information for the 837P/I encounters. As for the percent valid standard of 98.0 percent, all MCOs met the standard. Compared to the results in the SFY 2020 EDV study, all results were the same or better for all MCOs.
- **Initial Submission Within 14 Days of Claim Payment:** The percentage of encounters initially submitted to DHHS within 14 calendar days of the claim payment dates are the same as the standard of 100 percent for **ACNH**'s pharmacy encounters and **WS**'s institutional encounters. The only rate that was below the standard by more than 10.0 percentage points was from **NHHF**'s pharmacy encounters. The remaining rates were all above 95.0 percent. Compared to the results in the SFY 2020 EDV study, both **ACNH** and **NHHF** increased their rates for all three claim types.

Health Plan-Specific Conclusions and Recommendations

ACNH

ACNH's submitted encounters met the standards for the X12 EDI compliance edits; the accuracy for member identification numbers, billing providers, and servicing providers for all applicable encounter types; and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for pharmacy encounters.

HSAG recommends that **ACNH** focus on two areas to improve its encounter data submissions: percentage of 837P/I files confirmed by the reconciliation files and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for 837P/I encounters.

NHHF

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

HSAG recommends that **NHHF** focus on three areas to improve its encounter data submissions: percentage of 837P files confirmed by the reconciliation files, data accuracy related to the member identification numbers for 837P and pharmacy 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, the accuracy for member identification numbers in its pharmacy encounters, the accuracy for billing and servicing providers for all applicable encounter types, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for its 837I encounters.

HSAG recommends that **WS** focus on three areas to improve its encounter data submissions: percentage of 837P/I files confirmed by the reconciliation files, data accuracy related to the member identification numbers for its 837P/I encounters, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for its 837P and pharmacy encounters.

Comparative Analysis

Health Plan Comparisons

The comparative analysis examined the extent to which encounters submitted by the MCOs and maintained in DHHS' data warehouse (and the data subsequently extracted and submitted by DHHS to HSAG for the study) were complete and accurate when compared to data submitted by the MCOs to HSAG. Throughout the comparative analysis section, values in **red font** indicate rates needing MCOs' attention. In addition, *lower rates indicate better performance for omission and surplus rates while higher rates indicate better performance for accuracy rates*.

Record Completeness

Table 3-29 illustrates the percentage of records present in the files submitted by the MCOs that were not found in DHHS' files (record omission) and the percentage of records present in DHHS' files that were not present in the files submitted by the MCOs (record surplus). The value in the **green shaded** cell indicates a rate that improved from the SFY 2020 EDV study by more than 10 percentage points.

Table 3-29—Record Omission and Surplus Rates by MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
ACNH	10.4%	12.9%	0.7%	19.0%	6.4%	0.3%
NHHF	4.9%	4.6%	6.8%	1.1%	4.6%	0.2%
WS	0.1%	0.3%	0.6%	1.4%	12.1%	4.7%

For **ACNH** and **NHHF**, four rates needed attention. As for **WS**, two pharmacy encounter rates needed attention.

Element Omission and Surplus

Table 3-30 displays the element omission, element surplus, and element missing values results for each key data element from the professional encounters. *For the element omission and surplus indicators, lower rates indicate better performance.* However, for the element missing values indicator, lower or higher rates do not indicate better or poor performance.

Table 3-30—Data Element Omission, Surplus, and Missing by Data Element: Professional Encounters

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Beneficiary ID	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI*	0.0%	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Rendering Provider Number/NPI	0.0%	<0.1%	0.0%	22.6%	40.7%	0.0%	0.0%	0.0%	0.0%
Referring Provider Number/NPI	0.0%	1.4%	<0.1%	9.1%	0.0%	0.0%	60.3%	63.7%	72.0%
Primary Diagnosis Code	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Secondary Diagnosis Code	0.0%	<0.1%	<0.1%	0.0%	13.4%	0.0%	54.4%	54.6%	61.1%
Procedure Code	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Procedure Code Modifier	<0.1%	0.1%	<0.1%	<0.1%	0.1%	0.0%	59.3%	58.4%	61.9%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCO Carrier ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

* NPI = national provider identifier

For **ACNH** and **NHHF**, two rates needed attention. As for **WS**, only one rate needed attention.

Table 3-31 displays the element omission, element surplus, and element missing values results for each key data element from the institutional encounters.

Table 3-31—Data Element Omission, Surplus, and Missing by Data Element: Institutional Encounters

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Beneficiary ID	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Attending Provider Number/NPI	0.0%	<0.1%	7.6%	32.3%	0.0%	0.0%	0.1%	<0.1%	<0.1%
Referring Provider Number/NPI	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%	84.2%	93.3%	85.2%

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Primary Diagnosis Code	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Secondary Diagnosis Code	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	22.0%	21.8%	23.8%
Procedure Code	0.1%	0.3%	0.1%	0.1%	2.2%	0.0%	10.6%	16.7%	11.5%
Procedure Code Modifier	0.1%	0.7%	<0.1%	0.1%	1.1%	0.0%	84.4%	83.3%	82.7%
Primary Surgical Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	98.4%	93.1%	99.4%
Secondary Surgical Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	99.1%	95.8%	99.6%
Revenue Code	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
Diagnosis Related Group (DRG)	2.1%	0.3%	<0.1%	1.7%	0.3%	0.0%	95.1%	89.3%	98.6%
Header Paid Amount	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	14.0%	30.5%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCO Carrier ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

For **ACNH**, **NHHF**, and **WS**, four, two, and three institutional encounter rates needed attention, respectively.

Table 3-32 displays the element omission, element surplus, and element missing values results for each key data element from the pharmacy encounters.

Table 3-32—Data Element Omission, Surplus, and Missing by Data Element: Pharmacy Encounters

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Beneficiary ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%
Prescribing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%
NDC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Drug Quantity	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCO Carrier ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

The element omission and surplus rates as well as the element missing values rates for all MCOs were less than 0.1 percent for pharmacy encounters.

Element Accuracy

Element-level accuracy is limited to those records present in both data sources and with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. Higher data element accuracy rates indicate that the values populated for a data element in DHHS' submitted encounter data are more accurate. As such, for the accuracy indicator, higher rates indicate better performance.

Table 3-33 displays, for each key data element associated with professional encounters, the percentage of records with the same values in both the MCOs' submitted files and DHHS' data warehouse. The value in the **green shaded** cell indicates a rate that improved from the SFY 2020 EDV study by more than 10 percentage points.

Table 3-33—Data Element Percent of Accuracy by MCO: Professional Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	>99.9%
Detail Service From Date	>99.9%	99.9%	>99.9%
Detail Service To Date	>99.9%	99.9%	99.6%
Billing Provider Number/NPI	41.1%	>99.9%	>99.9%
Rendering Provider Number/NPI	99.9%	>99.9%	>99.9%
Referring Provider Number/NPI	100.0%	100.0%	100.0%
Primary Diagnosis Code	100.0%	93.8%	99.9%
Secondary Diagnosis Code	100.0%	93.1%	100.0%
Procedure Code	99.9%	99.2%	>99.9%
Procedure Code Modifier	>99.9%	>99.9%	>99.9%
Header Paid Amount	99.8%	87.7%	>99.9%
Detail Paid Amount	99.8%	98.3%	>99.9%
MCO Carrier ID	100.0%	100.0%	100.0%

While no rates needed **WS**'s attention, **ACNH** and **NHHF** needed to take action for one and three rates, respectively.

Table 3-34 displays, for each key data element associated with institutional encounters, the percentage of records with the same values in both the MCOs' submitted files and DHHS' data warehouse.

Table 3-34—Data Element Percent of Accuracy by MCO: Institutional Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	100.0%	>99.9%
Header Service From Date	100.0%	>99.9%	99.5%
Header Service To Date	100.0%	>99.9%	99.6%
Billing Provider Number/NPI	100.0%	>99.9%	100.0%
Attending Provider Number/NPI	100.0%	100.0%	0.1%
Referring Provider Number/NPI	100.0%	100.0%	100.0%
Primary Diagnosis Code	100.0%	100.0%	100.0%
Secondary Diagnosis Code	100.0%	100.0%	100.0%
Procedure Code	98.4%	91.2%	100.0%
Procedure Code Modifier	99.8%	99.0%	100.0%
Primary Surgical Procedure Code	100.0%	100.0%	100.0%
Secondary Surgical Procedure Code	100.0%	99.9%	100.0%
Revenue Code	98.9%	92.0%	>99.9%
DRG	96.4%	100.0%	99.9%
Header Paid Amount	>99.9%	95.7%	100.0%
Detail Paid Amount	98.1%	88.8%	100.0%
MCO Carrier ID	100.0%	100.0%	100.0%

While no rates needed **ACNH**'s attention, **NHHF** and **WS** needed to take action for three rates and one rate, respectively.

Table 3-35 displays, for each key data element associated with pharmacy encounters, the percentage of records with the same values in both the MCOs' submitted files and DHHS' data warehouse. The value in the **red shaded** cell indicates a rate that decreased from the SFY 2020 EDV study by more than 10 percentage points.

Table 3-35—Data Element Percent of Accuracy by MCO: Pharmacy Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	100.0%

Key Data Element	ACNH	NHHF	WS
Header Service From Date	100.0%	100.0%	96.0%
Billing Provider Number/NPI	100.0%	100.0%	100.0%
Prescribing Provider Number/NPI	>99.9%	>99.9%	100.0%
NDC	>99.9%	99.9%	100.0%
Drug Quantity	>99.9%	99.9%	97.0%
Header Paid Amount	99.7%	68.1%	>99.9%
MCO Carrier ID	100.0%	100.0%	100.0%

For pharmacy encounters, **NHHF** needed to take action for one rate.

Health Plan-Specific Conclusions and Recommendations

ACNH

Among the 162 rates listed in the comparative analysis section, **ACNH** needed to take action for 11 rates.

ACNH should investigate the following findings from the comparative analysis to determine whether the difference between DHHS' data and **ACNH**'s data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy.

- **ACNH** should investigate the root cause(s) for the results in Table 3-36 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-36—Results Needing Action From ACNH

Measure	Claim Type	Data Element	Rate
Record Omission	Professional	NA	10.4%
Record Surplus	Professional	NA	12.9%
Record Surplus	Institutional	NA	19.0%
Record Omission	Pharmacy	NA	6.4%
Element Surplus	Professional	Referring Provider Number/NPI	9.1%
Element Surplus	Institutional	Attending Provider Number/NPI	32.3%
Element Missing	Institutional	Primary Surgical Procedure Code	98.4%
Element Missing	Institutional	DRG	95.1%
Element Omission	Institutional	Detail Paid Amount	14.0%
Element Accuracy	Professional	Billing Provider Number/NPI	41.1%

- **ACNH** should confirm that when the rendering and billing provider numbers were identical, it did not populate the rendering provider numbers in the data extracted for the study.

NHHF

Among the 162 rates listed in the comparative analysis section, **NHHF** needed to take action for 15 rates.

NHHF should investigate the following findings from the comparative analysis to determine whether the difference between DHHS' data and **NHHF**'s data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy.

- **NHHF** should investigate the root cause(s) for the results in Table 3-37 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-37—Results Needing Action From NHHF

Measure	Claim Type	Data Element	Rate
Record Omission	Institutional	NA	6.8%
Record Omission	Pharmacy	NA	4.6%
Element Surplus	Professional	Secondary Diagnosis Code	13.4%
Element Missing	Institutional	Referring Provider Number/NPI	93.3%
Element Omission	Institutional	Detail Paid Amount	30.5%
Element Accuracy	Professional	Primary Diagnosis Code	93.8%
Element Accuracy	Professional	Secondary Diagnosis Code	93.1%
Element Accuracy	Professional	Header Paid Amount	87.7%
Element Accuracy	Institutional	Procedure Code	91.2%
Element Accuracy	Institutional	Revenue Code	92.0%
Element Accuracy	Institutional	Detail Paid Amount	88.8%
Element Accuracy	Pharmacy	Header Paid Amount	68.1%

- To improve the record omission and record surplus results for professional encounters, **NHHF** should ensure that the correct claim numbers and claim line numbers for its vision services are submitted to DHHS.
- **NHHF** should confirm that when the rendering and billing provider numbers were identical, it did not populate the rendering provider numbers in the data extracted for the study.

WS

Among the 162 rates listed in the comparative analysis section, WS needed to take action for seven rates.

WS should investigate the following findings from the comparative analysis to determine whether the difference between DHHS' data and WS's data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy.

- WS should investigate the root cause(s) for the results in Table 3-38 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-38—Results Needing Action From WS

Measure	Claim Type	Data Element	Rate
Record Omission	Pharmacy	NA	12.1%
Record Surplus	Pharmacy	NA	4.7%
Element Missing	Professional	Referring Provider Number/NPI	72.0%
Element Omission	Institutional	Attending Provider Number/NPI	7.6%
Element Missing	Institutional	Primary Surgical Procedure Code	99.4%
Element Missing	Institutional	DRG	98.6%
Element Accuracy	Institutional	Attending Provider Number/NPI	0.1%

Information Systems (IS) Review

During the SFY 2020 EDV study, HSAG conducted an IS review for ACNH. The IS review provided self-reported qualitative information from ACNH regarding encounter data processes. Based on the MCO contract and DHHS' data submission requirements (e.g., companion guides), ACNH has established encounter data submission and oversight processes via formal policy and procedure documents. These documents indicate the following:

- ACNH demonstrated its capacity to collect, process, and transmit to DHHS claims and encounter data meeting established quality specifications except the timely data submission from its dental, NEMT, and vision subcontractors (i.e., subcontractors should submit encounters to ACNH weekly instead of monthly).
- ACNH developed data review and correction processes that can promptly respond to quality issues identified by DHHS.
- ACNH described the role of internal personnel and departments, software systems, and/or external vendors employed for activities such as claims adjudication, provider and beneficiary information verification, and management of TPL information.
- ACNH provided high-level descriptions of the reports and/or data edits used to monitor the accuracy, completeness, and timeliness of data submitted by providers and subcontractors.

Based on the IS review activity, HSAG had the following recommendation for **ACNH**:

- Since DHHS requires that initial encounter data be submitted within 14 calendar days of claim payment, **ACNH** should require its dental, vision, and NEMT subcontractors to submit data to **ACNH** weekly.

Medical Record Review (MRR)

Health Plan Comparisons

During the SFY 2020 EDV study, HSAG evaluated encounter data completeness and accuracy through a review of medical records for physician services rendered between July 1, 2018, and June 30, 2019, for **NHHF** and **WS**. Since this was the first year for the MRR, DHHS will use these results to establish standards for future MRR activities. **ACNH** was not included in the MRR because that MCO did not begin operating in the New Hampshire MCM Program until September 2019.

Table 3-39 shows the medical record procurement status for each MCO, while Table 3-40 highlights the most common reasons medical record documentation was not submitted by each MCO for the 411 sampled beneficiaries.

Table 3-39—Medical Record Procurement Status

MCO	Number of Records Requested	Number of Records Submitted	Percentage of Records Submitted
NHHF	411	349	84.9%
WS	411	366	89.1%

Table 3-40—Reasons Medical Records Not Submitted for Sampled Beneficiaries, by MCO

Non-Submission Reason	NHHF		WS	
	Number	Percent	Number	Percent
Non-responsive provider or provider did not respond in a timely manner.	40	64.5%	33	73.3%
Medical records were not located at the facility.	11	17.7%	3	6.7%
Beneficiary was a patient of the practice; however, no documentation was available for requested dates of service.	5	8.1%	6	13.3%
Other.	3	4.8%	1	2.2%
Beneficiary was not a patient of the practice.	1	1.6%	2	4.4%
Closed facility.	2	3.2%	0	0.0%
Total*	**62**	**100.0%**	**45**	**100.0%**

* The sum of rates from all non-submission reasons may not equal 100 percent due to rounding.

NHHF had an 84.9 percent (349 cases) submission rate, while **WS** had an 89.1 percent (366 cases) submission rate. For both MCOs, the main non-submission reason was non-responsive provider or provider did not respond in a timely manner. Of note, due to the COVID-19 public health emergency, DHHS extended the time frame for the MCOs to procure medical records. However, the pandemic may still have contributed to providers not submitting medical records to HSAG in a timely manner.

Table 3-41 displays the results for each study indicator for the MRR. The symbol "—" indicates that the study indicator is not applicable for a data element. *For medical record omission and encounter data omission rates, lower values indicate better performance.*

Table 3-41—Results for Medical Record Review Study Indicators

	Medical Record Omission		Encounter Data Omission		Element Accuracy	
Key Data Elements	NHHF	WS	NHHF	WS	NHHF	WS
Date of Service	12.3%	8.4%	2.5%	3.7%	—	—
Diagnosis Code	22.2%	14.5%	2.2%	3.9%	98.3%	98.8%
Procedure Code	15.8%	14.9%	3.8%	13.2%	95.3%	93.1%
Procedure Code Modifier	21.7%	21.2%	3.4%	2.4%	99.8%	99.4%
All-Element Accuracy	—	—	—	—	70.6%	62.5%

Medical record omission occurred when an encounter data element was not documented in the medical record associated with a specific encounter. Encounter data omission occurred when an encounter data element was documented in the medical record but not found in the associated encounters. Overall, the medical record omission rates were higher than the encounter data omission rates for all key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) included in the analysis for both MCOs.

NHHF and **WS** had similar rates for medical record omission for the *Procedure Code* and *Procedure Code Modifier* data elements, while the difference between the MCOs' rates was 3.9 percentage points and 7.7 percentage points for the *Date of Service* and *Diagnosis Code* data elements, respectively.

NHHF and **WS** had similar rates for encounter data omission for all data elements except the *Procedure Code*, for which the difference between the MCOs' rates was 9.4 percentage points since the encounter data omission rate for **WS** was relatively high (13.2 percent).

The element accuracy rates for *Procedure Code* were the lowest when compared to the other two key data elements. Both participating MCOs had similar rates for *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier.* The difference between the MCOs for the *All-Element Accuracy* rates came from the medical record omission or encounter data omission.

Health Plan-Specific Conclusions and Recommendations

NHHF

NHHF had a relatively high (i.e., poor performance) medical record omission rate for all key data elements. This trend is consistent relative to the medical record submission rate, wherein an MCO with a relatively low medical record submission rate would generally show a higher medical record omission rate (i.e., poor performance) for each key data element. In contrast, the relatively low (i.e., better performance) encounter data omission rates indicate that the key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) found in the beneficiaries' medical records were well supported by the data found in the electronic data extracted from DHHS' data warehouse. The element accuracy rate for *Procedure Code* was the lowest when compared to *Diagnosis Code* and *Procedure Code Modifier*.

Based on findings from the MRR activity, HSAG recommends that **NHHF** focus on four areas in Table 3-42 to improve its encounter data completeness and accuracy.

Table 3-42—Recommendations From MRR for NHHF

Recommendations
NHHF should investigate the following non-submission reasons listed in Table 3-40 because these sampled dates of service were based on final paid encounters in DHHS' data warehouse. • Beneficiary was a patient of the practice; however, no documentation was available for requested dates of service. • Beneficiary was not a patient of the practice.
NHHF should educate its providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472 based on the "Vaccine Guidelines" in DHHS' Encounter Submission Guidelines document.
NHHF should consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews will then be provided to providers through periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices.

WS

WS had a relatively high medical record omission rate for all key data elements. This trend is consistent relative to the medical record submission rate, where an MCO with a relatively low medical record submission rate would generally show a higher medical record omission rate (i.e., poor performance) for each key data element. In contrast, the relatively low (i.e., better performance) encounter data omission rates indicate that three of the key data elements (i.e., *Date of Service*, *Diagnosis Code*, and *Procedure Code Modifier*) found in the beneficiaries' medical records were well supported by the data found in the electronic data extracted from DHHS' data warehouse. The element accuracy rate for *Procedure Code* was the lowest when compared to *Diagnosis Code* and *Procedure Code Modifier*.

Based on findings from the MRR activity, HSAG recommends that **WS** focus on four areas in Table 3-43 to improve its encounter data completeness and accuracy.

Table 3-43—Recommendations From MRR for WS

Recommendations
WS should investigate the following non-submission reasons listed in Table 3-40 because these sampled dates of service were based on final paid encounters in DHHS' data warehouse. • Beneficiary was a patient of the practice; however, no documentation was available for requested dates of service. • Beneficiary was not a patient of the practice.
While the pandemic due to COVID-19 may have prevented providers from submitting medical records to HSAG in a timely manner, **WS** should review the remaining non-submission reasons and brainstorm ideas to improve its medical record submission rates for future MRR activities.
WS should investigate the relatively high encounter data omission rate for the data element *Procedure Code* and implement any changes as needed.
WS should educate its providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472 based on the "Vaccine Guidelines" in DHHS' Encounter Submission Guidelines document.

For additional information concerning HSAG's methodology for EDV, see Appendix B Methodologies for Conducting EQR Activities, page B-27.

Other EQR Activities

Semi-Structured Qualitative Interviews

Fall Semi-Structured Interviews

DHHS requested an independent qualitative study of women ages 50 or older who were Medicaid MCM program beneficiaries at the time of sampling. Between October 13, 2020, and November 9, 2020, Horn Research[3-21] interviewed 30 members using four points of inquiry: Experience with Their MCO, Quality of Care, Preventive Screenings, and Access to Care.

Most participants reported that they understood their health plan well enough to effectively participate in their healthcare. Participants were most appreciative of the coverage afforded through their health plan and were most concerned about denials of treatments or tests, prior authorization delays, the lack of dental coverage, and difficulty with the transportation process. The vast majority of participants said

[3-21] Horn Research is a contractor of Health Services Advisory Group, which is New Hampshire's EQRO.

they were unaware of the complaint process available through their MCO. Those who had used it found the appeal and complaint processes cumbersome and ineffective.

The vast majority of participants said they had a good relationship with their provider. The key concerns identified by participants were a lack of availability and a lack of knowledge around mental health issues. Participants generally reported they had received, or planned to get, the vaccines recommended by their doctor. Overall, participants reported that their physician had not provided any suggestions to support them either before trying, or while taking, their medications. Nearly all participants said they were up to date on all relevant cancer screenings. The majority of participants said their providers had asked preventive health screening questions, and when needed, had offered suggestions to address tobacco cessation, diet and nutrition, and mental health.

Generally, participants were satisfied with their access to medications, therapies, and medical supplies and equipment. Participants reported varying experiences with transportation services, with challenges including unreliable pick-ups, aggressive driving, and a process that is difficult to navigate. Telehealth appointments generally were well received by participants.

Recommendations from the report include items that could improve ***access to care***, ***timeliness of care***, and ***quality of care***:

- *Review Prior Authorization Internal Operations*—Each MCO should review internal operations related to comments found in the report concerning issues with prior authorizations to determine if there are unnecessary barriers that delay or restrict care.
- *Refine Messaging Concerning Colonoscopy Screening*—Offering information about the procedure to reduce anxiety due to lack of knowledge may improve willingness to be screened.
- *Improve Transportation Service*—Greater oversight of these companies' practices as well as more efficient complaint processes may improve the transportation experience for particularly vulnerable populations.
- *Consider an Opt-in Hard-Copy Member Handbook*—The shift to online versions of the handbook can be burdensome to low-income and older beneficiaries, but universal provision of bulky handbooks is costly. Offering beneficiaries the chance to opt-in to receiving a hard-copy handbook may address this communication gap.
- *Continue Offering Telehealth Post-Pandemic*—Continuing to offer these options post-pandemic may improve beneficiaries' experiences while addressing some transportation issues.

Spring Semi-Structured Qualitative Study

DHHS requested an independent qualitative study of MCM program beneficiaries who had been diagnosed with either Type 1 or Type 2 diabetes. Between March 15, 2021, and April 5, 2021, Horn Research[3-22] interviewed 30 members, including four members who had both diabetes and a developmental disability. The study used four points of inquiry: Description of Participants, Access to

[3-22] Horn Research is a contractor of Health Services Advisory Group, which is NH's External Quality Review Organization.

Information and Services, Diabetes Self-Management Education and Support Programs, and Diabetes Care and Self-Management Skills.

Most participants reported well or adequately controlled glucose levels and recent HbA1c testing. Overall, participants said they had not faced challenges in getting answers to their questions about diabetes or medications and favor one-on-one interactions. Participants who received case management support from their MCO were enthusiastic about the service and had better HbA1c results than those who had not. A handful of participants reported challenges in accessing medications due to delays at their pharmacy, issues with prior authorization, and/or issues with transportation. The most significant problem described by participants was not receiving sufficient numbers of test strips and lancets to adequately cover their glucose testing needs.

A minority of participants said they had taken a class to learn how to manage their diabetes, but the bulk of these participants felt the class was helpful and gave them new information. Reasons for not attending a class included not needing the information; a lack of interest; a lack of awareness of, or availability of, classes; mental or emotional inability to attend; a lack of transportation; fear of COVID-19; or a lack of time. Participants universally reported receiving blood pressure testing, and nearly all said they had annual cholesterol and triglyceride testing. An annual retinal eye exam was reported by most, but not all, participants. Nearly all participants were suffering from at least one other physical health condition besides their diabetes, and most reported having what they needed to manage those conditions. Just over half of participants said they had experienced mental health issues in the past 30 days, a third of whom said they were not doing anything to address those difficulties. A third of participants said their diabetes was relevant to their mental health issues, both in terms of the disease causing stress and mental health issues affecting their diabetes.

Participants were most likely to say that the difficulties they faced in managing their disabilities were internal challenges, rather than external. Participants said managing their diet, following their diabetes regimen, and exercising were the most difficult challenges. Participants most frequently said having the willpower to make good food choices and the high cost of healthy foods made maintaining a healthy diet difficult. They also said a lack of motivation, cold weather, COVID-19, physical health limitations, and time limitations made it difficult to exercise.

Recommendations from the report include items that could improve ***access to care*** and ***quality of care***:

- *Case management for people recently diagnosed with diabetes*—Participants who reported access to a case manager through their MCO were more likely to report well-controlled blood glucose levels than those who did not have a case manager. This information suggests it is a helpful tool in diabetes self-management, particularly soon after diagnosis.
- *Diabetes self-management education and support*—A majority of participants did not attend diabetes self-management education classes because they did not perceive the need, did not know classes were available, or were not offered the opportunity to attend. Diabetes self-management classes that are tailored to involve families/caregivers provide new information concerning the lifespan of the disease and should be made available to all MCM program members with diabetes. The classes need to be available at flexible times and should offer one-on-one support to the members. Support for

mental health should also be included in these efforts to address the stressors associated with diabetes and the impact of mental health issues on diabetes self-management.

- *Provide prevention services to those at high risk*—Participants wish they had knowledge to prevent the development of diabetes, and many are interested in supports to lose weight and becoming more physically active. Providing prevention services to those at high risk for developing diabetes or with poor glucose control, including programming tailored to those with mobility limitations, may serve to reduce overall disease impact.
- *Research into encouraging healthy behaviors*—Motivation and willpower were identified as key challenges in diabetes self-management. Interventions to encourage, or incentivize, healthy behaviors and outcomes, such as attendance at diabetes self-management classes, weight loss, and lowered A1c levels, should be explored to address those motivation challenges.
- *Ensure people have sufficient test strips and lancets*—A streamlined process which allows members access to test strips and lancets in order to refine their diet in accordance with their providers' testing recommendations may improve blood glucose level monitoring and outcomes. This process could include revising limits on test strips, reducing approval wait times, and ensuring beneficiaries understand their transportation benefit includes transportation to the pharmacy.
- *Support to access healthy foods*—Participants frequently mentioned not being able to afford healthy food as a barrier to healthy eating. Interventions which provide, or link people to, fresh produce and other healthy foods could have a positive effect on diabetes self-management for Medicaid beneficiaries. MCOs could provide programs directly or partner with other providers to do so.

For additional information concerning HSAG's methodology for conducting semi-structured member interviews, see Appendix B Methodologies for Conducting EQR Activities, page B-41.

Secret Shopper Survey

During SFY 2021, HSAG completed study development and survey preparation activities for the administration of a telephone survey to assess provider information data accuracy and appointment availability among physical health specialty provider locations contracted with one or more Medicaid MCOs as of December 15, 2020. DHHS approved the study methodology, customized survey script, and study materials for HSAG's use in requesting the MCOs' provider data. Additionally, HSAG and DHHS identified the eligible survey population and finalized a sampling plan.

When DHHS approved the original timeline for the SFY 2021 Specialty Provider Survey in November 2020, HSAG was scheduled to field the survey calls beginning in February 2021. However, due to the continuing impact of the COVID-19 public health emergency on providers' office operations, DHHS and HSAG agreed to delay fielding the survey until later in 2021. As a result of this delay, the Specialty Provider Survey calls will occur during November 2021, and findings will be included in the SFY 2022 technical report. Findings from the report may include items that could improve ***access to care*** and ***timeliness of care***.

For additional information concerning HSAG's methodology for conducting a secret shopper survey, see Appendix B Methodologies for Conducting EQR Activities, page B-43.

Provider Satisfaction Survey

DHHS contracted with HSAG to administer a provider satisfaction survey in SFY 2020 to PCPs and specialists providing services to at least one of New Hampshire's MCOs (i.e., **ACNH**, **NHHF**, or **WS**). HSAG and DHHS developed a survey instrument designed to gain PCPs' and specialists' insight into the MCOs' performance and potential areas of performance improvement. Providers completed the surveys from August to December 2020. Due to the demands of the COVID-19 patients and reduced staffing at the providers' offices, surveys were not returned by providers as expected. HSAG extended the survey field and emailed and called providers to attempt to obtain more completed surveys; however, due to COVID-19, HSAG's added efforts were unable to boost response rates. The final aggregate response rate to the survey was extremely low (i.e., 3.5 percent). Due to the low response rate, HSAG was unable to generate results from the survey; therefore, provider satisfaction survey results cannot be included in this SFY 2021 technical report.

For additional information concerning HSAG's methodology for conducting the provider satisfaction survey, see Appendix B Methodologies for Conducting EQR Activities, page B-44.

4. Summary of Strengths and Opportunities for Improvement Concerning Quality, Timeliness of Care, and Access to Care Furnished for Each MCO

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.[4-1]

- ***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."[4-2] 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).[4-3]

The CFR also requires that the EQR results include a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed and conclusions were drawn as to the ***quality of care***, ***timeliness of care***, and ***access to care*** furnished by the MCO, PIHP, PAHP, or

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4-1 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: Nov 8, 2021.

4-2 NCQA. *2017 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2017: UM5.

4-3 U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 8, 2021.

PCCM entity in §438.364(a)(1).[4-4] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the ***quality of care***, ***timeliness of care***, and ***access to care*** furnished by each MCO.

First, HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain—***quality***, ***timeliness***, and ***access***—related to the care and services furnished by the MCO for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall ***quality of care***, ***timeliness of care***, and ***access to care*** and services furnished by the MCO. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the ***quality of care***, ***timeliness of care***, and ***access to care*** for the program.

The following sections of this report include the strengths and opportunities for improvement and provide an assessment and evaluation of the ***quality of care***, ***timeliness of care***, and ***access to care*** for each MCO by task. That information is followed by a section that identifies common themes and patterns that emerged across the EQR activities for the MCO and includes the aggregated strengths and weaknesses that affect ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM Program members.

[4-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Nov 8, 2021.

AmeriHealth Caritas New Hampshire

MCO Contractual Compliance

This was the second year that **ACNH** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 99.0 percent on the review. Of the six standards reviewed that included 193 applicable elements, **ACNH** achieved a 100 percent score in Care Management/Care Coordination, Quality Management, and TPL. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid MCM beneficiaries.

ACNH demonstrated strengths in Care Management/Care Coordination by generating a monthly report to identify members with high needs/high risks and ensuring that staff members contacted those members to determine if they would benefit from care management services. **ACNH** convened a care team consisting of an interdisciplinary team to discuss barriers to care and strategies to address those barriers. Team members included the medical director and representatives from care management, BH, SUD, pharmacy, utilization review, and population health. Ensuring that members receive care management services from multidisciplinary team members will assist in ensuring that the New Hampshire MCM Program members improve their ***access to care*** and ***quality of care***.

ACNH demonstrated strengths in Quality Management by ensuring that the quality committee adopted clinical practice guidelines (CPGs) from the American Society of Addiction Medicine (ASAM), the U.S. Preventive Services Task Force, American Academy of Pediatrics' (AAP's) Bright Futures, and Zero Suicide Consensus Guide for Emergency Departments. The Member Handbook and the Provider Manual addressed the dissemination of CPGs to providers, and upon request to members and potential members. The MCO also conducted a comprehensive medication review and counseling to any member upon request. Ensuring that practitioners follow nationally recognized CPGs will assist the New Hampshire MCM Program members in improving their ***quality of care***.

ACNH also demonstrated strengths by complying with requirements in the TPL Standard. Plan documents and staff interviews confirmed the implementation of TPL claims processing and handling of the recovery of applicable funds. The NH TPL Overpayments Resulting in Member Refunds process flowchart correctly illustrated the process used to ensure that **ACNH** returned appropriate overpayments to the member.

ACNH scored *Partially Met* in four elements from the Member Enrollment/Disenrollment, Member Services, and UM standards. Those elements represent an opportunity for improvement to ensure compliance with federal and State requirements in ***timeliness of care*** and ***access to care*** for the New Hampshire Medicaid beneficiaries.

To improve the Member Enrollment/Disenrollment requirements, **ACNH** must ensure that the notification of disenrollment rights is sent to members annually at least 60 calendar days before the start of the re-enrollment period. The Member Services Standard also requires **ACNH** to send a letter to members upon initial enrollment, and anytime the member requests a new PCP, confirming the

member's PCP and providing the PCP's name, address, and telephone number. HSAG did not find evidence of compliance with this requirement during the review. Sending PCP information to the New Hampshire MCM Program members will assist in ensuring that members have ***access to care***.

Improvements required in the UM Standard included ensuring that **ACNH** provides notice for denied authorization requests as expeditiously as the enrollee's condition requires and within state-established time frames that may not exceed 14 calendar days following receipt of the request for service. **ACNH** also must ensure that members receive written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Receiving timely notification of prior authorization decisions to deny a request may improve ***timeliness of care*** by alerting providers to send additional documentation for consideration or request alternative treatments and services that may be approved by the MCO.

After finalization of the SFY 2021 Compliance Review Report in August 2021, **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* during the compliance review. **ACNH** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2021 compliance review. HSAG will include a review of the SFY 2021 Compliance Review CAP items during the SFY 2022 compliance audit.

PIPs

ACNH collaborated with DHHS and the other two MCOs to select the topics for the two PIPs that were 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 2021, **ACNH** demonstrated the following strengths that positively impacted the ***quality of care*** and ***access to care***:

- Used QI science tools to identify and prioritize opportunities for improvement within current processes.
- Determined targeted interventions to test and developed sound intervention effectiveness measures.

- Began testing interventions using thoughtful and incremental Plan-Do-Study-Act (PDSA) cycles and making data-driven decisions based on testing results.

During SFY 2021, HSAG made the following recommendations to improve the ***quality of care*** and ***access to care*** for **ACNH** members as the MCO continues through the PIP process:

- **ACNH** should consider shorter testing periods and ensure timely, ongoing data collection and analyses of effectiveness data for each intervention. The testing methodology should allow **ACNH** to quickly gather data and make data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal.
- **ACNH** should revisit its key driver diagram and identified failure modes in the FMEA table to determine new member and provider-focused interventions to test through the extended SMART Aim end date of June 30, 2022. This will increase the likelihood of achieving the SMART Aim goal and desired outcomes for the projects.
- **ACNH** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found all 14 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors recommended that **ACNH**:

- Conduct internal audits of the INPASC.04 measure to ensure ongoing compliance with the measure specifications.
- Deploy a robust testing plan for future new measures or revisions to existing measures, which should include PSV of measure-level detailed data in alignment with the source systems. **ACNH** should conduct additional reviews of its performance measure detailed data in comparison to the DHHS performance measure specifications to ensure all source code has resulted in appropriate identification of claims, members, and other relevant performance measure information. Continuing to improve performance measure results will improve the ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM Program members.

NAV

ACNH fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory.

As a strength, HSAG's reviewers identified the sampled provider's name and location listed in **ACNH**'s submitted provider data in the online provider directory for 96.4 percent of the reviews (i.e., 267 out of 277 randomly sampled directory review cases). However, case-level results matched between **ACNH**'s

provider data and online directory profiles for less than 90 percent of sampled cases for the following indicators:

- Providers Found in Directory for DME Suppliers (80.0 percent)
- Provider Accommodates Physical Disabilities (89.1 percent)
- Non-English Language Speaking Provider (including American Sign Language) (8.6 percent)
- Provider Board Certification, if applicable for PCPs and BH Providers (33.1 percent)
- Provider URL (0.0 percent)

HSAG recommends that ACNH uses a variety of strategies to improve the accuracy of its provider data, including outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports. The findings related to this recommendation suggest that **ACNH** members may have challenges with ***access to care*** when attempting to identify a healthcare provider with specific characteristics (e.g., speaks a primary language other than English).

CAHPS

None of the 2021 measure rates representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains for **ACNH**'s adult and child Medicaid populations were statistically significantly higher or lower than the 2020 NCQA adult and child Medicaid national averages.

To improve CAHPS rates, **ACNH** could consider involving MCO staff members at every level to assist in improving ***quality of care***, ***timeliness of care***, and ***access to care***. **ACNH** also could implement a standardized onboarding process to educate new members about CAHPS measures in all departments.

To improve CAHPS rates related to ***quality of care***, **ACNH** could consider focusing on improving provider-patient communications through provider bulletins or trainings. 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. **ACNH** 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. To properly handle customer complaints, **ACNH** 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. Additionally, **ACNH** could 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 whether members are getting the help they need and identify potential areas for customer service improvement.

To improve CAHPS rates related to ***timeliness of care***, **ACNH** 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.

To improve CAHPS rates related to ***timeliness of care*** and ***access to care***, **ACNH** could encourage providers to expand their website to include health information, tools, and links to various types of information. Additionally, **ACNH** 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 **ACNH** and its members. **ACNH** could continuously monitor provider appointment accessibility, after-hours accessibility, and telephone accessibility. An evaluation of current **ACNH** call center hours and practices can be conducted to determine if the hours and resources meet members' needs.

HEDIS

Table 4-1 displays the rates achieved by **ACNH** and the comparison to national benchmarks that are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019.

Table 4-1—Summary of ACNH's Scores for MY 2020 HEDIS Measures With National Benchmarks

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	0	1	0	1	11	**13**
Acute and Chronic Care	1	3	2	3	2	**11**
Behavioral Health	8	2	1	1	0	**12**
All Domains	**9**	**6**	**3**	**5**	**13**	**36**
Percentage	**25.00%**	**16.67%**	**8.33%**	**13.89%**	**36.11%**	**100%**

ACNH's rates ranked at or above the 50th percentile for 18 measures (50.00 percent), with nine of these measures (25.00 percent) meeting or exceeding the 90th percentile. The rates for 18 measures (50.00 percent) fell below the 50th percentile.

This was the first year **ACNH** administered the HEDIS survey for its members in the New Hampshire MCM Program. HSAG organized, aggregated, and analyzed the validated HEDIS data to draw conclusions about **ACNH**'s performance in providing quality, accessible, and timely care to its members.

ACNH demonstrated strength for measures related to ***quality of care***, meeting or exceeding the 50th percentile for 16 of the 33 (48.48 percent) measure indicators 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):

- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—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**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

ACNH has opportunities for improvement related to ***quality of care***, with **ACNH**'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)—BMI Percentile—Total†, Counseling for Nutrition—Total†, and Counseling for Physical Activity—Total†*
- *Childhood Immunization Status (CIS)—Combination 2†(DTaP, IPV, MMR, HIB, HepB, VZV)* and *Combination 10† (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)*
- *Cervical Cancer Screening (CCS) †*
- *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*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator†*

- *Comprehensive Diabetes Care (CDC)—HbA1c Testing, HbA1c Poor Control (>9.0%),* and *HbA1c Control (<8.0%)*
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total†*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

To improve ***quality of care***, **ACNH** should educate members to understand the importance of receiving preventive care and remind providers to review preventive care measures for every patient at every visit to ensure that members receive timely preventive health screenings. **ACNH** also could continuously inform members through member newsletters about the importance of timely prenatal and postpartum care. Adopting CPGs for COPD and diabetes and disseminating those guidelines to all PCPs and specialists treating those diseases will positively impact the *Pharmacotherapy Management of COPD Exacerbation (PCE)* and *Comprehensive Diabetes Care (CDC)* measures.

ACNH demonstrated strength in measures related to ***timeliness of care***, meeting or exceeding the 50th percentile for nine of the 12 (75.00 percent) measures indicators 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):

- *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 Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total** and *Initiation of AOD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care†* and *Postpartum Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator†*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

To improve ***timeliness of care***, **ACNH** should continuously inform members through member newsletters about the importance of timely prenatal and postpartum care and the benefits of those visits to moms and babies. Adopting CPGs for COPD and disseminating those guidelines to all PCPs and pulmonologists will positively impact the *Pharmacotherapy Management of COPD Exacerbation (PCE)* measure.

ACNH demonstrated strength in measures related to ***access to care***, meeting or exceeding the 50th percentile for six of the 10 (60.00 percent) measure indicators 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):

- *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**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

ACNH has opportunities for improvement related to ***access to care***, with **ACNH**'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*†
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*† and *Postpartum Care*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

To improve ***access to care***, **ACNH** could consider focusing efforts on ensuring that adults have access to preventive and ambulatory health services. Encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits also could improve members' ***access to care***. Once again, the timeliness of prenatal and postpartum care needs to be improved since it is evident that these indicators affect overall ***quality of care***, ***timeliness of care***, and ***access to care***. **ACNH** also could include information in provider newsletters and perform targeted provider mailings concerning the importance of diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.

EDV

ACNH demonstrated strength by meeting the standard for the X12 EDI compliance edits; the accuracy for member identification numbers, billing providers, and servicing providers for all applicable encounter types; and the timely initial encounter data submissions to DHHS within 14 days of the claim payment date for pharmacy encounters. While **ACNH** improved its rates, **ACNH** should continue to work to improve the percentage of 837P/I files confirmed by the reconciliation files. Developing an automatic process for preparing and submitting reconciliation files according to a fixed schedule may be helpful to improve these results. Although **ACNH**'s rates were slightly below the standard, **ACNH** should continue to work to improve its timely data submissions to DHHS so that **ACNH** can meet the corresponding standards. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may positively impact the ***timeliness*** issues. Determining ***access to care*** and health outcomes that represent ***quality of care*** could be challenging if **ACNH** does not submit accurate and timely encounter data to DHHS.

While **ACNH** had addressed the issue identified from the IS review activity, it has 11 rates to investigate from the comparative analysis results so that DHHS and **ACNH** can determine whether the difference between DHHS' data and **ACNH**'s data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy. A thorough investigation of example encounters with completeness and accuracy concerns may be helpful in revealing the root cause of the issues. Without complete and accurate encounter data in DHHS' data warehouse, it could be difficult to monitor and improve ***quality of care*** and ***access to care***.

ACNH Aggregated Conclusions Concerning Strengths and Weaknesses in the Domains of Access to Care, Timeliness of Care, and Quality of Care

Table 4-2—Conclusions Regarding ACNH's Strengths in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓	✓		**ACNH** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*, and the PIP activities positively impacted the HEDIS rate by achieving a percentile ranking for this measure that met or exceeded the 90th percentile.
✓	✓	✓	**ACNH** met the requirements for two performance measures included in the PMV activity: CLAIM.11—*Professional and Facility Medical Claim Processing Results* and CLAIM.24—*Timely Processing of All Clean Provider Claims: Ninety Days of Receipt*. These measures demonstrated correct and timely processing of professional and facility medical claims, and the findings correlate with the very high percentage scores achieved by **ACNH** in the EDV review of ongoing encounter data quality reports.
✓	✓		Another measure showing strong performance for **ACNH** during the PMV activity, SUD.25—*Continuity of Pharmacotherapy for Opioid Use Disorder*, could include members eligible to be included in the HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*. As previously noted, **ACNH** achieved a percentile ranking for this measure that met or exceeded the 90th percentile.
	✓	✓	**ACNH** demonstrated strength in the Care Management/Care Coordination standard during the compliance review by generating a monthly report to identify members with high needs/high risks and ensuring that staff members contacted those members to determine if they would benefit from care management services. **ACNH** convened a care team consisting of an interdisciplinary team to discuss barriers to care and strategies to address those barriers. Team members included the medical director and representatives from care management, BH, SUD, pharmacy, utilization review, and population health. Receiving care management services from multidisciplinary teams assists members in ensuring that the New Hampshire MCM Program members improve their ***access to care*** and ***timeliness of care***. Those efforts were evident in the BH HEDIS measures that achieved scores equal to or greater than the

Quality	Access	Timeliness	Strengths
			90th percentile: *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;* and *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Table 4-3—Conclusions Regarding ACNH's Weaknesses in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Weaknesses
✓	✓		**ACNH** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD)*; however, the measure scored below the 50th percentile. **Recommendation: ACNH** needs to continue to focus on this PIP topic to successfully complete PIP validation and to increase the score for the HEDIS measure.
✓	✓	✓	**ACNH** scored below the 25th percentile for the following preventive care HEDIS measures: *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; Cervical Cancer Screening (CCS); Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*. Related to this, the compliance review activity identified two CPGs available to **ACNH**'s providers that could directly affect rates for these measures: *Recommendations for Preventive Pediatric Health Care* and *Preventive Screenings/Care Recommendations: U.S. Preventive Services Task Force A and B Recommendations*. **Recommendation:** To verify providers have the necessary information to provide preventive services and screenings and improve related HEDIS scores, **ACNH** should consider redistributing CPGs to all PCPs and pediatricians with a reminder of the importance of ensuring that members receive appropriate preventive health screenings during every office visit.
	✓	✓	The PDV activity conducted during the NAV task revealed that **ACNH** did not meet the standard in five of the measures reviewed in the automated provider directory: listing DME supplies, indicating the offices that can accommodate members with physical disabilities, identifying the non-English language speaking providers, noting if PCPs and BH providers were board certified, and including the provider's URL. The HEDIS measure scoring below the 25th percentile, *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total* and the CAHPS measures, *Getting Needed Care* and *Getting Care Quickly*, will be positively impacted by including correct and complete information in the provider directory. Incomplete information in the automated provider directory could affect a member's choice of providers.

Quality	Access	Timeliness	Weaknesses
			Recommendation: **ACNH** should ensure that its provider directory is accurate and complete to inform members about available providers and services.

New Hampshire Healthy Families

MCO Contractual Compliance

This was the eighth year that **NHHF** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 99.5 percent on the review. Of the six standards reviewed that included 193 applicable elements, **NHHF** achieved a 100 percent score in Care Management/Care Coordination, Member Enrollment/Disenrollment, UM, Quality Management, and TPL. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM Program beneficiaries.

NHHF demonstrated strength in the Care Management/Care Coordination Standard by identifying priority populations with high risks/high needs to ensure that they receive assistance from a care manager if needed. **NHHF** ensures coordination between a member's participating providers and determines if the member needs assistance with the social determinants of health (SDoH). The MCO also manages transitions of care for all members moving from one clinical setting to another to unplanned or unnecessary readmissions, ED visits, or adverse health outcomes. Ensuring that members receive care management services and assistance with transitions of care will assist in ensuring that the New Hampshire MCM Program beneficiaries improve their ***timeliness of care***, ***access to care***, and ***quality of care***.

NHHF demonstrated strength in Member Enrollment/Disenrollment by permitting members to choose a PCP to the extent possible and in instances wherein the member does not select a PCP at the time of enrollment, assigning a PCP to that member. Ensuring that each member has a PCP will assist in ensuring that members have ***access to care***.

Strengths in the UM Standard included having all the required policies and procedures related to the authorization of services, using appropriately licensed clinicians to make UM decisions, basing authorizations on a comprehensive and individualized needs assessment that addresses all needs including SDoH and a person-centered planning process, applying consistent application of review criteria, and appropriately notifying members of a denied authorization request. Timely prior authorization decisions will assist members in improving ***timeliness of care*** and ***access to care***.

NHHF demonstrated strength in the Quality Management Standard by adopting CPGs from the ASAM, the U.S. Preventive Services Task Force, AAP's Bright Futures, and Zero Suicide Consensus Guide for Emergency Departments as required by DHHS. **NHHF** also maintained written policies and procedures concerning advance directives for adult members and educated staff members concerning the policies

and procedures related to advance directives. The MCO also conducted a comprehensive medication review and provided counseling to any member upon request. Continuing to ensure that practitioners follow nationally recognized CPGs and providing medication reviews and counseling will assist in improving the ***quality of care*** received by New Hampshire MCM Program beneficiaries.

NHHF also met all requirements in the TPL Standard by making every reasonable effort to determine if a liable third party should pay for services rendered to New Hampshire MCM Program beneficiaries. Recovered funds were used to offset the claims paid by Medicaid, and **NHHF** sent amounts left after paying the member's outstanding claims to the member as required by DHHS.

NHHF scored *Partially Met* in two elements from the Member Services standard. Those elements represent an opportunity for improvement to ensure compliance with federal and State requirements in ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire Medicaid beneficiaries. To improve the Member Services requirements, **NHHF** must inform members in the Welcome Packet of their right to receive a printed version of the provider directory upon request and ensure that member identification cards included information about how to file an appeal. Providing all required information in the new member Welcome Packets will improve ***access to care*** for those members.

After finalization of the SFY 2021 Compliance Review Report in July 2021, **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* during the compliance review. **NHHF** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2021 compliance review. HSAG will include a review of the SFY 2021 Compliance Review CAP items during the SFY 2022 compliance audit.

PIPs

As stated earlier, **NHHF** collaborated with DHHS and the other MCOs to select the topics for the two PIPs that were initiated in SFY 2020. During SFY 2021, 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. **NHHF** demonstrated the following strengths that positively impacted the ***quality of care*** and ***access to care***:

- Used QI science tools to identify and prioritize opportunities for improvement within current processes.
- Determined targeted interventions to test and developed sound intervention effectiveness measures.
- Began testing interventions using thoughtful and incremental PDSA cycles and making data-driven decisions based on testing results.

During SFY 2021, HSAG made the following recommendations to **NHHF** as it continues through the PIP process to improve ***quality of care*** and ***access to care***:

- **NHHF** should consider shorter testing periods and ensure timely, ongoing data collection and analyses of effectiveness data for each intervention. The testing methodology should allow **NHHF** to quickly gather data and make data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal.
- **NHHF** should revisit its key driver diagram and identified failure modes in the FMEA table to determine new member and provider-focused interventions to test through the extended SMART Aim end date of June 30, 2022. This will increase the likelihood of achieving the SMART Aim goal and desired outcomes for the projects.
- **NHHF** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found all 14 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.

NAV

NHHF fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory.

HSAG's reviewers identified the sampled provider's name and location listed in **NHHF**'s submitted provider data in the online provider directory for 82.9 percent of the reviews (i.e., 237 out of 286 randomly sampled directory review cases). Additionally, case-level results matched between **NHHF**'s provider data and online directory profiles for less than 90 percent of sampled cases for the following indicators:

- Providers Found in Directory for PCPs (81.0 percent)

- Providers Found in Directory for BH Providers (84.5 percent)
- Provider Telephone Number (81.9 percent)
- Provider Type/Specialty (89.5 percent)
- Provider Accommodates Physical Disabilities (26.2 percent)
- Provider Completed Cultural Competency Training (70.0 percent)
- Non-English Language Speaking Provider (including American Sign Language) (73.8 percent)
- Provider URL (0.0 percent)

HSAG recommends that **NHHF** use a variety of strategies to improve the accuracy of its provider data, including outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports. The findings related to this recommendation suggest that New Hampshire Medicaid beneficiaries may have challenges with ***access to care*** when attempting to identify a healthcare provider with specific characteristics (e.g., able to accommodate beneficiaries with physical disabilities).

CAHPS

For one 2021 adult Medicaid population measure and one child Medicaid population measure, the rate was statistically significantly higher than the 2020 NCQA adult and child Medicaid national average. These measures represent responses related to ***quality of care*** and ***access to care*** (i.e., *How Well Doctors Communicate* and *Getting Needed Care*). The remaining seven 2021 adult and 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 2020 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***, ***timeliness of care***, and ***access to care***. **NHHF** could implement a standardized onboarding process to educate new employees about CAHPS measures in all departments. To improve CAHPS rates related to ***quality of care***, **NHHF** could consider focusing on improving provider-patient communications through provider bulletins or trainings. 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. **NHHF** 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. To properly handle customer complaints, **NHHF** 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. Additionally, **NHHF** could 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 whether members are getting the help they need and identify potential areas for customer service improvement.

To improve CAHPS rates related to ***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.

To improve CAHPS rates related to ***timeliness of care*** and ***access to care***, **NHHF** could encourage providers to expand their website to include health information, tools, and links to various types of information. 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 **NHHF** and its members. **NHHF** could continuously monitor provider appointment accessibility, after-hours accessibility, and telephone accessibility. An evaluation of current **NHHF** call center hours and practices can be conducted to determine if the hours and resources meet members' needs.

HEDIS

Table 4-4 displays the rates achieved by **NHHF** and the comparison to national benchmarks that are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019.

Table 4-4—Summary of NHHF's Scores for MY 2020 HEDIS Measures With National Benchmarks

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	0	3	0	9	4	**16**
Acute and Chronic Care	2	2	2	5	1	**12**
Behavioral Health	8	5	1	3	2	**19**
All Domains	**10**	**10**	**3**	**17**	**7**	**47**
Percentage	**21.28%**	**21.28%**	**6.38%**	**36.17%**	**14.89%**	**100%**

NHHF's rates ranked at or above the 50th percentile for 23 measures (48.94 percent), with 10 of these measures (21.28 percent) meeting or exceeding the 90th percentile. The rates for 24 measures (51.06 percent) fell below the 50th percentile.

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

NHHF demonstrated strength for measure indicators related to ***quality of care***, meeting or exceeding the 50th percentile for 21 of the 44 (47.73 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):

- *Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)* and Combination *10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- *Appropriate Testing for Children with Pharyngitis (CWP)*
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *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)**
- *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)—Initiation of AOD Treatment—Total** and *Engagement of AOD Treatment—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—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:

- *Breast Cancer Screening (BCS)*
- *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*

- *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†*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care†* and *Postpartum Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing†, HbA1c Poor Control (>9.0%),* and *HbA1c Control (<8.0%)*
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*
- *Asthma Medication Ratio (AMR)—Total*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) †*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) †*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total*

To improve ***quality of care***, **NHHF** should educate members to understand the importance of receiving preventive care and remind providers to review preventive care measures for every patient at every visit to ensure that members receive timely preventive health screenings. **NHHF** also could continuously inform members through member newsletters about the importance of timely prenatal and postpartum care. Adopting CPGs for COPD and diabetes and disseminating those guidelines to all PCPs and specialists treating those diseases will positively impact the *Pharmacotherapy Management of COPD Exacerbation (PCE)* and *Comprehensive Diabetes Care (CDC)* measures. **NHHF** also could furnish information in provider newsletters and perform targeted provider mailings concerning asthma medications and the importance of metabolic monitoring for children and adolescents on antipsychotics.

NHHF demonstrated strength in measure indicators related to ***timeliness of care***, meeting or exceeding the 50th percentile for 11 of the 16 (68.75 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):

- *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** and *Continuation and Maintenance Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total** and *Engagement of AOD Treatment—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total**

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*† and *Postpartum Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*†
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*†

To improve ***timeliness of care***, **NHHF** should continuously inform members through member newsletters about the importance of timely prenatal and postpartum care and the benefits to both moms and babies. Adopting CPGs for COPD and disseminating those guidelines to all PCPs and pulmonologists will positively impact the *Pharmacotherapy Management of COPD Exacerbation (PCE)* measure.

NHHF demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for eight of the 13 (61.50 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):

- *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** and *Continuation and Maintenance Phase*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total** and *Engagement of AOD Treatment—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

NHHF has opportunities for improvement related to ***access to care***, with **NHHF**'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*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*† and *Postpartum Care*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* †
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)* †

To improve ***access to care***, **NHHF** could consider focusing efforts on ensuring that adults have access to preventive and ambulatory health services. Encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits also could improve members' ***access to care***. Once again, the timeliness of prenatal and postpartum care needs to be improved since it is evident that these indicators affect overall ***quality of care***, ***timeliness of care***, and ***access to care***. **NHHF** also could furnish information in provider newsletters and perform targeted provider mailings concerning the importance of diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications and diabetes monitoring for people with diabetes and schizophrenia.

EDV

NHHF met the standard for the X12 EDI compliance edits, the accuracy for member identification numbers in its 837I encounters, and the accuracy for billing and servicing providers in all applicable encounter types. Although slightly below the standard, **NHHF** should continue to work to improve its data accuracy for the member identification number in its 837P and pharmacy encounters. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. **NHHF** should continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for all three encounter types, especially for pharmacy encounters, so that **NHHF** can meet the standards. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the ***timeliness*** issues. Lastly, while it has improved the percentage of 837P files confirmed by the reconciliation files, **NHHF** has room for improvement. Developing an automatic process for preparing and submitting reconciliation files according to a fixed schedule may be helpful to improve this rate. Determining ***access to care*** and health outcomes that represent ***quality of care*** could be challenging if **NHHF** does not submit accurate and timely encounter data to DHHS.

NHHF has 15 rates to investigate from the comparative analysis results so that DHHS and **NHHF** can determine whether the difference between DHHS' data and **NHHF**'s data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy. A thorough investigation of example encounters with completeness and accuracy concerns may be helpful in revealing the root cause of the issues. In addition, based on the MRR, **NHHF** has three recommendations to improve encounter data completeness and accuracy. Without complete and accurate encounter data in DHHS' data warehouse, it could be difficult to monitor and improve ***quality of care*** and ***access to care***.

NHHF Aggregated Conclusions Concerning Strengths and Weaknesses in the Domains of Access to Care, Timeliness of Care, and Quality of Care

Table 4-5—Conclusions Regarding NHHF's Strengths in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓	✓		**NHHF** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD*

Quality	Access	Timeliness	Strengths
			Treatment—Total, and the PIP activities positively impacted the HEDIS rate by achieving a percentile ranking for this measure that met or exceeded the 75th percentile.
✓	✓	✓	**NHHF** met the requirements for two performance measures included in the PMV activity: CLAIM.11—*Professional and Facility Medical Claim Processing Results* and CLAIM.24—*Timely Processing of All Clean Provider Claims: Ninety Days of Receipt.* These measures demonstrated correct and timely processing of professional and facility medical claims, and the findings correlate with the high percentage scores achieved by **NHHF** in the EDV review of ongoing encounter data quality reports.
✓	✓		Another measure showing strong performance for **NHHF** during the PMV activity, SUD.25—*Continuity of Pharmacotherapy for Opioid Use Disorder*, could include members eligible to be included in the HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* (*IET—Engagement*). As previously noted, **NHHF** achieved a percentile ranking for this measure that met or exceeded the 75th percentile.
	✓	✓	**NHHF** demonstrated strength in the Care Management/Care Coordination standard during the compliance review by identifying priority populations with high risks/high needs to determine if they would benefit from care management services. **NHHF** ensured coordination between a member's participating providers and also determined if the member was in need of assistance with SDoH. The MCO also managed transitions of care for all members moving from one clinical setting to another to unplanned or unnecessary readmissions, ED visits, or adverse health outcomes. Ensuring that members received care management services and assistance with transitions of care improved their ***timeliness of care*** and ***access to care***. Those efforts were evident in the BH HEDIS measures that achieved scores equal to or greater than the 90th percentile: *Follow-Up After Hospitalization for Mental Illness (FUH)* (both indicators), *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA), Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total, Follow-Up After Emergency Department Visit for Mental Illness (FUM)* (both indicators), *and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—30-Day Follow Up—Total.*

Table 4-6—Conclusions Regarding NHHF's Weaknesses in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Weaknesses
✓	✓		**NHHF** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD)*; however, the measure scored below the 25th percentile. **Recommendation: NHHF** needs to continue to focus on this PIP topic to successfully complete PIP validation and to increase the score for the HEDIS measure.
✓	✓	✓	**NHHF** scored below the 25th percentile for the following preventive care HEDIS measures: *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total,* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*. Related to this, the compliance review activity identified two CPGs available to **NHHF**'s providers that could directly affect rates for these measures: *Recommendations for Preventive Pediatric Health Care* and *Preventive Screenings/Care Recommendations: U.S. Preventive Services Task Force A and B Recommendations*. **Recommendation:** To verify providers have the necessary information to provide preventive services and screenings and improve related HEDIS scores, **NHHF** should consider redistributing CPGs to all PCPs and pediatricians with a reminder of the importance of ensuring that members receive appropriate preventive health screenings during every office visit.
	✓	✓	The PDV activity conducted during the NAV task revealed that **NHHF** did not meet the standard in seven of the measures reviewed in the automated provider directory: listing all PCPs and BH providers in the directory, including the providers' correct telephone number, identifying the providers type/specialty, indicating the offices that can accommodate members with physical disabilities, noting if the provider completed cultural competency training, identifying the non-English language speaking providers, and including the provider's URL. The HEDIS measure scoring below the 50th percentile, *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total* and the CAHPS measures, *Getting Needed Care* and *Getting Care Quickly*, will be positively impacted by including correct and complete information in the provider directory. **Recommendation: NHHF** should ensure that its provider directory is accurate and complete to inform members about available providers and services.

Well Sense

MCO Contractual Compliance

This was the eighth year that **WS** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 97.4 percent on the review. Of the six standards reviewed that included 193 applicable elements, **WS** achieved a 100 percent score in Member Services, UM, Quality Management, and TPL. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM Program beneficiaries.

WS demonstrated strength in the Member Services Standard by sending information concerning a PCP's name, address, and telephone number to members upon enrollment; mailing new member welcome letters anytime the member requests a new PCP, as required by DHHS; assisting members in transitioning to a new provider when required; and ensuring that member information meets formatting and language requirements. The **WS** Member Handbook also contained all items as stipulated by federal and State requirements. Furnishing PCP information and meeting the formatting and language requirements for printed material will assist members by improving ***access to care.***

WS demonstrated strength in the UM Standard by developing, operating, and maintaining a UM Program that uses appropriately licensed clinicians to make authorization decisions. The MCO used the New Hampshire MCM Program standard prior authorization form and consistently applied review criteria for authorization decisions. **WS** ensured that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. The MCO sent written denial notices within time frames specified and processed denied files as required by DHHS. Processing prior authorization requests with appropriately licensed clinicians will assist in ensuring that members receive ***access to care***. Sending timely notification of prior authorization decisions to deny a request will positively impact ***timeliness of care*** by alerting providers to submit additional documentation for consideration or request alternative treatments and services that may be approved by the MCO.

WS demonstrated strength in the Quality Management Standard by adopting CPGs from the ASAM, the U.S. Preventive Services Task Force, AAP's Bright Futures, and Zero Suicide Consensus Guide for Emergency Departments as required by DHHS. The MCO disseminated CPGs to all providers whose practice may benefit from the information and upon request to members and potential members. **WS** maintained policies and procedures concerning advance directives and educated staff about advance directives information and requirements. Ensuring that practitioners follow nationally recognized CPGs will assist in ensuring that the New Hampshire MCM Program members improve their ***quality of care***.

WS also demonstrated strength in the TPL Standard by ensuring that the MCO made every reasonable effort to determine the liable third party to pay for services rendered to New Hampshire MCM Program beneficiaries. **WS** submitted any new, changed, or terminated private insurance data to DHHS through a

weekly file transfer and handled overpayments appropriately. The MCO also assured that amounts received beyond a member's outstanding claims were returned to the member.

WS scored *Partially Met* in four elements and *Not Met* in three elements from the Care Management/ Care Coordination and Member Enrollment and Disenrollment standards. Those elements represent an opportunity for improvement to ensure compliance with federal and State requirements in ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries.

WS could improve the Care Management/Care Coordination Standard by ensuring that care managers sign a conflict-free statement which includes not being related by blood or marriage to a member, financially responsible for a member, or having any legal power to make financial or health-related decisions for the member. To assist with informing providers about hospital ADTs, **WS** must ensure that the information from the ADT data is made available to PCPs, BH providers, integrated delivery networks, local care management networks, and other care management entities within 12 hours of receipt of the ADT. **WS** must conduct an HRA of all existing and newly enrolled members within 90 calendar days of the effective date of the MCO enrollment to identify members who may have unmet healthcare needs and/or special healthcare needs. The HRA also must be shared with the member's assigned PCP for inclusion in the member's medical record and within seven calendar days of completing the screening. **WS** must submit any change in its risk stratification methodologies, to include any additions or deletions to that methodology, for DHHS' review 90 calendar days prior to the change being implemented. **WS** must share the results of the comprehensive assessment in writing with the member's local community-based care team within 14 calendar days to inform care planning and treatment planning, and to prevent duplication of activities, with member consent. Improving these elements of care management/care coordination will assist in improving the ***quality of care*** for New Hampshire MCM Program beneficiaries.

WS could improve the Member Enrollment and Disenrollment Standard by ensuring that member status change notifications are sent to DHHS within five business days when it identifies information about a member's circumstances that may affect the member's eligibility, including changes in the member's residence, such as out-of-state claims, or the member's death.

After finalization of the SFY 2021 Compliance Review Report in September 2021, **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* during the compliance review. **WS** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2021 compliance review. HSAG will include a review of the SFY 2021 Compliance Review CAP items during the SFY 2022 compliance audit.

PIPs

WS collaborated with DHHS and the other MCOs to select the topics for the two PIPs that were initiated in SFY 2020. During SFY 2021, 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. **WS** demonstrated the following strengths that positively impacted the ***quality of care*** and ***access to care***:

- Used QI science tools to identify and prioritize opportunities for improvement within current processes.
- Determined targeted interventions to test and developed sound intervention effectiveness measures.
- Began testing interventions using thoughtful and incremental PDSA cycles and making data-driven decisions based on testing results.

During SFY 2021, HSAG made the following recommendations to **WS** as it continues through the PIP process to improve the ***quality of care*** and ***access to care***:

- **WS** should consider shorter testing periods and ensure timely, ongoing data collection and analyses of effectiveness data for each intervention. The testing methodology should allow **WS** to quickly gather data and make data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal.
- **WS** should revisit its key driver diagram and identified failure modes in the FMEA table to determine new member and provider-focused interventions to test through the extended SMART Aim end date of June 30, 2022. This will increase the likelihood of achieving the SMART Aim goal and desired outcomes for the projects.
- **WS** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found 13 of 14 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors recommended that **WS**:

- Enhance its internal quality assurance processes, to conduct ongoing PSV of the detailed data reported in support of the DHHS performance measures, in comparison to its applicable source systems. This PSV should include performing UAT on all newly implemented reporting to ensure 100 percent compliance with the DHHS performance measure specifications. **WS** should conduct

additional reviews of its performance measure detailed data in comparison to the DHHS performance measure specifications to ensure all source code has resulted in appropriate identification of claims, members, and other relevant performance measure information. **WS** should consider conducting this review at least prior to each submission of performance measure data to DHHS to ensure the data are accurate.

- Complete a full root cause analysis to determine the necessary corrections required to ensure both ACCESSREQ.05 and TIMELYCRED.01 are able to be reported in future reporting periods. While TIMELYCRED.01 was determined to be *Reportable* due to manual data corrections made by **WS** which resulted in updated, reportable rates, the source code was not resulting in accurate data. Although manual reporting is acceptable, it can result in a higher risk of error due to data entry mistakes made by the individuals documenting the data. The ACCESSREQ.05 performance measure will require **WS** to complete corrective action to further revise its source code to ensure the code includes only member requests for assistance in accessing PCPs.

NAV

WS fully participated in the SFY 2021 PDV, and its website met the federal requirements and MCM contract requirements pertaining to the information that must be included in an online provider directory, except the DME supplier directory.

HSAG's reviewers identified the sampled provider's name and location listed in **WS**'s submitted provider data in the online provider directory for 62.8 percent of the reviews (i.e., 187 out of 298 randomly sampled directory review cases). Additionally, case-level results matched between **WS**'s provider data and online directory profiles for less than 90 percent of sampled cases for the following indicators:

- Providers Found in Directory for BH Providers (41.2 percent)
- Providers Found in Directory for DME Providers (66.7 percent)
- Provider's Name (88.2 percent)
- Provider Type/Specialty (65.8 percent)
- Provider Accommodates Physical Disabilities (88.2 percent)
- Provider Completed Cultural Competency Training (20.9 percent)
- Non-English Language Speaking Provider (including American Sign Language) (62.0 percent)
- Provider Primary Language (62.0 percent)
- Provider Board Certification, if applicable for PCPs and BH Providers (71.0 percent)
- Provider Office Hours (88.8 percent)
- Provider URL (3.2 percent)

The PMV study also revealed the difficulty **WS** members may have in locating BH specialists and DME providers in the automated directory. HSAG recommends that **WS** use a variety of strategies to improve the accuracy of its provider data, including outreach among contracted providers, reconciliation of

internal provider data against the SFY 2021 PDV results, and review of provider data oversight processes and reports. The findings related to this recommendation suggest that New Hampshire MCM Program beneficiaries experience challenges with ***access to care*** when attempting to identify those providers.

CAHPS

No 2021 measure rates for **WS**'s child Medicaid population were statistically significantly higher than the 2020 NCQA child Medicaid national averages; however, one 2021 measure rate related to ***quality of care*** and ***access to care*** (i.e., *Getting Needed Care*) was statistically significantly higher than the 2020 NCQA adult Medicaid national average for the adult Medicaid population. Eight 2021 child measure rates and the remaining seven adult 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 2020 NCQA adult and child Medicaid national averages.

WS could implement a standardized onboarding process to educate new employees about CAHPS measures in all departments. To improve CAHPS rates for ***quality of care***, **WS** should consider focusing on improving provider-patient communications through provider bulletins or trainings. 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. **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. 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. Additionally, **WS** could 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 whether members are getting the help they need and identify potential areas for customer service improvement.

To improve CAHPS rates related to ***timeliness of care***, **WS** should 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.

To improve CAHPS rates related to ***timeliness of care*** and ***access to care***, **WS** should encourage providers to expand their website to include health information, tools, and links to various types of information. Additionally, **WS** 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 **WS** and its members. **WS** could continuously monitor provider appointment accessibility, after-hours accessibility, and telephone accessibility. **WS** could also conduct an evaluation of current **WS** call center hours and practices to determine if the hours and resources meet members' needs.

HEDIS

Table 4-7 displays the rates achieved by **WS** and national benchmarks that are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019.

Table 4-7—Summary of Scores for MY 2020 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	0	1	0	3	12	**16**
Acute and Chronic Care	2	3	2	2	3	**12**
Behavioral Health	6	2	3	3	5	**19**
All Domains	**8**	**6**	**5**	**8**	**20**	**47**
Percentage	**17.02%**	**12.77%**	**10.64%**	**17.02%**	**42.55%**	**100%**

WS's rates ranked at or above the 50th percentile for 19 measures (40.43 percent), with eight of these measures (17.02 percent) meeting or exceeding the 90th percentile. The rates for 28 measures (59.57 percent) fell below the 50th percentile.

HSAG organized, aggregated, and analyzed the validated HEDIS data to draw conclusions about **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***.

WS demonstrated strength for measure indicators related to ***quality of care***, meeting or exceeding the 50th percentile for 17 of 44 (38.64 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):

- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- *Appropriate Testing for Children with Pharyngitis (CWP)*
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *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**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—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:

- *Breast Cancer Screening (BCS)* †
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total*†, *Counseling for Nutrition—Total*†, and *Counseling for Physical Activity—Total*†
- *Childhood Immunization Status (CIS)—Combination 2*† *(DTaP, IPV, MMR, HIB, HepB, VZV)* and *Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)*
- *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*†
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*† and *Postpartum Care*
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing*†, *HbA1c Poor Control (>9.0%,)*†, and *HbA1c Control (<8.0%)*†
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*
- *Asthma Medication Ratio (AMR)—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total, Cholesterol Testing—Total*†, and *Blood Glucose and Cholesterol Testing—Total*†
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*†

- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)†*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)†*

To improve ***quality of care***, **WS** should educate members to understand the importance of receiving preventive care and remind providers to review preventive care measures for every patient at every visit to ensure that members receive timely preventive health screenings. **WS** also could continuously inform members through member newsletters about the importance of timely prenatal and postpartum care. Adopting CPGs for diabetes and disseminating those guidelines to all PCPs and specialists treating those diseases will positively impact the *Comprehensive Diabetes Care (CDC)* measure. **WS** also could include information in provider newsletters concerning plan all-cause readmissions and perform targeted provider mailings concerning asthma medications, the importance of metabolic monitoring for children and adolescents on antipsychotics, use of first-line psychosocial care for children and adolescents on antipsychotics, and follow-up care for children prescribed ADHD medication.

WS demonstrated strength in measure indicators related to ***timeliness of care***, meeting or exceeding the 50th percentile for 10 of the 16 (62.50 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)—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*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—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:

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care†* and *Postpartum Care*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase†*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) †*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) †*

To improve ***timeliness of care***, **WS** should continuously inform members through member newsletters about the importance of timely prenatal and postpartum care and the benefits to both moms and babies. Providers also need to be aware of the importance of follow-up care for children prescribed ADHD medication.

WS demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for six of the 13 (46.20 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):

- *Ambulatory Care (AMB)–ED Visits—Total**
- *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*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—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*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care† and Postpartum Care*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) †*
- *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†*

To improve ***access to care***, **WS** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory health services. Encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits also will improve members' ***access to care***. Once again, the timeliness of prenatal and postpartum care needs to be improved since it is evident that these indicators affect overall ***quality of care***, ***timeliness of care***, and ***access to care***. **WS** also could provide information in provider newsletters and perform targeted provider mailings concerning the importance of diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications and diabetes monitoring for people with diabetes and schizophrenia.

EDV

WS met the standard for the X12 EDI compliance edits, the accuracy for member identification numbers in its pharmacy encounters, the accuracy for billing and servicing providers for all applicable encounter types, and the timely initial encounter data submissions to DHHS within 14 days of the claim payment

date for its 837I encounters. While **WS**'s rates were slightly below the standard, **WS** should continue to work to improve its data accuracy for the member identification numbers for its 837P/I encounters. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. While **WS**'s rates were slightly below the standard, **WS** should continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for its 837P and pharmacy encounters so that **WS** can meet the corresponding standards. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission will assist in correcting the ***timeliness*** issues. Lastly, while it has improved the percentage of 837I files confirmed by the reconciliation files, **WS** has room for improvement for the 837P/I rates. Developing an automatic process for preparing and submitting reconciliation files according to a fixed schedule may be helpful to improve them. Determining ***access to care*** and health outcomes that represent ***quality of care*** could be challenging if **WS** does not submit accurate and timely encounter data to DHHS.

WS has seven rates to investigate from the comparative analysis results so that DHHS and **WS** can determine whether the difference between DHHS' data and **WS**'s data was due to issues from the data extraction for the EDV study or whether the difference indicates issues with DHHS' encounter data completeness and accuracy. A thorough investigation of example encounters with completeness and accuracy concerns may be helpful in revealing the root cause of the issues. In addition, based on the MRR, **WS** has four recommendations to improve encounter data completeness and accuracy. Without complete and accurate encounter data in DHHS' data warehouse, it could be difficult to monitor and improve ***quality of care*** and ***access to care***.

WS Aggregated Conclusions Concerning Strengths and Weaknesses in the Domains of Access to Care, Timeliness of Care, and Quality of Care

Table 4-8—Conclusions Regarding WS's Strengths in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓	✓		**WS** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*, and **WS** chose to focus on opioid abuse or dependence treatment. The PIP activities positively impacted the HEDIS rate by achieving a percentile ranking for this measure that met or exceeded the 75th percentile.
✓	✓	✓	**WS** met the requirements for two performance measures included in the PMV activity: CLAIM.11—*Professional and Facility Medical Claim Processing Results* and CLAIM 24—*Timely Processing of All Clean Provider Claims: Ninety Days of Receipt.* These measures demonstrated correct and timely processing of professional and facility medical claims, and the findings correlate with the high percentage scores achieved by **WS** in the EDV review of ongoing encounter data quality reports.

Quality	Access	Timeliness	Strengths
✓	✓		Another measure showing strong performance for **WS** during the PMV activity, SUD.25—*Continuity of Pharmacotherapy for Opioid Use Disorder*, could include members eligible to be included in the HEDIS measure, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*. As previously noted, **WS** achieved a percentile ranking for this measure that met or exceeded the 75th percentile.
	✓		**WS** demonstrated strength in the Member Services standard during the compliance review by ensuring that the Member Handbook contained all items as stipulated by federal and State requirements. Ensuring that members receive complete and correct information concerning the health care services covered by the New Hampshire MCM Program and the definition of what constitutes an "emergency service" and an "emergency medical condition" contributed to the HEDIS measure *Ambulatory Care—Total (AMB)—ED Visits—Total* meeting or exceeding the 90th percentile.

Table 4-9—Conclusions Regarding WS's Weaknesses in Access, Quality, and Timeliness of Care

Quality	Access	Timeliness	Weaknesses
✓	✓		**WS** implemented HSAG's rapid-cycle PIP approach in SFY 2021. The PIP was also a HEDIS measure, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*; however, the measure scored below the 25th percentile. **Recommendation:** **WS** needs to continue to focus on this PIP topic to successfully complete PIP validation and to increase the score for the HEDIS measure.
✓	✓	✓	**WS** scored below the 25th percentile for the following preventive care HEDIS measures: *Breast Cancer Screening (BCS); 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 (DTaP, IPV, MMR, HIB, HepB, VZV); 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;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care.* The compliance review activity identified the CPGs available to **WS**'s providers that could directly affect rates for these measures: *Recommendations for Preventive Pediatric Health Care, Preventive Screenings/Care Recommendations: U.S. Preventive Services Task Force A and B Recommendations, Recommended Immunizations Schedule for Persons 0–18 Years Old,* and *Perinatal Care Guidelines*. **Recommendation:** To verify practitioners have the necessary information to provide preventive services and screenings and improve related HEDIS

Quality	Access	Timeliness	Weaknesses
			scores, **WS** should consider redistributing CPGs to all PCPs and pediatricians with a reminder of the importance of ensuring that members receive appropriate preventive health screenings during every office visit.
	✓	✓	The PDV activity conducted during the NAV task revealed that **WS** did not meet the standard in nine of the measures reviewed in the automated provider directory: listing all BH and DME providers in the directory, including the providers' name, identifying the providers' type/specialty, indicating the offices that can accommodate members with physical disabilities, noting if the provider completed cultural competency training, identifying the non-English language speaking providers and the provider's primary language, listing if PCPs and BH provider are board certified, identifying the providers' office hours, and including the provider's URL. The HEDIS measure scoring below the 50th percentile, *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total,* and the CAHPS measures, *Getting Needed Care* for children and *Getting Care Quickly* for adults and children, will be positively impacted by including correct and complete information in the provider directory. **Recommendation: WS** should ensure that its provider directory is accurate and complete to inform members about available providers and services.
	✓		**WS** did not pass the measure ACCESSREQ.05 during the PMV audit. ACCESSREQ.05 is reported by county, and the specifications developed by DHHS indicate that the measure was designed to determine the *ease with which an individual can obtain needed medical services.* The HEDIS measure scoring below the 50th percentile, *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total,* and the CAHPS measures, *Getting Needed Care* for children and *Getting Care Quickly* for adults and children will be impacted by **WS** improving the ACCESSREQ.05 measure.

5. Assessment of the New Hampshire MCM Quality Strategy

Background

DHHS developed the New Hampshire MCM Quality Strategy dated SFY 2020 as required by 42 CFR §438.340. The final rule issued by CMS, Department of Health and Human Services, 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 for 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

DHHS provided HSAG with the most recent version of the New Hampshire MCM Quality Strategy.[5-2] The DHHS website also provided links to the New Hampshire Medicaid Care Management Quality Performance Report dated November 2020 and the Quality Strategy Effectiveness Analysis dated June 2021 for HSAG's review.[5-3] After receiving the documents, HSAG reviewed the goals of the New

[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: Nov 2, 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, 2021.

[5-3] Ibid.

Hampshire MCM Quality Strategy and determined the following information as required in 42 CFR §438.364(a)(4):

> *...recommendations for improving the quality of health care services furnished by each MCO...including how the State could target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.*[5-4]

Findings Related to 42 CFR §438.364(a)(4)

The New Hampshire MCM Quality Strategy includes specific goals for four annual preventive care measures (i.e., Objective 1.1) and six annual treatment measures (i.e., Objective 1.2). The national benchmarks used as a comparison in this report are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2020 representing MY 2019. For the HEDIS measures noted in the quality strategy, DHHS established the goal of achieving the 75th percentile of the national Medicaid HMO percentiles. The only exception to that rate is the goal of the 90th percentile established for *Immunizations for Adolescents—Combination 2*.

Table 5-1 displays the HEDIS rates for the New Hampshire MCM Program for MY 2019 and MY 2020. This table is similar to information included in the New Hampshire Medicaid Care Management Quality Performance Report dated November 2020 with rates for MY 2018 and MY 2019. In Table 5-1 the rate achieved by the New Hampshire MCM Program in MY 2020 is displayed with the percentile achieved under that score. A comparison is also shown to the rate achieved in the prior year, MY 2019, and the MY 2020 cell is shaded to reflect the performance as explained in the table legend.

Table 5-1—Comparison of MY 2019 HEDIS Rates to MY 2020 HEDIS Rates for the New Hampshire MCM Program

DHHS New Hampshire Medicaid Care Management (MCM) Quality Strategy Objective and HEDIS Measures	NH MY 2019 Rate	NH MY 2020 Rate and Percentile
Objective 1.1: Preventive Care Measures		
Immunizations for Adolescents Combination Without HPV—Combination 1 (IMA)	78.2%	74.3% <25th Percentile
Immunizations for Adolescents Combination Including HPV—Combination 2 (IMA)	33.1%	31.4% 25th–49th Percentile
Chlamydia Screening in Women—Total (CHL)	48.1%	46.5% <25th Percentile

[5-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 2, 2021.

DHHS New Hampshire Medicaid Care Management (MCM) Quality Strategy Objective and HEDIS Measures	NH MY 2019 Rate	NH MY 2020 Rate and Percentile
Prenatal and Postpartum Care—Postpartum Care (PPC)	79.2%	73.1% 25th–49th Percentile
Objective 1.2: Treatment Measures		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	82.7%	76.2% <25th Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	76.6%	72.6% ≥90th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	75.4%	62.4% 25th–49th Percentile
Follow-Up Care for Children Prescribed ADHD Medications—Continuation and Maintenance (ADD)	52.3%	53.6% 25th–49th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total	22.0%	22.9% 75th–89th Percentile
Use of Imaging Studies for Low Back Pain (LBP)	75.5%	76.5% 50th–74th Percentile

Table Legend			
Performance below the 50th Percentile	Performance below the 75th Percentile but equal to or above the 50th Percentile	Improved performance from the prior year, but below the 75th Percentile	Performance equal to or above the 75th Percentile

Evaluation

Preventive Care Measures

Two of the four preventive care measures achieved a rate equal to or above the 25th percentile but below the 50th percentile in MY 2020, and two rates fell below the 25th percentile. All four rates declined from the previous year. The goal for the *Immunizations for Adolescents Combination Including HPV—Combination 2 (IMA*) is the 90th percentile, and the goal for the other three measures is to achieve the 75th percentile.

A contributing factor to the lower rates in MY 2020 could have been the COVID-19 public health emergency that impacted beneficiaries' ability to travel to appointments and required the temporary closing of providers' offices to limit the spread of the disease. Although the use of telemedicine increased during the pandemic, it was difficult to conduct a visit for the preventive care measures via telehealth because the measures required a physical examination, an immunization, or a screening test.

Treatment Measures

Excluding the *Appropriate Use of Imaging Studies for Low Back Pain* measure, the treatment measures listed in the New Hampshire MCM Quality Strategy are BH measures, and those measures scored better than the preventive care measures. Only one rate fell below the 25th percentile, two were in the 25th–49th percentile, one was in the 75th–90th percentile, and one exceeded the 90th percentile. The goal in the quality strategy for all treatment measures is to achieve the 75th percentile.

Recommendations Concerning How DHHS Can Better Target Goals and Objectives in the Quality Strategy as Outlined in 42 CFR §438.364(a)(4)

In this section, HSAG is outlining how the evaluation findings could inform the State's approach to targeting goals and objectives in its quality strategy that improve the ***access to care, timeliness of care,*** and ***quality of care.***

Recommendation 1: Create new or revise existing objectives in the MCM quality strategy to require MCOs to conduct a barrier analysis to improve preventive care rates.

To improve the rates for preventive care, DHHS could require the MCOs to evaluate the rates of the four preventive care measures to identify disparate populations and encourage prioritized outreach to those members. Identifying the barriers to receiving preventive care (i.e., lack of transportation, lack of child care, lack of awareness of the need for preventive care) could assist the MCOs in identifying strategies to overcome those barriers. If the MCOs offer incentives for members to receive preventive care, the incentives may need to be reevaluated to ensure that they achieve the purpose intended. Overcoming those barriers will improve ***timeliness of care*** and ***access to care***.

Recommendation 2: Continue to include postpartum care visits as a measure in Objective 1.1 in the MCM quality strategy.

Increasing the rate for postpartum visits may also have an effect on the care women receive for mental health issues that are often undiagnosed. The Office on Women's Health of the U.S. Department of Health & Human Services reports that "one in nine new mothers has postpartum depression."[5-5] Since postpartum depression could be detected by a provider during a postpartum visit, the American College of Obstetricians and Gynecologists recommends "that all obstetrician-gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum

[5-5] U.S. Department of Health & Human Services: Office on Women's Health. (2019). *Postpartum depression.* Available at: https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression. Accessed on: Nov 1, 2021.

visit for each patient."[5-6] Ensuring that beneficiaries receive postpartum visits will improve ***access to care, timeliness of care,*** and ***quality of care***.

Recommendation 3: Create new or revise existing objectives in the MCM quality strategy to require MCOs to redistribute CPGs to all PCPs and pediatricians.

The HEDIS section of this report displays New Hampshire MCM Program statewide average percentile rankings (e.g., Table 3-17) for nine prevention measures with 16 indicators that include the three preventive care measures listed in Table 5-1. Only seven of those 16 indicator rates exceeded the 25th percentile. The compliance review activity identified CPGs available to **ACNH**, **NHHF**, and **WS** providers that directly affect rates for these measures. Although the CPGs are located on the MCOs' provider portals, DHHS should consider requiring the MCOs to redistribute those guidelines to all PCPs and pediatricians with a reminder of the importance of ensuring that members receive appropriate screenings for preventive health during every office visit. MCOs must continually remind providers to conduct preventive care screenings during all office visits, regardless of the reason for the visit. Those *missed opportunities* may be contributing to the lower rate for the preventive care measures. Ensuring that members receive appropriate screenings for preventive health during every office visit will improve the ***timeliness of care*** and ***quality of care*** received by New Hampshire beneficiaries.

Recommendation 4: Create new or revise existing objectives in the MCM quality strategy to require MCOs to improve the quality of information on the provider directories.

Because members may select specialists (e.g., BH professionals) when they need care, it is essential that the MCOs' provider directories display complete and accurate information. The NAV section of this report contains opportunities for improving the information found in provider directories to include listing all BH providers and their subspecialties in the directories and being able to search for those providers in the automated directory. The scores achieved by the MCOs in matching information in the provider data files to the automated directory for that indicator ranged from 41.2 percent to 96.5 percent. Improving this indicator will positively affect ***access to care, timeliness of care,*** and ***quality of care***.

Provider directories also should identify providers who speak languages other than English. All beneficiaries need to be informed of the availability of language translation services to include American Sign Language. Matching the provider data files with the provider directory produced rates ranging from 8.6 percent to 73.8 percent for non-English-speaking providers (including American Sign Language). DHHS should consider ensuring that all provider directories include the identification of providers who speak languages other than English to improve ***access to care***.

[5-6] American College of Obstetricians/Gynecologists. (2018). Perinatal Depression, Vol. 132, No. 5. Available at: https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf. Accessed on: Nov 1, 2021.

Recommendation 5: Continue to include objectives in the MCM quality strategy related to the MCOs' Performance Improvement Projects.

Two of the treatment measures are also the PIP topics for the MCOs. The *Diabetes Screening for People with Mental Illness Who Are Using Antipsychotic Medications* measure is a PIP topic for all three MCOs, and the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* measure is a PIP topic for both **ACNH** and **NHHF**. **WS** chose to focus on *Continued Engagement of Opioid Abuse or Dependence Treatment.* In SFY 2021, the New Hampshire MCOs progressed through Module 3—Intervention Testing. When the PIPs progress to Module 4—PIP Conclusions, key findings, comparisons of successful and unsuccessful interventions, and outcomes achieved will be summarized. The MCOs 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. Once DHHS receives the PIP conclusions from the three MCOs, successful interventions could be shared with all MCOs to improve statewide rates for these measures. Improving these measures by using successful interventions identified during the PIP process will improve ***access to care*** and ***quality of care*** for the New Hampshire MCM Program beneficiaries.

Conclusions

Table 5-2 is a summary of the rates achieved by the 10 measures included in the New Hampshire MCM Quality Strategy.

Table 5-2—Summary of Rates for MY 2020 HEDIS Measures Listed in the New Hampshire MCM Quality Strategy With National Comparative Rates

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	0	0	0	2	2	**4**
Treatment	0	1	1	2	2	**6**
All Domains	**0**	**1**	**1**	**4**	**4**	**10**
Percentage	**0.0%**	**10.0%**	**10.0%**	**40.0%**	**40.0%**	**100%**

After reviewing the rates achieved for the 10 measures, it appears that only two measures met or exceeded the 50th percentile. One of the measures achieved the goal of meeting the 75th percentile. It is unlikely that the remaining eight measures (i.e., measures below the 50th percentile) will be able to achieve the 75th percentile by the end of SFY 2022. One of those measures, *Immunizations for Adolescents Combination Including HPV—Combination 2 (IMA)*, has a goal of achieving the 90th percentile next year, and it is currently below the 50th percentile. If the number of people contracting COVID-19 continues to lessen, the number of travel and business restrictions imposed on beneficiaries and providers as a result of the pandemic in MY 2019 may decrease. Rates for MY 2021 may improve;

however, it is unlikely that seven rates will achieve the 75th percentile next year or that the *Immunizations for Adolescents (Combination Including HPV)—Combination 2 (IMA)* measure will achieve the 90th percentile.

DHHS could consider implementing the Quality Improvement System for Managed Care (QISMC) methodology for reducing the gap between the performance measure rates and achieving the 75th percentile. A QISMC goal provides realistic targets by reducing the gap annually by 10 percent. Identifying the desired improvement goals and specifying improvement targets based on the current rates for each measure will positively impact ***timeliness of care***, ***access to care***, and ***quality of care*** for the New Hampshire MCM Program beneficiaries.

6. Follow-Up on Prior Recommendations

The following section presents HSAG's recommendations made in the prior year's EQR report (i.e., SFY 2020 EQR Technical Report) and an assessment of the actions that were implemented to correct the areas of improvement. The results are reported for **ACNH**, **NHHF**, and **WS**.

AmeriHealth Caritas New Hampshire

The SFY 2020 EQR Technical Report contained opportunities for improvement for **ACNH** related to the contract compliance audit and EDV. The following tables display the follow-up required during the corrective action process for compliance and from the self-reported follow-up activities conducted by **ACNH** during SFY 2021 to correct the issues identified as requiring improvement for EDV.

MCO Contractual Compliance

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** during SFY 2020 because this was the first compliance review conducted for that health plan. HSAG reviewed sixteen standards for **ACNH** (including 525 elements). HSAG received a completed CAP from **ACNH** for each element found noncompliant in the 14 standards listed below, and after reviewing the documents submitted by **ACNH**, HSAG determined that all items were compliant with the revisions instituted by **ACNH** during the CAP process. More than one *Partially Met* or *Not Met* finding may be attributed to the measures listed for each standard.

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 I—Delegation and Subcontracting	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Informing subcontractors about the grievance and appeal system; 2. Enumerating all statements required by DHHS in the four subcontract reviewed during the compliance audit; and 3. Including items in plan documents that are required by DHHS in the management of subcontractors: a. Notifying DHHS of identified deficiencies or areas of improvement in the subcontractor's performance;	16 Applicable Elements: 9 *Partially Met* 4 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	b. Notifying DHHS within five business days after receiving notice of a subcontractor's intent to terminate a contract; c. Providing to DHHS a transition plan to DHHS in the event of a material change, breach, or termination of a subcontractor agreement;		
ACNH's Contract Compliance CAP Response #1			
ACNH included the required language in an exhibit document sent with its subcontracts, revised the Delegate and Subcontractor Attestation, and updated the Member Handbook and Provider Manual to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **ACNH** continued to comply with the CAPs developed for this Standard.			

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 II—Emergency and Post-Stabilization Care	The partially met items in this Standard included HSAG's inability to find plan documents that included ensuring payment for emergency services when a representative or the MCO instructs the member to seek those services	13 Applicable Elements: 1 *Partially Met*	*Met*
ACNH's Contract Compliance CAP Response #2			
ACNH revised the UM Program Description to meet the requirements of 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 III—Care Management/ Care Coordination	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Not requiring a health risk assessment for members residing in a nursing facility more than 100 days; 2. Submitting changes to the **ACNH** risk stratification methodologies 90 days prior to any changes being implemented; 3. Conducting reassessment for members receiving ongoing care management upon DHHS' request; and	33 Applicable Elements: 2 *Partially Met* 2 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	4. Updating care plans at least quarterly or at the request of DHHS;		
ACNH's Contract Compliance CAP Response #3			
ACNH revised policies, procedures, checklists, and program documents; trained staff members; and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **ACNH** continued to comply with the CAPs developed for this Standard.			

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 V—Behavioral Health	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Ensuring delivery of all Medicaid state plan services for members as ordered by any court within the State 2. Connecting members discharged into homelessness to care management within 24 hours of release; and 3. Delivering evidence-based supported employment to eligible members;	29 Applicable Elements: 2 *Partially Met* 1 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #4			
ACNH revised policies and procedures, updated the UM Program Description, trained staff members, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **ACNH** continued to comply with the CAPs developed for this Standard.			

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 VI—Enrollment and Disenrollment	The partially met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Notifying DHHS within five business days when it identifies information that may affect a member's Medicaid eligibility; 2. Ensuring that members may request disenrollment without cause when DHHS imposes a sanction on the MCO;	18 Applicable Elements: 5 *Partially Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #5			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	3. Furnishing all relevant information to DHHS for determinations regarding disenrollment within three business days after receiving the request; and 4. Delineating all reasons that the MCO cannot request disenrollment		
ACNH's Contract Compliance CAP Response #5			
ACNH revised policies and procedures, trained staff members, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **ACNH** continued to comply with the CAPs developed for this Standard.			

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 VII—Member Services	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Ensuring that all required information is sent to DHHS when requesting disenrollment of a member; 2. Sending members a letter upon initial enrollment and anytime the member requests a new PCP with the PCPs name, address, and telephone number; 3. Including large print taglines on all member information concerning the availability of written translation, oral interpretation services, and the toll-free teletypewriter/telecommunication device for the deaf (TTY/TDD) telephone number; 4. Furnishing large-print written member information upon request; 5. Reissuing identification cards when there is a change to the information on the card; 6. Including all required information in the member handbook and ensuring that DHHS is notified at least 30 days prior to revisions to the handbook; 7. Creating a written policy concerning Member Rights; 8. Including all required topics in welcome calls to new members; 9. Listing all participating provider types and information as required in the provider directory; 10. Updating the provider directory and paper copies of the directory as required;	49 Applicable Elements: 11 *Partially Met* 4 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #6			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	11. Notifying members that information provided electronically is also available in paper form without charge upon request; and 12. Ensuring that information on ACNH's website is up to date and written in Spanish;		
ACNH's Contract Compliance CAP Response #6			
ACNH revised policies and procedures, trained staff members, updated the Member Handbook and new member call script, updated the provider Data Intake Form, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that ACNH continued to comply with the CAPs developed for this Standard.			

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 IX—Grievances and Appeals	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following ACNH requirements: 1. Resolving grievances timely when a member requests disenrollment; 2. Establishing the timeline of notice of termination, suspension, or reduction of authorized services when the MCO has verified probable fraud by the member; 3. Ensuring written notice to members on the date of action when the adverse action is a denial of payment or reimbursement; 4. Providing notice on the date that the timeframes expire when decisions are not reached within the timeframe for either standard or expedited service authorizations; 5. Including reasons that members may request an expedited resolution of a State fair hearing; 6. Acknowledging receipt of each grievance and appeal unless the member or authorized provider requested expedited resolution; and 7. Furnishing all required information in a written notice of resolution for an appeal in easily understood language.	86 Applicable Elements: 3 *Partially Met* 4 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #7			
ACNH revised policies and procedures, trained staff members, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that ACNH continued to comply with the CAPs developed for this Standard.			

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: Standard X—Access	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Creating written policies and procedures concerning the selection and retention of participating providers; 2. Ensuring that an adequate number of participating physicians have admitting privileges at participating acute-care hospitals; 3. Maintaining a program for children with special health care needs that includes standing referrals to ensure timely access to specialists; 4. Providing pregnant women access to childcare and transportation to aid in treatment participation; 5. Ensuring access to specialty hospital services and Centers of Excellence; 6. Considering the linguistic capabilities of providers and use of innovative technological solutions when developing the provider network; 7. Maintaining the geographic access requirement as defined by DHHS for the provider network; 8. Contracting with providers specializing in pediatric genetics; 9. Establishing the process to transition care for new members receiving treatment from a non-participating provider who refuses to contract with **ACNH**; and 10. Conducting a face-to-face visit to complete a comprehensive assessment and update a member's care plan when a member is hospitalized.	51 Applicable Elements: 10 *Partially Met* 2 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #8			
ACNH revised policies and procedures, revised its data intake form and provider directory; documented and monitored **ACNH**'s program for children with special health care needs; updated the list of facilities providing specialty hospital services; considered geographic requirements, linguistic capabilities of providers and the availability of triage lines, telemedicine, e-visits when developing its provider network; and clarified services available to member during transitions of care.			

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**
Standard XI—Network Management	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Requesting additional information from providers within 10 days if new or missing information is required for credentialing; 2. Paying providers retroactively for 30 or 45 days if **ACNH** does not process a completed credentialing application within the timeframes established by DHHS; 3. Making credentialing policies and procedures available to applicants upon written request; 4. Notifying applicants of incomplete credentialing applications within 15 days of receiving the application; 5. Operating a dedicated telephone number to assist providers as required by DHHS; 6. Notifying participating providers at the time they enter into a contract with **ACNH** about the assistance available to members filing grievances and appeals; 7. Ensuring that the provider appeals and State fair hearing procedures follows all DHHS requirements; 8. Conducting primary source verification for all providers who have hospital privileges as required by DHHS; and 9. Processing all credentialing applications within the timeframe established by DHHS.	87 Applicable Elements: 7 *Partially Met* 4 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #9			
ACNH updated plan documents to include all credentialing requirements, the provider manual, and the provider appeals policies and processes. **ACNH** also revised credentialing verification documents and trained staff to ensure processing of applications occurred within the required time period and included verification of hospital privileges.			

Table 6-10—Contract Compliance—Opportunities for Improvement and MCO Response #10

HSAG Contract Compliance Opportunities for Improvement #10			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Standard XII—Utilization Management (UM)	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Ensuring that UM policies and procedures contain all DHHS' requirements;	37 Applicable Elements: 7 *Partially Met* 6 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #10			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	2. Issuing private duty nursing, personal care attendants, and therapy authorizations for the time period required by DHHS; 3. Communicating changes in clinical review criteria to participating provider and members at least 30 days prior to the change; 4. Allowing up to six skilled nursing visits per benefit period for members without requiring prior authorization; 5. Providing written notice of denial information to providers and members as required by DHHS; 6. Making decisions for routine and urgent requests in a timely manner; and 7. Issuing written notification of adverse benefit determinations as required by DHHS.		
ACNH's Contract Compliance CAP Response #10			
ACNH updated UM policies, procedures, and processes and the UM Program Description to meet the requirements of this standard; and retrained staff members to ensure compliance with the revisions in the documents. **ACNH** also submitted reports to demonstrate compliance with the timeliness standards. **ACNH** retrained staff members to ensure compliance with the processing of denial requests.			

Table 6-11—Contract Compliance—Opportunities for Improvement and MCO Response #11

HSAG Contract Compliance Opportunities for Improvement #11			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Standard XIII—Quality Management	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Ensuring that decisions regarding UM, member education and coverage of services are consistent with **ACNH**'s CPGs; 2. Maintaining written policies and procedures concerning advance directives and educating staff members about those requirements; 3. Revising plan documents to reflect changes in State law concerning advance directives in the timeframe required by DHHS; and 4. Developing medication management protocols for children with special health care needs as required by DHHS.	18 Applicable Elements: 3 *Partially Met* 2 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #11			
ACNH updated policies and procedures and developed medication management protocols for children with special health care needs to include the requirement of this Standard.			

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

HSAG Contract Compliance Opportunities for Improvement #12			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Standard XIV—Substance Use Disorder (SUD)	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Identifying alternative viable means for communicating with members in discharge plans; 2. Attempting at least three calls to members within three days of discharge from the emergency room; 3. Contacting treatment providers requesting them to make contact with members who were not reached within three days of discharge from the emergency room; 4. Furnishing monthly comparative prescribing data to providers concerning their morphine equivalent dosing levels as required by DHHS; 5. Transitioning care for members with a non-fatal overdoes to the community as required by DHHS; 6. Providing required interventions for members discharging against medical advice; 7. Following the prior authorization requirements for medication assisted treatment as required by DHHS; 8. Contacting providers when **ACNH** has concerns about the appropriateness of a course of treatment; 9. Working with the Division for Children, Youth, and Families to provide SUD treatment as required by DHHS; 10. Following the DHHS-defined access standards for SUD providers; and 11. Ensuring the availability of the level of care for members as identified in the initial assessment.	50 Applicable Elements: 6 *Partially Met* 5 *Not Met*	*Met*
ACNH's Contract Compliance CAP Response #12			
ACNH revised policies, procedures, checklists, reporting requirements for sending comparative prescribing data to providers, and documents to monitor SUD providers as required by DHHS.			

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

HSAG Contract Compliance Opportunities for Improvement #13			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Standard XV—Fraud, Waste, and Abuse	The partially met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Reporting and recovering overpayments within the timeframe established by DHHS; 2. Ensuring that when maintaining and producing records for an investigation, **ACNH** follows the requirements established by DHHS; and 3. Complying with documentation and record requests during reviews by DHHS.	17 Applicable Elements: 3 *Partially Met*	*Met*
ACNH's Contract Compliance CAP Response #13			
ACNH updated policies concerning reporting and recovery of over payments to comply with required timelines, compliance when maintaining and producing records for an investigation, and complying with document request during a review by DHHS.			

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

HSAG Contract Compliance Opportunities for Improvement #14			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Standard XVI—Financial/third Party Liability	The partially met items in this Standard included HSAG's inability to find plan documents with the following **ACNH** requirements: 1. Developing policies and procedures to describe the process for pursuing third-party liability and cost avoidance activities through coordination of benefits relating to federal and private health insurance resources.	7 Applicable Elements: 1 *Partially Met*	*Met*
ACNH's Contract Compliance CAP Response #14			
ACNH updated policies and procedures to meet the requirements of this Standard.			

EDV

The SFY 2020 EQR Technical Report contained opportunities for improvement for ACNH related to EDV. The activities implemented by ACNH during SFY 2021 to improve the EDV results are shown below.

Table 6-15—EDV—Opportunities for Improvement and MCO Response #1

ACNH's EDV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.9%	100%
ACNH's EDV Response #1			
The small discrepancy in member identification is due to duplication of member records in our Claims processing system that are tied to newborns. Our Enrollment and Claims Operational teams implemented a fix in February 2021 to cut down on these duplicate member records. ACNH loads State eligibility data on a daily basis to ensure the most up to date information is available during creation of encounter files. ACNH also regularly reviews encounter rejections tied to eligibility issues and performs resubmissions as needed. In addition, the State provides a monthly report to ACNH showing accuracy of member Medicaid identification numbers which ACNH reviews for discrepancies. Based on the State's monthly report, ACNH is showing 100% accuracy for 837P encounters from December 2020–June 2020 (latest report available).			

Table 6-16—EDV—Opportunities for Improvement and MCO Response #2

ACNH's EDV Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	73.0%	100%
ACNH's EDV Response #2			
For 837P encounters, ACNH acknowledges gaps in submission timeliness during implementation and stabilization periods. Some of our delegated services had slight delays in the first few months of processing and our transportation delegate had some persistent problems that were ultimately resolved in April of 2020. ACNH has developed internal reports to monitor encounter timeliness in addition to the monthly report provided by the State. ACNH regularly reviews these reports internally as well as with the 3rd party vendors and escalates when necessary. For instance, in May 2021 ACNH identified missed 837P timeliness metric as being due to our Vision vendor which ultimately was the result of lack of training for new employees. The vendor addressed this gap with their employees thru training, put a temporary audit in place to validate before submission, and is looking at a change to automate the submission process on their side to avoid future hiccups.			

Table 6-17—EDV—Opportunities for Improvement and MCO Response #3

ACNH's EDV Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional Encounters (837I): Initial Submission Within 14 Days of Claim Payment	76.2%	100%
ACNH's EDV Response #3			
For 837I encounters, **ACNH** acknowledges gaps in submission timeliness during implementation and stabilization periods. **ACNH** has developed internal reports to monitor encounter timeliness in addition to the monthly report provided by the State. **ACNH** regularly reviews these reports internally for any gaps or areas of improvement.			

Table 6-18—EDV—Opportunities for Improvement and MCO Response #4

ACNH's EDV Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	86.9%	100%
ACNH's EDV Response #4			
For Pharmacy encounters, **ACNH** did not begin submissions until December 2019 while the contract started in September 2019 resulting in the missed timeliness. **ACNH** Operations team monitors the weekly submission of National Council for Prescription Drug Program (NCPDP) files, reaches out to the vendor anytime a file is not received on its regularly scheduled day and escalates when necessary. This oversight is ongoing and will continue for the duration of the contract. In addition, the State provides a monthly report to **ACNH** showing accuracy of NCPDP timeliness which **ACNH** reviews for discrepancies. Based on the State's monthly report, **ACNH** is showing 100% accuracy for NCPDP encounters from December 2020 – June 2020 (latest report available).			

New Hampshire Healthy Families

The SFY 2020 EQR Technical Report contained opportunities for improvement for **NHHF** related to the contract compliance audit, HEDIS, and EDV. The following tables display the follow-up required during the corrective action process for compliance and the self-reported follow-up activities conducted by **NHHF** during SFY 2021 to correct the issues identified as requiring improvement for HEDIS and EDV.

MCO Contractual Compliance

HSAG reviewed one-third of the compliance standards for **NHHF** during SFY 2020, which included five elements and 209 elements. HSAG received a completed CAP from **NHHF** for each element found noncompliant in the four standards listed below, and HSAG determined that all items were compliant with the revisions instituted by **NHHF** during the CAP process. More than one *Partially Met* or *Not Met* finding may be attributed to the measures listed for each standard.

Table 6-19—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 I—Delegation and Subcontracting	The partially met item in this Standard included HSAG's inability to find plan documents with the following **NHHF** requirement: 1. Notifying subcontractors concerning the assistance available to members filing an appeal.	16 Applicable Elements: 1 *Partially Met*	*Met*
NHHF's Contract Compliance CAP Response #1			
NHHF revised the required language in its subcontracts to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **NHHF** continued to comply with the CAPs developed for this Standard.			

Table 6-20—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 V—Behavioral Health	The partially met item in this Standard included HSAG's inability to find plan documents with the following **NHHF** requirement: 1. Ensuring that members discharged into homelessness are connected to care management within 24 hours of release.	29 Applicable Elements: 1 *Partially Met*	*Met*
NHHF's Contract Compliance CAP Response #2			
NHHF revised policies and procedures, trained staff members, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **NHHF** continued to comply with the CAPs developed for this Standard.			

Table 6-21—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 XI—Network Management	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **NHHF** requirements: 1. Ensuring that behavioral health providers know when and how to refer members who need physical health services; 2. Furnishing all application and credentialing policies and procedures available for review to applying health care professionals upon written request; 3. Notifying health care providers of an incomplete application in the time frame required by DHHS;	106 Applicable Elements: 5 *Partially Met* 3 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	4. Furnishing provider training to providers and their staff regarding the requirements of the DHHS Agreement within 30 calendar days of entering into a contract with a provider; 5. Informing providers about the availability of assistance to the member when filing grievances and appeals when the provider enters into a contract with **NHHF**; 6. Conducting primary source verification for all providers who have hospital privileges as required by DHHS; and 7. Verifying the review of ongoing adverse events for providers in recredentialing.		
NHHF's Contract Compliance CAP Response #3			
NHHF revised policies and procedures; trained staff members; updated the provider manual, orientation, and provider education and training materials; and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **NHHF** continued to comply with the CAPs developed for this Standard.			

Table 6-22—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 XIV—Substance Use Disorder (SUD)	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **NHHF** requirements: 1. Ensuring that final discharge instruction sheets are provided to members or their authorized representative as required by DHHS; 2. Furnishing the discharge progress notes to treatment providers as required by DHHS; 3. Identifying alternative viable means for communicating with members in discharge plans; 4. Attempting at least three calls to members within three days of discharge from the emergency room; 5. Contacting treatment providers requesting them to make contact with members who were not reached within three days of discharge from the emergency room; 6. Scheduling appointments and arranging for transportation for SUD members after discharge; 7. Transitioning care for members with a non-fatal overdoes to the community as required by DHHS;	50 Applicable Elements: 7 *Partially Met* 2 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	8. Providing required interventions for members discharging against medical advice; and 9. Contacting providers when **NHHF** has concerns about the appropriateness of a course of treatment.		
NHHF's Contract Compliance CAP Response #4			
NHHF revised policies, procedures, and program documents; trained staff members; and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **NHHF** continued to comply with the CAPs developed for this Standard.			

HEDIS

The SFY 2020 EQR Technical Report contained opportunities for improvement for **NHHF** related to HEDIS. The activities implemented by **NHHF** during SFY 2021 to improve the HEDIS results are shown below.

Table 6-23—HEDIS—Opportunities for Improvement and MCO Response #1

NHHF's HEDIS Opportunities for Improvement #1			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #1			
NHHF makes Care Gap reports available to providers which includes members in need of Chlamydia testing, on the Provider Portal. Provider Relations representatives from the Plan educate providers about this Provider portal tool and share how to identify members in need of screening. A Quick Reference Guide, identifying appropriate coding opportunities for testing, is shared with providers on the Provide website and updates are included in the Provider Newsletter. **NHHF** continues to send a reminder for this valuable screening to members as part of a "Well Woman" mailer that is sent the month of the member's birthday. **NHHF** is in the process of developing an educational outreach program to providers to bring Care Gaps lists and the educational material directly to the offices. This program is in process, but has been delayed due to the need to focus resources on more critical member preventive visits during the global pandemic. Finally, **NHHF** plans to participate in a DHHS-driven State-wide discussion/conference related to this screening and the challenges that the entire state is having to improve compliance. Due to the COVID19 virus, this activity has been delayed. All activities will be across all age groups.			

Table 6-24—HEDIS—Opportunities for Improvement and MCO Response #2

NHHF's Contract Compliance Review: Opportunities for Improvement #2			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #2			
NHHF makes Care Gap reports available to providers which includes members in need of Chlamydia testing, on the Provider Portal. Provider Relations representatives from the Plan educate providers about this Provider portal tool and share how to identify members in need of screening. A Quick Reference Guide, identifying appropriate coding opportunities for testing, is shared with providers on the Provide website and updates are included in the Provider Newsletter. **NHHF** continues to send a reminder for this valuable screening to members as part of a "Well Woman" mailer that is sent the month of the member's birthday. **NHHF** is developing an educational outreach program to providers to bring Care Gaps lists and the educational material directly to the offices. This program will be deployed as appropriate based on priorities relating to the COVID19 pandemic and its impact on preventive screenings. Finally, **NHHF** plans to participate in a DHHS-driven State-wide discussion/conference related to this screening and the challenges that the entire state is having to improve compliance. Due to the COVID19 virus, this activity has been delayed.			

EDV

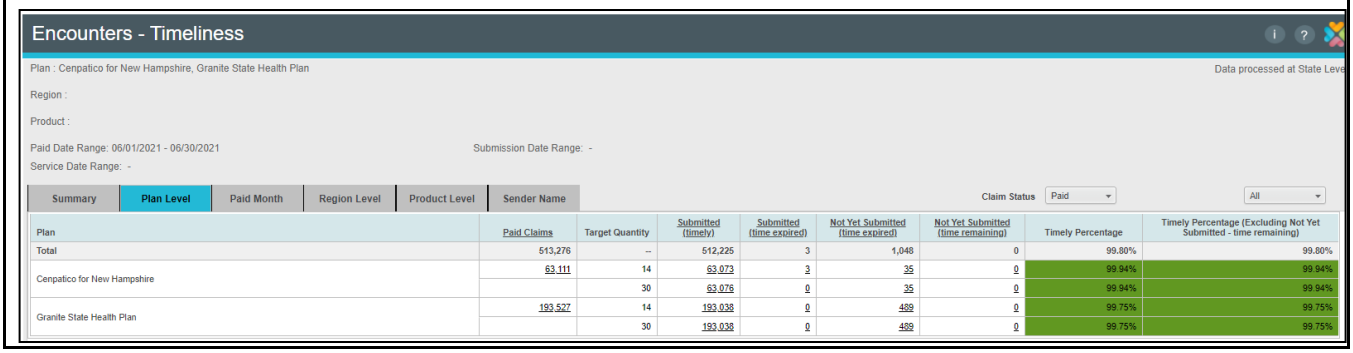
The SFY 2020 EQR Technical Report contained opportunities for improvement for **NHHF** related to EDV. The activities implemented by **NHHF** during SFY 2021 to improve the EDV results are shown below.

Table 6-25—EDV—Opportunities for Improvement and MCO Response #1

NHHF's EDV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.7%	100%
NHHF's EDV Response #1			
The 0.3% discrepancy in member identification numbers was 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 6-26—EDV—Opportunities for Improvement and MCO Response #2

NHHF's EDV Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	86.1%	100%
NHHF's EDV Response #2			
NHHF has put reports in place to measure timeliness on a weekly basis for medical, behavior and vision. Following review of these reports any necessary action is taken to mitigate identified concerns.			


Encounters - Timeliness

Plan : Cenpatico for New Hampshire, Granite State Health Plan — Data processed at State Leve

Region :

Product :

Paid Date Range: 06/01/2021 - 06/30/2021 — Submission Date Range: -

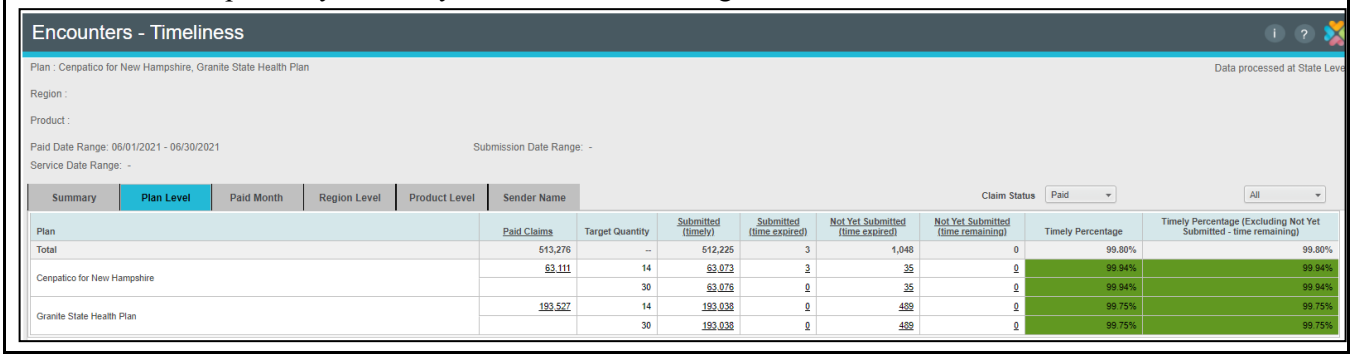
Service Date Range: -

Summary | Plan Level | Paid Month | Region Level | Product Level | Sender Name — Claim Status: Paid — All

Plan	Paid Claims	Target Quantity	Submitted (timely)	Submitted (time expired)	Not Yet Submitted (time expired)	Not Yet Submitted (time remaining)	Timely Percentage	Timely Percentage (Excluding Not Yet Submitted - time remaining)
Total	513,276	--	512,225	3	1,048	0	99.80%	99.80%
Cenpatico for New Hampshire	63,111	14	63,073	3	35	0	99.94%	99.94%
		30	63,076	0	35	0	99.94%	99.94%
Granite State Health Plan	193,527	14	193,038	0	489	0	99.75%	99.75%
		30	193,038	0	489	0	99.75%	99.75%

Table 6-27—EDV—Opportunities for Improvement and MCO Response #3

NHHF's EDV Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional Encounters (837I): Initial Submission Within 14 Days of Claim Payment	97.7%	100%
NHHF's EDV Response #3			
NHHF has put reports in place to measure timeliness on a weekly basis for medical and behavior. Following review of these reports any necessary action is taken to mitigate identified concerns.			


Encounters - Timeliness

Plan : Cenpatico for New Hampshire, Granite State Health Plan — Data processed at State Leve

Region :

Product :

Paid Date Range: 06/01/2021 - 06/30/2021 — Submission Date Range: -

Service Date Range: -

Summary | Plan Level | Paid Month | Region Level | Product Level | Sender Name — Claim Status: Paid — All

Plan	Paid Claims	Target Quantity	Submitted (timely)	Submitted (time expired)	Not Yet Submitted (time expired)	Not Yet Submitted (time remaining)	Timely Percentage	Timely Percentage (Excluding Not Yet Submitted - time remaining)
Total	513,276	--	512,225	3	1,048	0	99.80%	99.80%
Cenpatico for New Hampshire	63,111	14	63,073	3	35	0	99.94%	99.94%
		30	63,076	0	35	0	99.94%	99.94%
Granite State Health Plan	193,527	14	193,038	0	489	0	99.75%	99.75%
		30	193,038	0	489	0	99.75%	99.75%

Table 6-28—EDV—Opportunities for Improvement and MCO Response #4

NHHF's EDV Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	48.1%	100%
NHHF's EDV Response #4			

NHHF has put reports in place to measure timeliness on a weekly basis for pharmacy. Following review of these reports any necessary action is taken to mitigate identified concerns. Recent review of June 2021 pharmacy EQRO results indicated a potential error in the calculation of pharmacy encounter timeliness that is being reviewed by DHHS.

Centene NH Timeliness Report Initial '2021-08-16'-'2021-08-29'

CLNT_PROFL_ID	CLM_TXN_CD	Total_Line_Items	Submitted 0-14 Days	% Submitted 0-14 Days	Submitted GT Than 14 Days	% Submitted GT 14 Days
CENNH5436	B1	35,454	35,447	99.98%	7	0.02%
CENNH5436	B2	608	608	100.0%	0	0.00%

Well Sense Health Plan

The SFY 2020 EQR Technical Report contained opportunities for improvement for **WS** related to the contract compliance audit, HEDIS, and EDV. The following tables display the follow-up required during the corrective action process for compliance and the self-reported follow-up activities conducted by **WS** during SFY 2021 to correct the issues identified as requiring improvement for HEDIS and EDV.

MCO Contractual Compliance

HSAG reviewed one-third of the compliance standards for **WS** during SFY 2020, which included five standards and 211 elements. HSAG received a completed CAP from **WS** for each element found noncompliant in the four standards listed below, and HSAG determined that all items were compliant with the revisions instituted by **WS** during the CAP process. More than one *Partially Met* or *Not Met* finding may be attributed to the measures listed for each standard.

Table 6-29—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 I—Delegation and Subcontracting	The partially met items in this Standard included HSAG's inability to find plan documents with the following **WS** requirements: 1. Informing subcontractors about the grievance and appeal system; and	17 Applicable Elements: 3 *Partially Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	2. Enumerating all statements required by DHHS in the four subcontracts reviewed during the compliance audit.		
WS's Contract Compliance CAP Response #1			
WS included the required language in an addendum to its subcontracts and updated the Member Handbook to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **WS** continued to comply with the CAPs developed for this Standard.			

Table 6-30—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 V—Behavioral Health	The partially met items in this Standard included HSAG's inability to find plan documents with the following **WS** requirements: 1. Providing criteria for medical necessity determinations for mental health or SUD benefits to members, potential members, or providers upon request at no cost; and 2. Connecting members discharged into homelessness to care management within 24 hours of release.	29 Applicable Elements: 2 *Partially Met*	*Met*
WS's Contract Compliance CAP Response #2			
WS revised policies and procedures, trained staff members, updated the provider manual, and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **WS** continued to comply with the CAPs developed for this Standard.			

Table 6-31—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 XI—Network Management	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **WS** requirements: 1. Notifying participating providers at the time they enter into a contract with **WS** about the assistance available to members filing grievances and appeals;	107 Applicable Elements: 7 *Partially Met* 2 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	2. Furnishing provider training to providers and their staff regarding the requirements of the DHHS Agreement within 30 calendar days of entering into a contract with a provider; 3. Ensuring that all elements are included in the provider manual as required by DHHS; 4. Informing providers about the availability of assistance to the member when filing grievances and appeals when the provider enters into a contract with **WS**; 5. Advising provider of any changes to the provider appeals process at least 30 calendar days prior to implementation; 6. Including the following information in the provider appeals log: name, title, and credentials of the reviewers who determined the appeal decision; 7. Maintaining a log and record of all provider appeals including those handled by delegated entities for a period of not less than 10 years; and 8. Conducting primary source verification for all providers who have hospital privileges as required by DHHS;		
WS's Contract Compliance CAP Response #3			
WS revised policies and procedures; updated reports; trained staff members; updated the provider manual, orientation, and provider education and training materials; refined workflow documents; and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **WS** continued to comply with the CAPs developed for this Standard.			

Table 6-32—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 XIV—Substance Use Disorder	The partially met and not met items in this Standard included HSAG's inability to find plan documents with the following **WS** requirements: 1. Ensuring that final discharge instruction sheets are provided to members or their authorized representative as required by DHHS;	50 Applicable Elements: 3 *Partially Met* 2 *Not Met*	*Met*

HSAG Contract Compliance Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	2. Furnishing the discharge progress notes to treatment providers as required by DHHS; 3. Contacting treatment providers requesting them to make contact with members who were not reached within three days of discharge from the emergency room; 4. Providing required interventions for members discharging against medical advice; and 5. Following the prior authorization requirements for medication assisted treatment as required by DHHS.		
WS's Contract Compliance CAP Response #4			
WS revised policies, procedures, and program documents; revised workflow documents; updated the provider manual; trained staff members; and implemented the revised procedures to ensure compliance with the requirements stipulated by DHHS. During the SFY 2021 compliance audit, HSAG reviewed the revisions to ensure that **WS** continued to comply with the CAPs developed for this Standard.			

HEDIS

The SFY 2020 EQR Technical Report contained opportunities for improvement for **WS** in HEDIS. The activities implemented by **WS** during SFY 2021 to improve the HEDIS results are shown below.

Table 6-33—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response			
September 2021 update: We continue 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 and provide education to members or			

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
parents/guardians of members as appropriate. We will continue to develop and implement interventions to achieve improvement in the rate and performance compared to national benchmarks.			

EDV

The SFY 2020 EQR Technical Report contained opportunities for improvement for **WS** related to EDV. The activities implemented by **WS** during SFY 2021 to improve the EDV results are shown below.

Table 6-34—EDV—Opportunities for Improvement and MCO Response #1

WS's EDV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy Encounters: Validity of Member Identification Number—Percent Present	17.9%	100%
WS's EDV Response #1			
September 2021 updates: The root cause was attributed to reconciliation files not being submitted along with resubmission files. We have implemented processes to ensure future submissions include the reconciliation file. Ongoing monitoring remains in process.			

Table 6-35—EDV—Opportunities for Improvement and MCO Response #2

WS's EDV Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Validity of Member Identification Number—Percent Valid	99.5%	100%
WS's EDV Response #2			
September 2021 updates: Remediation efforts, including ongoing monitoring, remain in process to improve our overall data accuracy for member identification numbers for both 837 P/I encounters. Due to the temporary member identification process, improvements are being made to increase the validity percentage.			

Table 6-36—EDV—Opportunities for Improvement and MCO Response #3

WS's EDV Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Validity of Member Identification Number—Percent Valid	99.2%	100%
WS's EDV Response #3			
September 2021 updates: Remediation efforts, including ongoing monitoring, remain in process to improve our overall data accuracy for member identification numbers for both 837 P/I encounters. Due to the temporary member ID process, improvements are being made to increase the validity percentage.			

Table 6-37—EDV—Opportunities for Improvement and MCO Response #4

WS's EDV Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy Encounters: Billing Provider Information—Percent Valid	18.2%	100%
WS's EDV Response #4			
September 2021 updates: The MCO results referenced in this Table are directly attributed to **WS**'s former pharmacy benefit manager (PBM), Envision, whose contract ended on 12/31/2020. **WS** transitioned to a new PBM, Express Scripts (ESI), effective 1/1/2021. ESI currently has a manual submission process which is monitored by **WS** information technology staff prior to submission to DHHS. **WS** partners with ESI operations staff to assist with resolution of any encounter issues and continues to work with DHHS on behalf of our PBM on error resolution and to remediate any system or process limitations at DHHS. Additionally, ESI maintains a quarterly Encounter Advisory Collaboration Session with Boston Medical Center Health Plan staff during which the group provides a deep dive into all rejection observations and trends with assigned action items.			

Table 6-38—EDV—Opportunities for Improvement and MCO Response #5

WS's EDV Opportunities for Improvement #5			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	99.1%	100%
WS's EDV Response #5			
September 2021 updates: Remediation efforts, including ongoing monitoring, remain in process to improve the percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for all three encounter types.			

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

WS's EDV Opportunities for Improvement #6			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Initial Submission Within 14 Days of Claim Payment	98.7%	100%
WS's EDV Response #6			
September 2021 updates: Remediation efforts, including ongoing monitoring, remain in process to improve the percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for all three encounter types.			

Table 6-40—EDV—Opportunities for Improvement and MCO Response #7

WS's EDV Opportunities for Improvement #7			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.9%	100%
WS's EDV Response #7			
September 2021 updates: Remediation efforts, including ongoing monitoring, remain in process to improve the percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for all three encounter types.			

Appendix A. Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

- **AAP**—Adults' Access to Preventive/Ambulatory Health Services; American Academy of Pediatrics
- **ABX**—Antibiotic Utilization
- **ACNH**—AmeriHealth Caritas New Hampshire
- **ADD**—Follow-Up Care for Children Prescribed ADHD Medication
- **ADHD**—attention-deficit/hyperactivity disorder
- **ADT**—admission, discharge, transfer
- **AHRQ**—Agency for Healthcare Research and Quality
- **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 of Addiction Medicine
- **BBA**—Federal Balanced Budget Act of 1997
- **BCS**—Breast Cancer Screening
- **BH**—behavioral health
- **BMI**—body mass index
- **CAHPS**—Consumer Assessment of Healthcare Providers and Systems
- **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
- **CM**—clinical modification
- **CMS**—Centers for Medicare & Medicaid Services
- **COPD**—chronic obstructive pulmonary disease
- **COVID-19**—coronavirus disease 2019
- **CPG**—clinical practice guideline
- **CWP**—Appropriate Testing for Children with Pharyngitis
- **CY**—calendar year
- **DHHS**—State of New Hampshire, Department of Health and Human Services
- **DME**—durable medical equipment
- **DRG**—diagnosis related group
- **DTaP**—diphtheria, tetanus, and acellular pertussis vaccine
- **EBI**—Enterprise Business Intelligence
- **eCOM**—Electronic Clinical Quality Measure
- **ED**—emergency department
- **EDA**—encounter data accuracy
- **EDC**—encounter data completeness
- **EDI**—electronic data interchange
- **EDT**—encounter data timeliness
- **EDV**—encounter data validation
- **EPSDT**—Early and Periodic Screening, Diagnostic, and Treatment
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **ESI**—Express Scripts
- **FAR**—final audit report
- **FFCRA**—Families First Coronavirus Response Act
- **FFS**—fee-for-service
- **FMEA**—failure modes and effects analysis
- **FUA**—Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence
- **FUH**—Follow-up After Hospitalization for Mental Illness
- **FUM**—Follow-Up After Emergency Department Visit for Mental Illness
- **HbA1c**—hemoglobin A1c; a measure of longer-term glucose management

- **HEDIS**—Healthcare Effectiveness Data and Information Set
- **HepA**—hepatitis A vaccine
- **HepB**—hepatitis B vaccine
- **HHS**—Health and Human Services
- **HIB**—Haemophilus influenzae type B vaccine
- **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- **HMO**—health maintenance organization
- **HPV**—human papillomavirus
- **HRA**—health risk assessment
- **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
- **IRR**—interrater reliability
- **IS**—information systems
- **ISCAT**—Information System Capability Assessment Tool
- **LBP**—Use of Imaging Studies for Low Back Pain
- **LO**—National Committee for Quality Assurance-Licensed Organization
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MMIS**—New Hampshire Medicaid Management Information System
- **MMR**—measles, mumps, and rubella vaccine
- **MRR**—medical record review
- **MRRT**—medical record review team
- **MY**—measurement year
- **NA**—not applicable; for HEDIS, small denominator
- **NAV**—network adequacy validation
- **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
- **NDC**—national drug code
- **NDR**—notification of diagnosis and/or referral
- **NEMT**—non-emergency medical transportation
- **NHHF**—New Hampshire Healthy Families
- **NPI**—National Provider Identifier
- **NR**—not reported
- **P**—professional
- **PAHP**—prepaid ambulatory health plan
- **PBM**—Pharmacy Benefit Manager
- **PCCM**—primary care case management
- **PCE**—Pharmacotherapy Management of COPD Exacerbation
- **PCP**—primary care provider
- **PCR**—Plan All-Cause Readmissions
- **PCV**—pneumococcal conjugate vaccine
- **PDF**—portable document format
- **PDSA**—Plan-Do-Study-Act
- **PDV**—provider directory validation
- **PHO**—physician-hospital organization
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **POS**—place of service
- **PPC**—Prenatal and Postpartum Care
- **PSV**—primary source verification
- **PTSD**—post-traumatic stress disorder
- **QAPI**—quality assessment and performance improvement
- **QI**—quality improvement
- **QISMC**—Quality Improvement System for Managed Care
- **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
- **TOB**—type of bill
- **TOC**—transition of care
- **TPL**—third-party liability
- **TTY/TDD**—teletypewriter/telecommunications device for the deaf
- **UAT**—user acceptance testing
- **UM**—utilization management
- **URI**—Appropriate Treatment for Children with Upper Respiratory Infection
- **URL**—uniform resource locator
- **USPS**—United States Postal Service
- **VZV**—varicella (chicken pox) vaccine
- **W30**—Well-Child in the First 30 Months of Life
- **WCC**—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- **WCV**—Child and Adolescent Well-Care Visits
- **WS**—Well Sense Health Plan

Appendix B. Methodologies for Conducting EQR Activities

The following sections include information concerning the objective of each activity included in this report, the technical methods of data collection and analysis, the description of data obtained, and how conclusions were drawn. The categorization of how HSAG expressed conclusions according to quality, timeliness of care, or access to care are based on the following definitions:

- ***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.[B-1]

- ***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."[B-2] 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).[B-3]

[B-1] 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: Nov 17, 2021.

[B-2] NCQA. *2017 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2020: UM5.

[B-3] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 17, 2021.

MCO Contractual Compliance

Objectives

The purpose of the compliance reviews, one of the mandatory EQR activities defined in 42 CFR §438.358(b)(1)(iii),[B-4] is to evaluate the quality of care, timeliness of care, and access to care and services the MCOs furnish to members. The evaluation includes determining MCO compliance with 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements included in the New Hampshire Medicaid Care Management Contract.[B-5,B-6,B-7] HSAG follows the guidelines set forth in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019,[B-8] to create the process, tools, and interview questions used for the compliance reviews. The results of the compliance reviews assist in identifying, implementing, and monitoring interventions to drive performance improvement for the New Hampshire MCM Program.

Technical Methods of Data Collection and Analysis

HSAG uses a 10-step process to conduct a compliance review which describes the technical methods of data collection and analysis as shown below.

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 compliance review team.

[B-4] 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 17, 2021.

[B-5] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #5 to the Medicaid Care Management Services Contract.* Available at: https://sos.nh.gov/media/p4yppqma/009-gc-agenda-012221.pdf. Accessed on: Nov 17, 2021.

[B-6] Department of Health and Human Services. (2016). 42 CFR §438. Available at: https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-part438.pdf. Accessed on: Nov 17, 2021.

[B-7] Centers for Medicare & Medicaid Services. (2018). Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf. Accessed on: Nov 17, 2021.

[B-8] 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/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Nov 17, 2021.

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 establishes to evaluate MCO performance during the compliance reviews. Frequently when an MCO is new to a state, HSAG conducts a webinar to explain detailed 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***, ***timeliness of care***, 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 determining 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. • Specify 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 concerning 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 IS 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 improving the MCO's processes, performance results, and/or documentation.
Step 8:	**Calculate the individual scores and determine the overall compliance score for performance.**
	After the compliance audit is completed, 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 element 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 CAP. HSAG works with the MCOs to correct all elements that scored below 100 percent compliance.

Step 10:	Corrective Action Plans (CAPs).
	The MCOs complete a CAP for any element scoring *Partially Met* or *Not Met* during the compliance review. DHHS and HSAG evaluate the corrections proposed by the MCOs to ensure that the revisions will satisfy the requirements. The CAP process continues until all elements meet the federal or State requirements included in the compliance review tool.

Description of Data Obtained

To assess the MCO's compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by the MCO, including, but not limited to, the following for the SFY 2021 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., January 31, 2021)
- The Member Handbook, newsletters, and additional documents sent to members
- The Provider Manual, newsletters, and other MCO communication to providers/subcontractors
- The automated member website
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- Financial and TPL documents
- Denials file review
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with the MCO's key staff members.

How Conclusions Were Drawn

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.

While the focus of a compliance review is to evaluate if the MCOs correctly implement the required federal and State requirements, the results of the review can also determine areas of strength and weakness for the MCOs related to ***access to care***, ***timeliness of care***, or ***quality of care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met, Partially Met*, and *Not Met* to determine how the elements relate to the three domains as defined on page B-1. At that point, HSAG can draw conclusions for each MCO concerning ***access to care***, ***timeliness of care***, or ***quality of care*** from the results of the compliance review.

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*. The CAP continues until all items achieve a *Met* status.

Based on the overall score achieved by each MCO, HSAG establishes a level of confidence rating for the compliance review as defined below:

90%–100%: High confidence in the MCO's compliance with State and federal requirements
80%–89%: Moderate confidence in the MCO's compliance with State and federal requirements
70%–79%: Low confidence in the MCO's compliance with State and federal requirements
Under 70%: No confidence in the MCO's compliance with State and federal requirements

SFY 2017–2019 Compliance Review Results

Table B-1 through Table B-4 display the standards included in the New Hampshire compliance reviews and the rates achieved by **NHHF** and **WS** during the three-year period of compliance reviews from SFY 2017–SFY 2019. There are no tables for **ACNH** because that MCO did not begin operating in New Hampshire until SFY 2020. The tables display the CFR reference, standard name as listed in 42 CFR §438, the name of the standards as listed in the MCM program contract with the MCOs, and the rates achieved during the three-year cycle beginning in 2020. The years HSAG reviewed the standards and the rates achieved by the MCOs are also included in the tables.

Table B-1 includes rates achieved by **NHHF** during the three-year cycle from 2017–2019.

Table B-1—Standards and Scores Achieved by NHHF in the Compliance Reviews From SFY 2017–2019

	CFR	Standard Name	2017	2018	2019
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting	100%	78.6%	
II.	NA	Plans Required by the Contract	87.5%	100%	100%
III.	438.114	Emergency and Post-Stabilization Care	100%	100%	
IV.	438.208	Coordination and Continuity of Care Care Management/Care Coordination	90.0%	96.4%	100%
V.	NA	Wellness and Prevention	100%	100%	
VI.	NA	Behavioral Health	100%	100%	100%
VII.	438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment	87.5%	90.0%	91.7%
VIII.	438.100	Enrollee Rights Member Services	100%	100%	100%
IX.	NA	Cultural Considerations	100%	100%	100%
X.	438.228	Grievance and Appeal Systems	100%	100%	100%
XI.	438.206	Availability of Services Access to Care	100%	100%	91.7%
XII.	438.214 438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	100%	100%	88.9%
XIII.	438.210	Coverage and Authorization of Services UM	100%	100%	100%

	CFR	Standard Name	2017	2018	2019
		438.358(b)(iii)	Three Year Period		
XIV.	438.236 438.224 438.330	Practice Guidelines	95.0%	100%	100%
		Confidentiality			
		Quality Assessment and Performance Improvement Program			
		Quality Management			
XV.	NA	Substance Use Disorder			64.3%
OVERALL RESULTS			**97.3%**	**98.0%**	**95.7%**

HSAG provides an in-depth review of the Health Information Systems requirements found in 42 CFR §438.242 during the annual evaluation of EDV found in the 2017, 2018, and 2019 New Hampshire EQR Technical Reports. The average rates achieved by **NHHF** during that review from SFY 2017–2019 are listed in Table B-2.

Table B-2—Scores Achieved by NHHF in the Health Information Systems Reviews From SFY 2017–2019

NHHF	Health Information Systems	2017	2018	2019
438.242	Health Information Systems	95.5%	97.7%	96.9%
	Encounter Data Validation			

Table B-3 includes rates achieved by **WS** during the three-year cycle from 2017–2019.

Table B-3—Standards and Scores Achieved by WS in the Compliance Reviews From SFY 2017–2019

	CFR	Standard Name	2017	2018	2019
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation	100%	85.7%	
		Delegation and Subcontracting			
II.	NA	Plans Required by the Contract	100%	90.0%	100%
III.	438.114	Emergency and Post-Stabilization Care	100%	100%	
IV.	438.208	Coordination and Continuity of Care	96.7%	100%	100%
		Care Management/Care Coordination			
V.	NA	Wellness and Prevention	100%	100%	
VI.	NA	Behavioral Health	100%	100%	91.7%
VII.	438.56	Disenrollment: Requirements and Limitations	100%	100%	100%
		Member Enrollment and Disenrollment			
VIII.	438.100	Enrollee Rights	100%	100%	100%
		Member Services			

	CFR	Standard Name	2017	2018	2019
		438.358(b)(iii)	Three Year Period		
IX.	NA	Cultural Considerations	100%	100%	100%
X.	438.228	Grievance and Appeal Systems	100%	100%	100%
XI.	438.206	Availability of Services Access to Care	100%	100%	100%
XII.	438.214 438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	95.0%	100%	88.9%
XIII.	438.210	Coverage and Authorization of Services UM	100%	100%	92.9%
XIV.	438.236 438.224 438.330	Practice Guidelines Confidentiality Quality Assessment and Performance Improvement Program Quality Management	95.5%	100%	100%
XV.	NA	Substance Use Disorder			71.4%
OVERALL RESULTS			**98.6%**	**98.8%**	**96.2%**

HSAG provides an in-depth review of the Health Information Systems requirements found in 42 CFR §438.242 during the annual evaluation of EDV found in the 2017, 2018, and 2019 New Hampshire EQR Technical Reports. The average rates achieved by **WS** during that review from SFY 2017–2019 are listed in Table B-4.

Table B-4—Scores Achieved by WS in the Health Information Systems Reviews From SFY 2017–2019

WS	Health Information Systems	2017	2018	2019
438.242	Health Information Systems	87.3%	86.9%	93.3%
DHHS	Encounter Data Validation			

SFY 2020–2022 Compliance Review Results

A new three-year period of compliance reviews began in SFY 2020. Table B-5 through Table B-10 present information concerning the compliance reviews conducted in SFY 2020 and SFY 2021. The tables display the CFR reference, standard name as listed in 42 CFR §438, the name of the standards as listed in the MCM program contract with the MCOs, and the rates achieved during the three-year cycle beginning in 2020. The years HSAG reviewed the standards and the rates achieved by the MCOs are also included in the tables.

Table B-5 includes the rates achieved by **ACNH** during the three-year period of reviews that began in SFY 2020. Because SFY 2020 was the first year of operation of **ACNH**, DHHS requested that HSAG review all the standards included in the compliance tool. After SFY 2020, **ACNH** began a review of one-third of the standards on the same cycle of standards as **NHHF** and **WS**.

Table B-5—Standards and Scores Achieved by ACNH in the Compliance Reviews During SFY 2020 and SFY 2021

	CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting	46.9%		
II.	438.114	Emergency and Post-Stabilization Care	96.2%		
III.	438.208	Coordination and Continuity of Care Care Management/Care Coordination	90.0%	100%	
IV.	NA	Wellness and Prevention	100%		
V.	NA	Behavioral Health	93.1%		
VI.	438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment	86.1%	97.1%	
VII.	438.100	Enrollee Rights Member Services	80.6%	99.0%	
VIII.	NA	Cultural Considerations	100%		
IX.	438.228	Grievance and Appeal Systems	93.6%		
X.	438.206	Availability of Services Access to Care	86.3%		
XI.	438.214 438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	91.4%		
XII.	438.210	Coverage and Authorization of Services UM	74.3%	96.9%	
XIII.	438.236 438.224 438.330	Practice Guidelines Confidentiality Quality Assessment and Performance Improvement Program Quality Management	80.6%	100%	
XIV.	NA	Substance Use Disorder	84.0%		
XV.	NA	Fraud, Waste, and Abuse*	91.2%		
XVI.	NA	Financial	92.9%		

	CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
XVII.	NA	TPL		100%	
OVERALL RESULTS			**93.9%**	**98.4%**	

* New standard as of SFY 2020

A comparison of the overall results from the compliance review in 2021 to the previous year (i.e., 2020) indicates that **ACNH** improved its score by 4.5 percentage points.

HSAG provides an in-depth review of the Health Information Systems requirements found in 42 CFR §438.242 during the annual evaluation of EDV for **ACNH** found in Section 3 of this report. The average rates achieved by **ACNH** during that review for SFY 2020 and SFY 2021 are listed in Table B-6.

Table B-6—Information System Review–ACNH

CFR	Health Information Systems	2020	2021	2022
438.242	Health Information Systems	96.9%	99.9%	
	Encounter Data Validation			

A comparison of the health information systems review score from 2021 to the previous year (i.e., 2020) indicates that **ACNH** improved its score by 3.0 percentage points. HSAG also includes information concerning health information systems in the HEDIS section of this report (pages 3-45–3-48) and in the PMV section for **ACNH** (page 3-18).

Table B-7 includes the rates achieved by **NHHF** during the three-year period of reviews that began in SFY 2020.

Table B-7—Standards and Scores Achieved by NHHF in the Compliance Reviews During SFY 2020 and SFY 2021

	CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation	96.9%		
		Delegation and Subcontracting			
II.	438.114	Emergency and Post-Stabilization Care			
III.	438.208	Coordination and Continuity of Care		100%	
		Care Management/Care Coordination			
IV.	NA	Wellness and Prevention			
V.	NA	Behavioral Health	98.3%		
VI.	438.56	Disenrollment: Requirements and Limitations		100%	
		Member Enrollment and Disenrollment			
VII.	438.100	Enrollee Rights		98.0%	

	CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
		Member Services			
VIII.	NA	Cultural Considerations			
IX.	438.228	Grievance and Appeal Systems			
X.	438.206	Availability of Services			
		Access to Care			
XI.	438.214 438.207	Provider Selection	94.8%		
		Assurance of Adequate Capacity and Services			
		Network Management			
XII.	438.210	Coverage and Authorization of Services		100%	
		UM			
XIII.	438.236 438.224 438.330	Practice Guidelines		100%	
		Confidentiality			
		Quality Assessment and Performance Improvement Program			
		Quality Management			
XIV.	NA	Substance Use Disorder	89.0%		
XV.	NA	Fraud, Waste, and Abuse*			
XVI.	NA	Financial	100%		
XVII.	NA	TPL		100%	
OVERALL RESULTS			**94.3%**	**99.5%**	

* New standard as of SFY 2020. This standard will be included in the 2022 compliance review.

A comparison of the overall results from the compliance review score from 2021 to the previous year (i.e., 2020) indicates that **NHHF** improved its score by 5.2 percentage points.

HSAG provides an in-depth review of the Health Information Systems requirements found in 42 CFR §438.242 during the annual evaluation of EDV for **NHHF** found in Section 3 of this report. The average rates achieved by **NHHF** during that review for SFY 2020 and SFY 2021 are listed in Table B-8.

Table B-8—Information System Review–NHHF

CFR	Health Information Systems	2020	2021	2022
438.242	Health Information Systems	96.7%	99.2%	
	Encounter Data Validation			

A comparison of the health information systems review score from 2021 to the previous year (i.e., 2020) indicates that **NHHF** improved its score by 2.5 percentage points. HSAG also includes information concerning health information systems in the HEDIS section of this report (pages 3-45–3-48) and in the PMV section for **NHHF** (page 3-18).

Table B-9 includes the rates achieved by **WS** during the three-year period of reviews that began in SFY 2020.

Table B-9—Standards and Scores Achieved by WS in the Compliance Reviews During SFY 2020 and SFY 2021

	WS	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting	91.2%		
II.	438.114	Emergency and Post-Stabilization Care			
III.	438.208	Coordination and Continuity of Care Care Management/Care Coordination		88.2%	
IV.	NA	Wellness and Prevention			
V.	NA	Behavioral Health	96.6%		
VI.	438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment		94.1%	
VII.	438.100	Enrollee Rights Member Services		100%	
VIII.	NA	Cultural Considerations			
IX.	438.228	Grievance and Appeal Systems			
X.	438.206	Availability of Services Access to Care			
XI.	438.214 438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	94.9%		
XII.	438.210	Coverage and Authorization of Services UM		100%	
XIII.	438.236 438.224 438.330	Practice Guidelines Confidentiality Quality Assessment and Performance Improvement Program Quality Management		100%	
XIV.	NA	Substance Use Disorder	93.0%		

	WS	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
XV.	NA	Fraud, Waste, and Abuse*			
XVI.	NA	Financial	100%		
XVII.	NA	TPL		100%	
OVERALL RESULTS			**94.5%**	**96.4%**	

* New standard as of SFY 2020. This standard will be included in the 2022 compliance review.

A comparison of the overall results from the compliance review score from 2021 to the previous year (i.e., 2020) indicates that **WS** improved its score by 1.9 percentage points.

HSAG provides an in-depth review of the Health Information Systems requirements found in 42 CFR §438.242 during the annual evaluation of EDV for **WS** found in Section 3 of this report. The average rates achieved by **WS** during that review for SFY 2020 and SFY 2021 are listed in Table B-10.

Table B-10—Information System Review–WS

CFR	Health Information Systems	2020	2021	2022
438.242	Health Information Systems	92.0%	99.7%	
	Encounter Data Validation			

A comparison of the health information systems review score from 2021 to the previous year (i.e., 2020) indicates that **WS** improved its score by 7.7 percentage points. HSAG also includes information concerning health information systems in the HEDIS section of this report (pages 3-45–3-48) and in the PMV section for **WS** (page 3-18).

PIPs

Validation of PIPs, as set forth in 42 CFR §438.358(b)(1)(i),[B-9] 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.

[B-9] 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 17, 2021.

Evaluation of the Implementation of the PIP

Objectives

The purpose of conducting PIPs, as required in 42 CFR §438.330(b)(1),[B-10] is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical and 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 MCO'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 and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[B-11]

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-12] For the rapid-cycle 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.

[B-10] 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 17, 2021.

[B-11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 17, 2021.

[B-12] 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 17, 2021.

- **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.

For both PIP topics, all three MCOs used claims data and applied specific queries to the applicable HEDIS measure to identify the eligible and targeted population for the rolling 12-month measurement period. Using the SMART Aim denominator, the MCOs ran a query to identify the numerator positive members and the results were displayed on a SMART Aim run chart.

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 reasonably linked to the QI strategies implemented by the MCO.

Confidence Levels for Modules 1–3 (PIP Initiation, Intervention Determination, and Intervention Testing)

- High confidence in reported PIP results: 100 percent of all module evaluation elements were *Achieved* across all steps validated.
- Moderate confidence in reported PIP results: 80 to 99 percent of all module evaluation elements were *Achieved* across all steps validated.
- Low confidence in reported PIP results: 60 to 79 percent of all module evaluation elements were *Achieved* across all steps validated.

- No confidence: Reported PIP results are not credible: Less than 60 percent of all module evaluation elements were *Achieved* across all steps validated.

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) are not scored. As the PIP progresses, and at the completion of Module 4 (PIP conclusions), HSAG uses the validation findings from modules 1 through 4 for each PIP to determine a final level of confidence representing the validity and reliability of the PIP.

Confidence Levels for Module 4 (PIP Conclusions)

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 reasonably 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 reasonably 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 reasonably 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, reliability, and quality of the MCO'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

Objectives

Validation of performance measures, as set forth in 42 CFR §438.358(b)(1)(ii),[B-13] 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.

Table B-11 presents the 14 state-selected performance measures for the SFY 2021 validation activities in New Hampshire. HSAG completed the reports for this activity in May 2021.

Table B-11—Performance Measures Audited by HSAG for SFY 2021

Performance Measures
ACCESSREQ.05: *Requests for Assistance Accessing MCO Designated Primary Care Providers by County*
CLAIM.11: *Professional and Facility Medical Claim Processing Results*
CLAIM.24: Claims: *Timely Processing of All Clean Provider Claims: Ninety Days of Receipt*
APPEALS.19: *Member Appeals Received*
PROVAPPEAL.01: *Resolution of Provider Appeals Within 30 Calendar Days*
INPASC.04: *Inpatient Hospital Utilization—Ambulatory Care Sensitive Conditions*
MEMCOMM.24: *Member Communications: Messages Returned by the Next Business Day*
NHHREADMIT.10: *Readmissions to NH Hospital Within 30 Days*
NEMT.18: *Results of Scheduled NEMT [Non-Emergency Medical Transportation] Trips by Outcome*
TIMELYCRED.01: *Timely Provider Credentialing—PCPs [Primary Care Providers]*
SERVICEAUTH.15: *Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-Home and Community Based Care (HCBC) Waiver Populations*
SUD.25: Continuity of Pharmacotherapy for Opioid Use Disorder
SUD.28: *Member Retention in SUD [Substance Abuse Disorder] Treatment*
SUD.51: *Member Access to SUD Services Following SUD Assessment and Diagnosis*

[B-13] U. S. Government Printing Office. (2020). *Activities related to external quality reviews.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Sept 23, 2021.

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[B-14]

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, PSV, programming logic review and inspection of dated job logs, and computer database and file structure review.

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 HSAG noted an area of noncompliance 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-12.

Table B-12—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.

[B-14] 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 23, 2021.

- Final performance measure rates.

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

How Conclusions Were Drawn

Based on the acceptable level achieved by the MCO per measure, HSAG establishes an overall level of confidence for the performance validation review based on each MCO following state-specific measure guidelines as defined below:

0 measures determined to be not acceptable: High confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measures.

1–2 measures determined to be not acceptable: Moderate confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measures.

3–4 measures determined to be not acceptable: Low confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measures.

5 or more measures determined to be not acceptable: No confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measures.

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. The results of the validation process also determined areas of strength and weakness for the MCOs related to ***access to care***, ***timeliness of care***, or ***quality of care***. Once HSAG completed the validation process, the reviewers evaluated the designation category (i.e., R, NR, NB) for each performance measure to determine how the elements related to the three domains of care as defined on page B-1. At that point, HSAG drew conclusions for each MCO concerning ***access to care***, ***timeliness of care***, or ***quality of care*** from the results of the PMV activity.

NAV

Objectives

The goal of the SFY 2021 PDV was to determine if the information in each MCO's online provider directory found on the respective MCO's website matched the MCO's internal provider data and whether each MCO's website met the federal requirements at §42 CFR 438.10(h) and the MCM Services Contract, Amendment #5 requirements in §4.4.1.5.[B-15]

[B-15] State of New Hampshire Department of Health and Human Services. (2020). Medicaid Care Management Services Contract, Amendment #5. Available at: https://sos.nh.gov/media/p4yppqma/009-gc-agenda-012221.pdf. Accessed on: Nov 17, 2021.

Additionally, HSAG collaborated with DHHS to develop and administer a questionnaire to collect network data structure information from each MCO, including information on how the MCO ensures the accuracy and timeliness of Medicaid provider information in its data systems.

Technical Methods of Data Collection and Analysis

HSAG used two main data sources to address the PDV objectives: 1) MCOs' self-reported Data Structure Questionnaire responses, and 2) MCOs' provider data files reflecting PCPs; BH providers, including those subcontracted by the MCO; and DME suppliers.

HSAG collaborated with DHHS to develop a nine-element Data Structure Questionnaire with the goal of eliciting targeted information regarding each MCO's provider data structure and methods for identifying and classifying providers associated with the MCM program services. HSAG incorporated DHHS' feedback on the draft questionnaire before distributing a final version for the MCOs' completion. Prior to distributing the questionnaire to the MCOs, HSAG hosted a webinar with the MCOs and DHHS to describe the purpose and content of the questionnaire, as well as the expected timeline for the MCOs' participation. After receiving the completed questionnaires, HSAG reviewed the MCOs' responses and collaborated with the MCOs to resolve questions identified during HSAG's review process.

With DHHS' approval, HSAG developed a data requirements document to request each MCO's provider data. Each MCO submitted provider data to HSAG, reflecting PCPs, BH providers, and DME suppliers actively enrolled with the MCO to serve New Hampshire MCM Program members as of December 15, 2020. HSAG included out-of-state offices for PCPs or BH providers located in Maine, Massachusetts, and Vermont in the list of provider locations eligible for inclusion in the directory review (i.e., the sample frame). HSAG excluded provider records from the sample frame when the MCO indicated that the provider was not expected to be displayed in the online directory (e.g., a provider contracted using a letter of agreement or single case agreement).

HSAG applied a two-stage random sample to the sample frame to generate a list of providers and provider locations (i.e., "directory review cases") by MCO and provider category from a de-duplicated list of PCPs, BH providers, and DME suppliers unique by the provider's name and NPI within each MCO and provider category. HSAG identified all MCO-contracted locations for each sampled provider and randomly selected one location to be reviewed (i.e., the provider location). Provider locations selected for the directory were unique to each MCO, and a provider location may have been included in the directory review for more than one MCO. Sample sizes were based on the total number of unique providers for each MCO, with proportional distribution between provider categories (i.e., PCP, BH, and DME).

Description of Data Obtained

HSAG received each MCO's responses to the DHHS-approved Data Structure Questionnaire in January 2021 regarding the MCO's current provider network structures. In addition to qualitative responses for

the nine questionnaire elements, three elements required that the MCO include supplemental documentation supporting its responses (e.g., data layouts or sample reports).

During February and March 2021, HSAG's reviewers compared data values for each sampled case between the MCOs' provider data files and the MCOs' online provider directories. HSAG's reviewers recorded findings from this comparison in an electronic data collection tool. If the provider's identifying information and location were not found in the online provider directory, the reviewer noted that information and stopped the review.

How Conclusions Were Drawn

The MCOs' self-reported provider data structure questionnaire responses were specific to each MCO's operations and were used to contextualize MCOs' provider network processes, rather than draw specific conclusions. However, HSAG's review of the MCOs' online provider directories identified focused opportunities for improvement among study indicators scoring less than 90 percent compliance or instances in which the MCO did not adhere to federal or State regulations for online provider directories. Including correct and complete provider data in the provider directory directly affects a member's choice of PCP and the member's ***access to care*** as defined on page B-1.

CAHPS

Objectives

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. **ACNH**, **NHHF**, and **WS** obtained 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 2021 CAHPS surveys for **ACNH**, **NHHF**, and **WS**.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical methods of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid population. **ACNH**, **NHHF**, and **WS** used a mixed-mode methodology for data collection for the adult and child Medicaid

populations.[B-16] Adult members and parents or caretakers of child members completed the surveys in 2021, following NCQA's data collection protocol.

The CAHPS 5.1H Surveys included a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed the patient's perspectives on care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite scores.[B-17] 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, HSAG calculated 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). This percentage is referred to as a question summary rate (i.e., positive response). For each of the four composite measures, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composites was a response of "Usually/Always." The percentage of positive responses is referred to as a global proportion for the composite measures. HSAG presented the positive rates in the report for **ACNH**, **NHHF**, and **WS**, which 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 this report, HSAG included results 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. HSAG used a cross (+) to denote CAHPS scores with fewer than 100 respondents. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to 2020 NCQA CAHPS adult and general child Medicaid national averages, where applicable.[B-18]

HSAG compared each measure rate to the NCQA national average and identified a statistically significant difference by using the confidence interval for each measure rate. The figures display measure rates, confidence intervals, and the NCQA national averages. Information provided below the figures discusses statistically significant differences between each measure rate's lower and upper confidence intervals and the NCQA national average.

[B-16] For the adult and child Medicaid populations, **ACNH**, **NHHF**, and **WS** used a mixed-mode (i.e., mail, telephone, and Internet protocol) survey methodology pre-approved by NCQA.

[B-17] For this report, the 2021 Child Medicaid CAHPS results presented for **ACNH**, **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.

[B-18] National data were obtained from the 2020 Quality Compass.

Description of Data Obtained

The CAHPS survey asks members or parents/caretakers to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. **ACNH**, **NHHF**, and **WS** contracted with a CAHPS vendor to administer the survey to adult members and parents or caretakers of child members. The CAHPS survey asks about members' experience with their health plan during the last six months of the measurement period (i.e., July through December 2020).

The MCOs' CAHPS vendors administered the surveys from February to May 2021. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[B-19] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Conclusions Were Drawn

To draw conclusions for this report, HSAG used the information supplied by the MCOs to evaluate the results of the survey. HSAG compared the MCOs' adult and child 2021 CAHPS survey results to the 2020 NCQA CAHPS adult and general child Medicaid national averages to determine opportunities for improvement.

To begin to draw conclusions from the data, HSAG categorized the rates as statistically significantly higher than the national average, neither statistically significantly higher nor lower than the national average, or statistically significantly lower than the national average. The analysis of the 2021 CAHPS scores for **ACNH**, **NHHF**, and **WS** revealed that one child and one adult measure rate for **NHHF** and one adult measure rate for **WS** scored statistically significantly above the national averages. The remaining rates for all three MCOs were neither statistically significantly higher nor lower than the national averages.

Even though none of the MCO survey results were *statistically significantly* lower than the national averages, HSAG concluded that MCOs could improve the measure rates that were lower than the national averages and encouraged the MCOs to focus on activities to assist in increasing measure rates above the national averages for subsequent surveys. HSAG drew conclusions concerning ***access to care***, ***timeliness of care***, or ***quality of care*** by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains as noted on page B-1.

[B-19] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

HEDIS

Objectives

HSAG's primary objectives in completing the HEDIS section of the NH EQR Technical Report are to:

1. Verify **ACNH**, **NHHF**, and **WS** met the requirements of the HEDIS IS Standards review set forth by NCQA.
2. Retrieve, present, and compare the IDSS auditor locked rates achieved by **ACNH**, **NHHF**, and **WS** for the measures DHHS selected for the HEDIS MY 2020 activities.
3. Determine strengths and opportunities for improvement concerning the quality and timeliness of, and access to care for **ACNH**, **NHHF**, and **WS** based on the rates achieved for HEDIS MY 2020 and the definition of the domains included in page B-1.

Technical Methods of Data Collection and Analysis

ACNH, **NHHF**, and **WS** generated HEDIS rates for the indicators prescribed by DHHS and contracted with independent CHCAs to validate and confirm the rates generated by each respective MCO. HSAG compiled the information for the HEDIS section of this report by receiving the **ACNH**, **NHHF**, and **WS** FARs and the IDSS files approved by an NCQA LO.

Description of Data Obtained

The types of data obtained from **ACNH**, **NHHF**, and **WS** included:

- The FAR, which was prepared by each MCO's NCQA LO. The report details key elements from the HEDIS MY 2020 audit review season, including:
  - Audit Team Information
  - Organization Information
  - Audit Information
  - Survey Sample Frame
  - Supplemental Data (if applicable)
  - Source Code Review (if applicable)
  - MRR Validation
  - IS Standards Compliance
  - Audit Design Reference Tool
  - Final Audit Opinion
  - Audit Review Table
- The HEDIS MY 2020 Medicaid IDSS data-filled, auditor-locked workbook, which was generated by NCQA as part of the IDSS reporting process. This file included the final HEDIS rates that were reviewed, verified, and locked by the MCO's NCQA LO.

How Conclusions Were Drawn

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-13 The measures marked NA relate to utilization of services.

Table B-13—HEDIS MY 2020 Measures Activity Components Assessing Quality, Timeliness, and Access

Performance Measures	Quality	Timeliness	Access
Prevention			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			✓
Breast Cancer Screening (BCS)	✓		
Well-Child Visits in the First 30 Months of Life (W30)	✓	✓	✓
Child and Adolescent Well-Care Visits (WCV)	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓		
Childhood Immunization Status (CIS)	✓		
Immunizations for Adolescents (IMA)	✓		
Cervical Cancer Screening (CCS)	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✓		
Chlamydia Screening in Women (CHL)	✓		
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Acute and Chronic Care			
Appropriate Testing for Children with Pharyngitis (CWP)	✓		
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	✓		
Pharmacotherapy Management of COPD Exacerbation (PCE)	✓	✓	
Comprehensive Diabetes Care (CDC)	✓		
Controlling High Blood Pressure (CBP)	✓		
Use of Imaging Studies for Low Back Pain (LBP)	✓		
Asthma Medication Ratio (AMR)	✓		
Plan All-Cause Readmissions (PCR)	✓		
Ambulatory Care (AMB)—Total	NA	NA	NA
Antibiotic Utilization(ABX)—Total	NA	NA	NA
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
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)	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	✓		
Antidepressant Medication Management (AMM)	✓		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)	✓	✓	✓
Identification of Alcohol and Other Drug Services (IAD)	NA	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness (FUH)	✓	✓	✓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUM)	✓	✓	

EDV

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCOs to monitor and improve quality of care, establish performance measure rates, generate accurate and reliable reports, and obtain utilization and cost information. The completeness and accuracy of these data are essential in the State's overall management and oversight of the New Hampshire MCM Program.

During SFY 2021, DHHS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019,[B-20] HSAG conducted the following two core evaluation activities for all three MCOs:

- Ongoing encounter data quality reports—assess monthly and quarterly the completeness, accuracy, and timeliness of MCOs' encounter data files submitted to DHHS

[B-20] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 17, 2021.

- Comparative analysis—analysis of DHHS' electronic encounter data completeness and accuracy through a comparative analysis between DHHS' electronic encounter data and the data extracted from the MCOs' data systems

In addition, the following two EDV activities from the SFY 2020 EDV study were in progress at the time the 2020 New Hampshire EQR Technical Report was written. As a result, the following activities are shown in this year's technical report:

- IS review for **ACNH**—assessment of DHHS' and/or **ACNH**'s IS and processes. Of note, HSAG conducted this activity only for **ACNH** in SFY 2020 because HSAG conducted the IS review activity for **NHHF** and **WS** during SFY 2018. **ACNH** did not begin operating in New Hampshire until September 2019.
- MRR for **NHHF** and **WS**—analysis of DHHS' electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period. HSAG sampled medical records with dates of service between July 1, 2018, and June 30, 2019, for the two MCOs for the MRR activity.

The following sections describe the methodology for each activity.

Ongoing Encounter Data Quality Reports

Objectives

The objective of the ongoing encounter data quality reports is to assess monthly and quarterly the completeness, accuracy, and timeliness of MCOs' encounter data files submitted to DHHS.

Technical Methods of Data Collection and Analysis

HSAG uses the same general process and files as DHHS' fiscal agent, Conduent, when collecting and processing encounter data for the monthly/quarterly encounter data quality reports. For example, daily or weekly, participating MCOs prepare and translate claims and encounter data into the 837P, 837I, and the proprietary 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 Electronic Data Interchange (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 (e.g., filename confirmation); 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 HSAG successfully translates the 837P/I files, 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. Additionally, HSAG processes the MCOs' pharmacy files simultaneously through a comparable process; however, the pharmacy files do not undergo EDI translation. Instead, HSAG processes the pharmacy files directly into HSAG's data warehouse.

In general, the ongoing encounter data quality reports assess measures in four domains such as submission accuracy and completeness (SAC), encounter data accuracy (EDA), encounter data timeliness (EDT), and encounter data completeness (EDC). For the SFY 2021 study, DHHS focused on the following measures:

- **Study Indicator SAC.2**—Percentage of confirmed MCO file submissions

Measure Element	Specification
Numerator	Number of files, attested by the MCOs, that were confirmed during encounter data import processing
Denominator	Total number of files submitted within a month
File Type	Paid and denied encounters
Reporting Frequency	Monthly, but with weekly results
Reporting Level(s)	File-Level—by encounter type, MCO, and statewide

- **Study Indicator SAC.4**—Percentage of professional and institutional records passing X12 EDI compliance edits

Measure Element	Specification
Numerator	Number of professional and institutional records passing X12 EDI compliance edits
Denominator	Total number of professional and institutional records submitted within a month
File Type	Paid and denied professional and institutional encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, MCO, and statewide

- **Study Indicator EDA.1**—Percentage of records with values present for key data element (see Table B-14)

Measure Element	Specification
Numerator	Number of records with values present for a specific data element
Denominator	Total number of records passing X12 EDI compliance edits during measurement period
File Type	Final paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, MCO, and statewide

- **Study Indicator EDA.2**—Percentage of records with valid values for key data element (see Table B-14).

Measure Element	Specification
Numerator	Number of records with valid values for a specific data element
Denominator	Total number of records passing X12 EDI compliance edits during measurement period
File Type	Final paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, MCO, and statewide

Table B-14 highlights the key data elements evaluated for the Percent Present metric included in Study Indicator EDA.1 as well as the validity criteria used to calculate the Percent Valid metric in Study Indicator EDA.2.

Table B-14—Key Data Elements for Measures EDA.1 and EDA.2

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Beneficiary ID	√	√	√	In beneficiary file
Billing Provider Number	√	√	√	In provider file
Rendering/Attending/Prescribing Provider Number	√	√	√	In provider file
Primary Diagnosis Code	√	√		In national International Classification of Diseases, Tenth Revision, Clinical Modification (International Classification of Diseases [ICD-10-Clinical Modification [CM]) diagnosis code sets
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Code	√	√		In national CPT and HCPCS diagnosis code sets
Surgical Procedure Code		√		In national ICD-10-CM surgical procedure code sets
Revenue Code		√		In national revenue code sets
National Drug Code (NDC)			√	In national NDC code sets

- **Study Indicator EDT.2**—Percentage of encounters submitted to DHHS within 14 calendar days of claim detail payment date

Measure Element	Specification
Numerator	Number of records submitted to DHHS within 14 calendar days of claim detail payment date Note: When a claim is paid at the header level, the claim detail payment date may be populated only for one detail line. HSAG used the populated detail payment date to determine whether all detail lines met the 14-day criteria.
Denominator	Total number of records passing X12 EDI compliance edits and submitted during the measurement period
File Type	Paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, MCO, and statewide

- **Study Indicator EDC.4**—Number/percentage of visits by place of service (POS) and submission month for professional encounters

Measure Element	Specification
Numerator	Percentage of visits[1] in each POS category after EDI translation
Denominator	Submission month[2]
File Type	Final paid professional encounters
Reporting Frequency	Quarterly
Reporting Level(s)	Record-Level—by MCO and statewide

[1] A visit is defined by the unique combination of beneficiary identification, date of service, and provider identification.
[2] Submission months are reported for a rolling six months.

- **Study Indicator EDC.5**—Number/percentage of visits by type of bill (TOB) and submission month for institutional encounters for each submission month

Measure Element	Specification
Numerator	Percentage of visits[1] in each TOB category following EDI translation
Denominator	Submission month[2]
File Type	Final paid institutional encounters
Reporting Frequency	Quarterly
Reporting Level(s)	Record-Level—by MCO and statewide

[1] A visit is defined by the unique combination of beneficiary ID, date of service, and provider ID.
[2] Submission months are reported for a rolling six months.

- **Study Indicator EDA.3**—Number of unique final paid claims and total MCO paid amount as listed in the final quarterly reconciliation report template.

Measure Element	Specification
Metrics	a. Number of unique final claims b. Total MCO paid amount
File Type	Final paid claims and claim lines
Reporting Frequency	Quarterly
Reporting Level(s)	Record-Level—by encounter type, vendor (if appropriate), and MCO

Description of Data Obtained

Although HSAG prepared the ongoing reports monthly and quarterly for DHHS to monitor the MCOs' performance, this technical report shows the aggregate rates for encounter files received from MCOs between July 1, 2020, and June 30, 2021. These results are based on the data stored in HSAG's data warehouse, and for measures EDA.1 and EDA.2, HSAG determined the final encounters as of July 5, 2021.

How Conclusions Were Drawn

HSAG calculated the study indicators for each MCO and then compared the MCOs' rates with the following standards within Exhibit A of the MCO contract:[B-21]

- 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."
- Standard 5.1.3.34.2.3 requiring that "One-hundred percent (100%) of member identification numbers shall be accurate and valid."
- Standard 5.1.3.34.2.4 requiring that "Ninety-eight percent (98%) of billing provider information will be accurate and valid."
- Standard 5.1.3.34.2.5 requiring that "Ninety-eight percent (98%) of servicing provider information will be accurate and valid."
- Standard 5.1.3.34.3.1 states that "Encounter data shall be submitted weekly, within fourteen (14) calendar days of claim payment."

HSAG calculated results from the study and drew conclusions associated with ***access to care*** and also ***quality of care*** since determining quality can be challenging if the MCOs do not submit accurate and timely encounter data.

[B-21] New Hampshire Department of Health and Human Services. Care Management Services. Medicaid Care Management Services Contract. Available at: https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-exhibits.pdf. Accessed on: Nov 17, 2021.

Comparative Analysis

Objectives

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 each MCO's data systems. This step corresponds to another important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data for accuracy and completeness of reporting.

Technical Methods of Data Collection and Analysis

HSAG developed a data requirements document requesting claims and encounter data from both DHHS and the MCOs. Follow-up technical assistance meetings occurred approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare questions for the meeting.

Once HSAG received and processed the final set of data requested from DHHS and each MCO, HSAG conducted a series of comparative analyses, which were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in DHHS' data warehouse (record omission)
- The number and percentage of records present in DHHS' data warehouse but not in the MCOs' submitted files (record surplus)

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table B-15. The analyses focused on an element-level comparison for each data element.

Table B-15—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Beneficiary ID	√	√	√
Detail Service From Date	√		
Detail Service To Date	√		
Header Service From Date		√	√
Header Service To Date		√	
Billing Provider Number/NPI	√	√	√
Rendering Provider Number/NPI	√		
Attending Provider Number/NPI		√	

Key Data Elements	Professional	Institutional	Pharmacy
Prescribing Provider Number/NPI			√
Referring Provider Number/NPI	√	√	
Primary Diagnosis Code	√	√	
Secondary Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	
Primary Surgical Procedure Code		√	
Secondary Surgical Procedure Code		√	
NDC			√
Drug Quantity			√
Revenue Code		√	
DRG		√	
Header Paid Amount	√	√	√
Detail Paid Amount	√	√	
MCO Carrier ID	√	√	√

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in DHHS' data warehouse (element omission)
- The number and percentage of records with values present in DHHS' data warehouse but not in the MCOs' submitted files (element surplus)
- The number and percentage of records with values missing from both DHHS' data warehouse and the MCOs' submitted files (element missing values)

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and DHHS' data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCOs' submitted files and DHHS' data warehouse (element accuracy).

For the records present in both DHHS' and the MCOs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (all-element accuracy).

Description of Data Obtained

HSAG used data from both DHHS and the MCOs with dates of service between July 1, 2019, and June 30, 2020, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted professional,

institutional, and pharmacy encounters with MCO adjustment/paid dates on or before November 30, 2020, and submitted to DHHS on or before December 31, 2020. This anchor date allowed sufficient time for SFY 2021 encounters to be submitted, processed, and available for evaluation in the DHHS data warehouse.

Once HSAG received data files from all data sources, the analytic team conducted a preliminary file review to ensure that data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values assigned in those fields.
- Percentage of valid values—Values included are the expected values (e.g., valid ICD-10 codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that match between the data extracted from DHHS' data warehouse and the MCOs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring both MCOs and DHHS to resubmit data.

How Conclusions Were Drawn

Since DHHS had not yet established standards for results from the comparative analysis, HSAG selected results needing the MCOs' attention based on its experience. Table B-16 displays the criteria used.

Table B-16—Criteria Used to Determine Rates Needing the MCOs' Attention

Measure	Criteria
Record Omission	> 4.0%
Record Surplus	> 4.0%
Element Omission	> 5.0%
Element Surplus	> 5.0%
Element Missing	Deviate from other MCOs by more than 10.0 percentage points. In addition, for data elements with a high percentage of missing values (e.g., *Primary Surgical Procedure Code* and *DRG*), HSAG tightened the criteria to 5.0 percentage points.
Element Accuracy	< 95.0%

HSAG calculated results from the study and drew conclusions associated with ***access to care*** and also ***quality of care*** since determining quality can be challenging if the MCOs do not submit accurate and timely encounter data.

Information Systems Review

Objectives

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 the MCOs to DHHS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. This activity corresponds to Activity 2: Review the MCO's Capability in the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

To ensure the collection of critical information, HSAG 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. Of note, HSAG conducted this activity only for **ACNH** in SFY 2020 because HSAG conducted the IS review activity for **NHHF** and **WS** during SFY 2018. **ACNH** began operating in the New Hampshire MCM Program in September 2019.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives and validation activities currently put forth by DHHS. Documents requested included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and DHHS' current encounter data submission requirements. The information obtained from this review assisted in the development of a targeted questionnaire to address important topics of interest to DHHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

Based on the information provided by DHHS, HSAG developed a questionnaire, customized in collaboration with DHHS, to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. This assessment also included a review of supplemental documentation regarding other data systems, including enrollment and providers. Lastly, this review included specific topics of interest to DHHS.

Stage 3—Key Staff Member Interviews

After reviewing the completed assessments, HSAG followed up with key **ACNH** information technology personnel to clarify any questions which stemmed from questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Description of Data Obtained

Representatives from **ACNH** completed the DHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire includes an

attestation statement for **ACNH**'s chief executive officer or responsible individual to certify that the information provided was complete and accurate.

How Conclusions Were Drawn

HSAG made conclusions based on the CMS EQR Protocol 5; MCO contract; DHHS' data submission requirements (e.g., companion guides); and HSAG's experience working with other states regarding the IS review. HSAG calculated results from the study and drew conclusions associated with ***access to care*** and also ***quality of care*** since determining quality can be challenging if the MCOs do not submit accurate and timely encounter data.

Medical Record Review

Objectives

As outlined in the CMS protocol, MRR is a complex, resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid beneficiaries' access to and quality of healthcare services. The goal of the MRR is to evaluate 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 answered the following question:

- *Are the data elements in Table B-17 found on the professional encounters complete and accurate when compared to information contained within the medical records?*

Table B-17—Key Data Elements for MRR

Key Data Element	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

Technical Methods of Data Collection and Analysis

To answer the study question, HSAG conducted the following activities:

- Identified the eligible population and generated samples from data extracted from DHHS' data warehouse
- Assisted the MCOs to procure medical records from providers, as appropriate
- Reviewed medical records against DHHS' encounter data
- Calculated study indicators and presented study results to DHHS

Study Population

To be eligible for the MRR, a beneficiary had to be continuously enrolled in the same MCO during the study period (i.e., between July 1, 2018, and June 30, 2019) and have at least one professional visit during the study period. In addition, HSAG excluded beneficiaries with Medicare or other insurance coverage from the eligible population since DHHS does not have complete encounter data for all

services these beneficiaries received. After review of the encounter data extracted from DHHS' data warehouse, HSAG discussed with DHHS how to identify "professional visits" from the encounter data by restricting the service type, POS, and procedure code. Table B-18 displays DHHS' agreed-upon criteria to determine which "professional visits" should be included in the study.

Table B-18—Criteria for Professional Visits Included in the Study

Data Element	Criteria
Claim Type	**NHHF**
	MCO Medical Claims where claim number contains "NH"
	Behavioral Health Claims where claim number contains "BH"
	WS
	MCO Medical Claims where claim number starts with "E" or "S"
	Behavioral Health Claims where claim number starts with "B"
Place of Service	02 (Telehealth)
	11 (Office)
	12 (Home)
	13 (Assisted Living Facility)
	14 (Group Home)
	20 (Urgent Care Facility)
	23 (Emergency Room—Hospital)
	49 (Independent Clinic)
	50 (Federally Qualified Health Center)
	71 (Public Health Clinic)
	72 (Rural Health Clinic)
Procedure Code	If all detail lines for a visit had the following procedure codes, the visit was excluded from the study since these procedure codes are for services outside the scope of work for this study (e.g., durable medical equipment [DME], dental, and vision): • A procedure code starting with "B," "D," "E," "K," or "V" • Procedure codes between A0021 and A0999 (i.e., codes for transportation services) • Procedure codes between A4206 and A9999 (i.e., codes for medical and surgical supplies, miscellaneous, and investigational procedures) • Procedure codes between T4521 and T4544 (i.e., codes for incontinence supplies) • Procedure codes between L0112 and L4631 (i.e., codes for orthotic devices and procedures) • Procedure codes between L5000 and L9900 (i.e., codes for prosthetic devices and procedures)

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the beneficiary enrollment and encounter data extracted from DHHS' data warehouse. HSAG first identified all beneficiaries who met the study population eligibility criteria, and random sampling was used to select 411 beneficiaries[B-22] from the eligible population for each of the two MCOs. For each selected sampled beneficiary, HSAG used the SURVEYSELECT procedure in SAS to randomly select one professional visit[B-23] that occurred in the study period (i.e., between July 1, 2018, and June 30, 2019). Additionally, to evaluate whether any dates of service were omitted from DHHS' data warehouse, HSAG reviewed a second date of service rendered by the same provider during the review period. The providers selected the second date of service, which was closer to the selected date of service, from the medical records for each sampled beneficiary. If a sampled beneficiary did not have a second visit with the same provider during the review period, HSAG evaluated only one date of service for that beneficiary. As such, HSAG reviewed between 411 and 822 cases in total for each MCO.

Since HSAG selected an equal number of cases from each MCO to ensure an adequate sample size when reporting rates at the MCO level, adjustments were required to calculate the statewide rates to account for population differences among the MCOs. When reporting statewide rates, HSAG weighted each MCO's raw rates based on the volume of professional visits among the eligible population for that MCO. This approach ensured that no MCO was over- or underrepresented in the statewide rates.

Medical Record Procurement

Upon receiving the final sample list from HSAG, MCOs procured the sampled beneficiaries' medical records from their contracted providers for services that occurred during the study period. In addition, MCOs submitted the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance call with **NHHF** and **WS** to review the EDV project and the procurement protocols after distributing the sample list. HSAG instructed the MCOs to submit medical records electronically via an SFTP site to ensure the protection of personal health information. During the procurement process, HSAG worked with the MCOs to answer questions and monitor the number of medical records submitted. For example, HSAG provided an initial submission update when 40 percent of the records were expected to be submitted and a final submission status update following completion of the procurement period.

HSAG maintained all electronic medical records on a secure site, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all MRR and research activities, HSAG maintained a thorough Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and protection program in accordance with federal

[B-22] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent for potential MCO-to-MCO comparisons.

[B-23] To ensure that the MRR includes all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling.

regulations which included recurring training as well as policies and procedures that addressed physical security, electronic security, and day-to-day operations.

Review of Medical Records

HSAG's experienced medical record reviewers abstracted the medical records. To successfully complete the study, the project lead worked with the medical record review team (MRRT) beginning with the methodology phase. HSAG involved the MRRT during the tool design phase as well as tool testing to ensure that the abstracted data were complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the MRRT drafted an abstraction instruction document specific to the study for training. Concurrent with record procurement activities, the MRRT trained the medical record reviewers on the specific study protocols and conducted interrater reliability (IRR) and rater-to-standard testing. All medical record reviewers had to achieve a 95 percent accuracy rate for the training/testing cases before they were allowed to review medical records.

During the MRR, HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. HSAG designed the tool with edits to assist in the accuracy of data collection. The validation included a review of specific data elements identified in sample cases and compared to corresponding documentation in the medical record. HSAG regularly evaluated IRR among reviewers, as well as reviewer accuracy, throughout the study. Reviewers documented issues and decisions raised during the evaluation process in the abstraction instruction document and communicated to all reviewers in a timely manner. In addition, HSAG analysts regularly reviewed the export files from the abstraction tool to ensure complete, accurate, and consistent abstraction results.

The validation of encounter data incorporated a unique two-way approach through which HSAG chose encounters from both electronic encounter data and medical records and subsequently compared them with one another. HSAG compared claims/encounters chosen from DHHS' data system against the medical record and visit records from the medical record and against DHHS' encounter data. This process allowed the study to identify services documented in the beneficiaries' medical records that were missing from DHHS' system as well as surplus encounters that were present in DHHS' data system but not documented in the beneficiaries' medical records. For services in both data sources, HSAG completed an analysis of coding accuracy. HSAG considered information that existed in both data sources but whose values did not match as discrepant.

Study Indicators

Once HSAG's trained reviewers completed the MRR, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators to report the MRR results:

- *Medical record omission rate*: the percentage of dates of service identified in the electronic encounter data that were not found in the beneficiaries' medical records. HSAG also calculated this rate for the other key data elements in Table B-17.

- *Encounter data omission rate*: the percentage of dates of service from beneficiaries' medical records that were not found in the electronic encounter data. HSAG also calculated this rate for the other key data elements in Table B-17.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the beneficiaries' medical records.
- *Overall accuracy rate:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

Description of Data Obtained

Since HSAG regularly received member eligibility/enrollment data from DHHS, HSAG submitted a data requirements document to DHHS to request professional encounter data and provider data. Based on these data, HSAG randomly selected samples and then submitted them to MCOs for medical record procurement. Once HSAG received medical records from MCOs, HSAG's trained reviewers tracked them into an HSAG-designed electronic data collection tool and conducted validation. HSAG designed the tool with edits to assist in the accuracy and consistency of data collection. Finally, HSAG analysts exported information collected from the electronic tool, reviewed the data, and calculated study indicators based on the data.

How Conclusions Were Drawn

This is the first year for DHHS to conduct a MRR for its encounters; therefore, there are no standards. The results will serve as the baseline for future MRR activities. HSAG made conclusions based on the CMS EQR Protocol 5 and HSAG's experience working with other states regarding MRR. HSAG calculated results from the study and drew conclusions associated with ***access to care*** and also ***quality of care*** since determining quality can be challenging if the MCOs do not submit accurate and timely encounter data.

Semi-Structured Interviews

Objectives

In SFY 2021, DHHS defined two topics to be explored through semi-structured qualitative interviews with MCO members. The purpose of this qualitative research was to engage members in a conversation concerning a specific topic to better understand their perception of the benefits, care, and services they received from their MCOs. All participants received a summary of the purpose of the project at the beginning of the interview, and the facilitator read a statement verifying the confidentiality of the information collected. The researcher used open-ended questions to collect first-hand knowledge and experiences about the members' participation in the MCM program.

Technical Methods of Data Collection and Analysis

During SFY 2021, the fall interviews included female MCO members ages 50 and over as of September 25, 2020. These women were asked about their experience with Medicaid managed care, the quality of the care, preventive screenings, access to care, and telehealth. Members included in the spring interviews included beneficiaries who had been diagnosed with either Type 1 or Type 2 diabetes. The questions asked during the interviews with these members included access to information and services, diabetes self-management education and support programs, and diabetes care and self-management skills. Every interview session concluded by asking participants for suggested improvements to the MCM program.

After DHHS defined the study topic, the researcher developed the Key Points of Inquiry for the study. An interview guide, approved by DHHS, contained the framework for the open-ended questions to be asked during the MCO member interviews. DHHS created a data file of the population eligible to be included in the study and uploaded the file to HSAG's SFTP site. The researcher accessed the information from the site and selected the sample of members who were contacted by letter requesting their participation in the study.

Members interested in the study responded by calling a toll-free number or emailing the researcher who scheduled and conducted telephone interviews. The interviews were led by an experienced facilitator with participant responses captured in real-time through verbatim note-taking. The interview guide contained the questions to be answered by the members to ensure consistency in receiving information from the study participants. The interviews lasted approximately 25 to 30 minutes, and members received a gift card in appreciation of their participation. Interviews continued until the data reached *saturation*. Saturation occurred when no new themes emerged from the interviews. During SFY 2021, saturation was achieved after interviewing 30 members for each study.

After completing the telephone interviews, a researcher with extensive experience and training in qualitative analysis reviewed and analyzed the information by identifying, coding, and categorizing primary patterns found in the data.

Description of Data Obtained

The real-time, verbatim note-taking transcription of the members' answers to the interviewer questions comprised the data obtained by the interviewer for the study.

How Conclusions Were Drawn

The researcher formed conclusions for the studies by identifying consistent patterns found during the analysis of the data. As patterns emerged, the interviewer determined the number of MCM program beneficiaries who discussed the same issues to identify the most prominent topics to be included in the reports to DHHS. Information obtained from the MCO members supported the validity of the data from the study but cannot be assumed to be *statistically* representative of the entire population in the New

Hampshire MCM Program. The information presented in the reports identified salient issues relevant to the population, provided contextual information for the larger assessment process, and identified avenues for further research. Recommendations from the reports include items to improve ***access to care***, ***timeliness of care***, and ***quality of care***

Secret Shopper Survey

Objectives

The primary purpose of the SFY 2021 Specialty Provider Survey was to evaluate New Hampshire's Medicaid managed care network of physical health specialty locations.[B-24] Specific survey objectives included the following:

- Determine whether specialty locations accepted patients enrolled with a Medicaid MCO
- Determine whether specialty locations accepted new patients
- Determine appointment availability with the sampled specialty locations for nonurgent services

Technical Methods of Data Collection and Analysis

To address the survey objectives, HSAG was scheduled to conduct a telephone survey among a sample of physical health specialty locations contracted with one or more of the MCOs. Callers would have inquired about appointment availability for nonurgent services for Medicaid managed care enrollees served by at least one of the participating MCOs. To include a comparison of the MCM program results to a commercial insurance plan, the DHHS-approved survey script also included elements to request appointment availability information using the Anthem State Health Employee Plan.

Each MCO submitted provider data to HSAG, reflecting physical health specialty practitioners actively enrolled with the MCO to serve New Hampshire Medicaid members as of December 15, 2020. HSAG included out-of-state offices located in Maine, Massachusetts, and Vermont in the list of provider locations eligible for survey inclusion (i.e., the sample frame). HSAG was scheduled to selected survey cases by MCO and provider category from a de-duplicated list of unique provider locations.[B-25]

[B-24] The Specialty Provider Survey was originally scheduled to include the following physical health specialty categories, with varying provider data values by MCO: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology (Ear, Nose, and Throat), Gastroenterology, Hematology and Oncology, Neurology, Obstetrics and Gynecology, Ophthalmology, Pulmonology, and Urology.

[B-25] When the survey was paused in February 2021, HSAG was in the process of sampling the survey cases from unique provider locations within each MCO and provider specialty category, based on the locations' telephone number and United States Postal Service (USPS) standardized address. The number of individual providers associated with each unique provider location would vary.

Description of Data Obtained

Survey calls were originally scheduled to take place beginning in February 2021, with HSAG's callers abstracting survey responses into an electronic data collection instrument that aligned with the DHHS-approved survey script. DHHS and HSAG agreed to delay fielding the survey until later in the year, and calls are scheduled to be completed during November 2021.

How Conclusions Were Drawn

Due to the continuing impact of the COVID-19 public health emergency on providers' office operations and the subsequent delay in fielding the survey, no survey results were available for conclusions related to this activity. Once HSAG collects the survey responses, however, HSAG will electronically tabulate answers to the survey questions and draw conclusions based on the provider locations' responses. The information obtained from the Secret Shopper Survey will be included in the SFY 2022 New Hampshire EQR Technical Report. Recommendations from the report could include items to improve ***access to care*** and ***timeliness of care***.

Provider Satisfaction Survey

Objectives

The goal of the provider satisfaction survey is to provide feedback to DHHS as it relates to PCPs' and specialists' perceptions of the MCOs.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of a provider satisfaction survey to a sample of 1,500 providers. Providers eligible for sampling included PCPs or specialists who were providing services to MCO members and were contracted with at least one of the MCOs. HSAG used the proportion of PCPs and specialists in the provider data that were received from the MCOs in January 2020 to obtain the sample sizes by provider type. Additionally, HSAG sampled each provider specialty proportional to the specialty's population size in the MCOs' data files.

The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. Providers were given two options for completing the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey by logging on to the survey website with a designated, provider-specific login. HSAG sent the first survey mailing to providers on August 12, 2020, and a second survey mailing to all non-respondents on September 9, 2020. The survey was administered from August to December 2020.

In the absence of a well-accepted, valid, reliable, and robust data collection tool (i.e., survey instrument) that could be applied to evaluate the experience of PCPs and specialists providing services to the Medicaid population, HSAG developed a customized provider satisfaction survey instrument in collaboration with DHHS. The final survey instrument contained 21 questions.

Description of Data Obtained

The data HSAG expected to obtain from the survey were answers to the 21 questions included in the final survey instrument. The survey covered topics that assessed primary care and specialty providers' level of satisfaction with the MCOs in multiple areas, such as claims processing, procedures and timeliness for obtaining non-pharmacy authorization information, access to the MCOs' complex case/care managers, formulary, pharmacy authorizations, call center staff, obtaining member information from the MCOs' call center, and provider relations. Additional survey questions asked about providers' overall level of satisfaction with the MCOs, the ability to access knowledgeable UM staff, interpreter services, and providers' understanding of the Alternative Payment Model.

Data were obtained from 50 provider satisfaction surveys that providers returned to HSAG.

Due to a low response rate of 3.5 percent, HSAG did not perform an analysis on the survey results.

How Conclusions Were Drawn

Due to low response rates for the provider satisfaction survey, HSAG did not perform an analysis on the survey results; therefore, HSAG was unable to draw any conclusions from the data.