State of New Hampshire
Department of Health and Human Services

2022 New Hampshire External Quality Review Technical Report

April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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Health Services Advisory Group, Inc., confirms that no one conducting 2022 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) 2021, there were 228,752 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[1-1]

During state fiscal year (SFY) 2022, 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 2022, 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 conducted semi-structured member interviews at the MCM program level, completed a reveal caller telephone survey with specialty providers, and discussed topics to consider for the implementation of a quality study.

The SFY 2022 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 2021 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 July 22, 2022 (data loaded through end of June 2022).

[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 a *Met* rate for the compliance review standards, targeted improvement activities for **ACNH** should focus on measures that did not meet the standard for NAV, CAHPS, HEDIS, EDV, and a reveal caller telephone survey with specialty providers.

Table 1-1—Opportunities for Improvement for ACNH

EQR Activity	Measure/Standard	ACNH's Results	Standard
Contract Compliance Audit	Standard X—Access	99.1%	100%
	Standard XV—Fraud, Waste, and Abuse (FWA)	91.7%	100%
Network Adequacy Validation (NAV)	Matching Between Two Data Sources (i.e., Online Directory and Telephone Survey Information): Provider Contact Information (i.e., Provider Address, Suite Number, and Provider Telephone Number)	<90%	90%
CAHPS	Child Medicaid CAHPS Results: *Rating of Health Plan*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average
	Child Medicaid CAHPS Results: *Rating of Specialist Seen Most Often**	Statistically significantly lower than the National Average	Equal to or Higher than the National Average
HEDIS	*Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal; tetanus, diphtheria, and acellular pertussis [Tdap])* and *Combination 2 (Meningococcal, Tdap, human papillomavirus [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
	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

EQR Activity	Measure/Standard	ACNH's Results	Standard
	Asthma Medication Ratio (AMR)—Total	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
Encounter Data Validation (EDV)	**Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG**		
	Record Omission Professional (P) Claims	4.7%	≤4.0%
	Record Omission Pharmacy Claims	6.9%	≤4.0%
Reveal Caller Telephone Survey	Provider Non-Response Rate (i.e., Unable to Reach the Provider at Location Specified by Calling the Telephone Number Listed in the Directory)	>55%	10%

* Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Table 1-2 contains a list of the opportunities for improvement for **NHHF**. Since the MCO completed CAPs to remedy the elements not achieving a *Met* rate for the compliance review standards, targeted improvement activities for **NHHF** should focus on measures that did not meet the standard for NAV, HEDIS, EDV, and a reveal caller telephone survey with specialty providers.

Table 1-2—Opportunities for Improvement for NHHF

EQR Activity	Measure/Standard	NHHF's Results	Standard
Contract Compliance Audit	Standard X—Access	99.1%	100%
	Standard XV—FWA	97.2%	100%
Network Adequacy Validation (NAV)	Matching Across Two Data Sources (i.e., Online Directory and Telephone Survey Information): Provider Contact Information (i.e., Provider Address, Suite Number, ZIP Code, Provider Telephone Number, and Providers Accepting New Patients)	<90%	90%
HEDIS	*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
	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	NHHF's Results	Standard
Encounter Data Validation (EDV)	**Ongoing Encounter Data Quality Reports**		
	837P: Initial Submission Within 14 Days of Claim Payment	82.8%	100%
	837 Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
	Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG		
	Record Omission for Institutional (I)	11.4%	≤4.0%
	Record Omission for Pharmacy	5.5%	≤4.0%
	Element Accuracy (I)–Procedure Code, Procedure Code Modifier, and Detail Paid Amount	92.7%–93.5%	≥95.0%
Reveal Caller Telephone Survey	Provider Non-Response Rate (i.e., Unable to Reach the Provider at Location Specified by Calling the Telephone Number Listed in the Directory)	>55%	10%

Table 1-3 contains a list of the opportunities for improvement for **WS**. Since the MCO completed CAPs to remedy the elements not achieving a *Met* rate for the compliance review standards, targeted improvement activities for **WS** should focus on measures that did not meet the standard for NAV, CAHPS, HEDIS, EDV, and a reveal caller telephone survey with specialty providers.

Table 1-3—Opportunities for Improvement for WS

EQR Activity	Measure/Standard	WS's Results	Standard
Contract Compliance Audit	Standard IX—Grievances and Appeals Systems	99.3%	100%
	Standard X—Access	97.3%	100%
	Standard XV—FWA	97.2%	100%
Network Adequacy Validation (NAV)	Matching Across Two Data Sources (i.e., Online Directory and Telephone Survey Information): Provider Contact Information (i.e., Provider Address, Suite Number, and Providers Accepting New Patients)	<90%	90%
CAHPS	Adult Medicaid CAHPS Results: *Rating of Personal Doctor*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average

EQR Activity	Measure/Standard	WS's Results	Standard
HEDIS	*Breast Cancer Screening (BCS)*	Below the 25th Percentile	Equal to or Higher than the National Average
	Chlamydia Screening in Women (CHL)—21–24 Years and *Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Use of Imaging for Low Back Pain (LBP)	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
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	**Information System Review**		
	Perform quality checks on the non-emergency medical transportation (NEMT) and vision encounters before and/or after submitting encounters to DHHS	NEMT vendor in implementation phase: No quality checks established; due to low volume of vision encounters, no quality checks established	Conduct quality checks for subcontractors
	Perform quality checks to evaluate whether the payment fields in the encounters align with the financial reports	No quality checks established by WS to reconcile encounters with financial reports	Conduct quality checks for paid amounts
	Understand the purpose of the denied response files	Confusion regarding the purpose of the denied response files	NA
	Ongoing Encounter Data Quality Reports		
	837 Professional (P): Validity of Member Identification Number—Percent Valid	99.9%	100%
	837 Institutional (I) Encounters: Validity of Member Identification Number—Percent Valid	99.8%	100%
	837P: Initial Submission Within 14 Days of Claim Payment	97.9%	100%

EQR Activity	Measure/Standard	WS's Results	Standard
	837I: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
	837 Pharmacy: Initial Submission Within 14 Days of Claim Payment*	91.1%	100%
	Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG		
	Record Surplus Pharmacy	4.4%	≤4.0%
	Element Missing: P (BH, Durable Medical Equipment [DME], and Vision)–Referring Provider Number/National Provider Identifier [NPI]	72.8%	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS.
	Element Missing: P (Vision)—Secondary Diagnosis Code and Procedure Code Modifier	NA	
	Element Missing: (I) BH—Referring Provider Number/NPI and Attending Provider Number/NPI	NA	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS.
Reveal Caller Telephone Survey	Provider Non-Response Rate (i.e., Unable to Reach the Provider at Location Specified by Calling the Telephone Number Listed in the Directory)	>55%	10%

* Because **WS**'s new pharmacy subcontractor went through a production implementation between July and October 2021, the rate displayed in the table is for pharmacy encounters received between November 2021 and June 2022.

2. Overview of the MCM Program

The New Hampshire statewide MCM program is the primary method of service delivery, covering 97.2 percent[2-1] of the New Hampshire Medicaid population as of December 1, 2021. At the end of CY 2021, there were 228,752 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[2-2] That number represents an increase of 24,353 beneficiaries from the end of CY 2020 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 EBI Start of Month Member Tables as of July 22, 2022 (data loaded through end of June 2022).
[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 2022:

- **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 19 states and has contracted with DHHS to perform EQR activities for New Hampshire since 2013.

The SFY 2022 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 2022.

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 2022. The tasks include MCO contractual compliance, PIPs, PMV, NAV, CAHPS, HEDIS, EDV, semi-structured qualitative interviews, a reveal caller survey with specialty providers, and a quality study.

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 9, 2022.

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 9, 2022.

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 contains 18 standards and in SFY 2022, HSAG reviewed seven of the standards (i.e., approximately one-third of the total standards reviewed during a three-year period) as shown in Table 3-1.

Table 3-1—Standards Included in the New Hampshire SFY 2022 Compliance Review

Standard	42 CFR	CFR Standard Name	New Hampshire Standard Name
II	§438.114	Emergency and Post-Stabilization Services	Emergency and Post-Stabilization Care
IV	Not Applicable (NA)*	NA	Wellness/Prevention/Member Education
VIII	NA*	NA	Cultural and Accessibility Considerations
IX	§438.228	Grievance and Appeal Systems	Grievances and Appeals Systems
X	§438.206	Availability of Services	Access
XV	NA*	NA	FWA
XVIII	§438.242	Health Information Systems (IS)	Health IS

* This standard contains requirements found in the New Hampshire Medicaid Care Management Contract between DHHS and the MCOs. There are no corresponding federal requirements.

3-3 State of New Hampshire Department of Health and Human Services. (2019). *Amendment #8 to the Medicaid Care Management Services Contract.* Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Nov 9, 2022.

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 9, 2022.

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 9, 2022.

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/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 9, 2022.

The seven standards included requirements that affect the ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries. The review period covered CY 2021. 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
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., December 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
- FWA documents
- Grievance file reviews
- Appeal file reviews
- Documentation supporting requirements for the health IS
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG scheduled the three two-day compliance reviews in April 2022. Due to the coronavirus disease 2019 (COVID-19) pandemic, DHHS and HSAG agreed to perform this year's review virtually using Webex. The use of Webex, which supported an end-to-end encryption, 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 3-2 displays the comparison rates achieved by the three MCOs for the SFY 2022 compliance review activity and the level of confidence associated with the overall scores.

Table 3-2—Rates Achieved by the MCOs for the SFY 2022 Compliance Review

Standard	Standard Name	ACNH	NHHF	WS
II	Emergency and Post-Stabilization Care	100%	100%	100%
IV	Wellness/Prevention/Member Education	100%	100%	100%
VIII	Cultural and Accessibility Considerations	100%	100%	100%
IX	Grievances and Appeals Systems	100%	100%	99.3%
X	Access	99.1%	99.1%	97.3%
XV	FWA	91.7%	97.2%	97.2%
XVIII	Health IS	100%	100%	100%
Overall Results		**99.2%**	**99.6%**	**98.8%**
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 98.8 percent or higher. The scores for the individual standards ranged from 91.7 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 scoring *Partially Met* or *Not Met* into compliance with the State contract requirements and federal regulations. At the conclusion of the CAP process, all standards achieved a 100 percent score. The elements included in the CAPs will be reviewed during the SFY 2023 compliance review to ensure continued compliance by each MCO.

[3-7] Ibid.

Conclusions and Recommendations for MCO Contractual Compliance

ACNH

HSAG conducted the compliance review for **ACNH** on April 19 and 20, 2022. Table 3-3 details the scores achieved by **ACNH** for the seven standards included in the SFY 2022 review.

Table 3-3—Compliance Review Scores for ACNH

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II	Emergency and Post-Stabilization Care	13	13	13	0	0	100%
IV	Wellness/Prevention/Member Education	5	5	5	0	0	100%
VIII	Cultural and Accessibility Considerations	10	10	10	0	0	100%
IX	Grievances and Appeals Systems	148	148	148	0	0	100%
X	Access	55	55	54	1	0	99.1%
XV	FWA	18	18	15	3	0	91.7%
XVIII	Health IS	7	7	7	0	0	100%
Overall Results		**256**	**256**	**252**	**4**	**0**	**99.2%**

* ***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.

The **ACNH** compliance tool included seven standards representing 256 applicable elements. **ACNH** *Met* the requirements for 252 elements and *Partially Met* the requirements for four elements. **ACNH** achieved an overall score of 99.2 percent. Of the seven standard areas reviewed, **ACNH** achieved 100 percent compliance on five standards, demonstrating adherence to all requirements within:

- Emergency and Post-Stabilization Care
- Wellness/Prevention/Member Education
- Cultural and Accessibility Considerations
- Grievances and Appeals Systems
- Health IS

ACNH received a score of 91.7 percent or higher but less than 100 percent on the remaining two standards, representing areas of relative strength in:

- Access
- FWA

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

This year's review included file reviews of a random sample of grievance and appeal files. **ACNH** achieved a 100 percent score in both file reviews.

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

- Ensure that providers are aware of the requirement to consult with the Division for Children, Youth, and Families (DCYF) regarding medical and psychiatric matters for members who are children in State custody/guardianship.
- Create written policies for all employees and any subcontractor or agent of the MCO that contain detailed information about the False Claims Act (FCA) and other federal and State laws.
- Include the requirement in plan documents indicating that DHHS may recover overpayments that are not recovered by or returned to the MCO within 60 calendar days of notification by DHHS to pursue.
- Document in written plan materials that it can employ pre-payment review in the following circumstances: Upon new participating provider enrollment or for delayed payment during provider education.

NHHF

HSAG conducted the compliance review for **NHHF** on April 5 and 6, 2022. Table 3-4 details the scores achieved by **NHHF** for the seven standards included in the SFY 2022 review.

Table 3-4—Compliance Review Scores for NHHF

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II	Emergency and Post-Stabilization Care	13	13	13	0	0	100%
IV	Wellness/Prevention/Member Education	5	5	5	0	0	100%
VIII	Cultural and Accessibility Considerations	10	10	10	0	0	100%
IX	Grievances and Appeals Systems	150	150	150	0	0	100%
X	Access	55	55	54	1	0	99.1%
XV	FWA	18	18	17	1	0	97.2%
XVIII	Health IS	7	7	7	0	0	100%
Overall Results		**258**	**258**	**256**	**2**	**0**	**99.6%**

* ***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 seven standards representing 258 applicable elements. **NHHF** *Met* the requirements for 256 elements and *Partially Met* the requirements for two elements. **NHHF** achieved an overall score of 99.6 percent. Of the seven standard areas reviewed, **NHHF** achieved 100 percent compliance on five standards, demonstrating adherence to all requirements within:

- Emergency and Post-Stabilization Care
- Wellness/Prevention/Member Education
- Cultural and Accessibility Considerations
- Grievances and Appeals Systems
- Health IS

NHHF received a score of 97.2 percent or higher but less than 100 percent on the remaining two standards, representing areas of relative strength in:

- Access
- FWA

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

This year's review included file reviews of a random sample of grievance and appeal files. **NHHF** achieved a 100 percent score in both file reviews.

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

- Provide the notice of termination of a contracted provider to members 30 calendar days prior to the effective date of the termination.
- Include the requirement in plan documents to confirm that the MCO and its subcontractors provide any data access or detail records upon written request from DHHS within three business days of the request for any potential FWA investigation, provider or claims audit, or for MCO oversight reviews.

WS

HSAG conducted the compliance review for **WS** on April 7 and 8, 2022. Table 3-5 details the scores achieved by **WS** for the seven standards included in the SFY 2022 review.

Table 3-5—Compliance Review Scores for WS

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II	Emergency and Post-Stabilization Care	13	13	13	0	0	100%
IV	Wellness/Prevention/Member Education	5	5	5	0	0	100%

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
VIII	Cultural and Accessibility Considerations	10	10	10	0	0	100%
IX	Grievances and Appeals Systems	147	147	145	2	0	99.3%
X	Access	55	55	53	1	1	97.3%
XV	FWA	18	18	17	1	0	97.2%
XVIII	Health IS	7	7	7	0	0	100%
Overall Results		**255**	**255**	**250**	**4**	**1**	**98.8%**

* ***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 seven standards representing 255 applicable elements. **WS** *Met* the requirements for 250 elements, *Partially Met* the requirements for four elements, and scored *Not Met* for the requirements in one element. **WS** achieved an overall score of 98.8 percent. Of the seven standard areas reviewed, **WS** achieved 100 percent compliance on four standards, demonstrating adherence to all requirements within:

- Emergency and Post-Stabilization Care
- Wellness/Prevention/Member Education
- Cultural and Accessibility Considerations
- Health IS

WS received a score of 97.2 percent or higher but less than 100 percent on the remaining three standards, representing areas of relative strength in:

- Grievances and Appeals Systems
- Access
- FWA

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

This year's review included file reviews of a random sample of grievance and appeal files. **WS** achieved a 100 percent score in both file reviews.

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

- Ensure that if the MCO extends the time frame for an expedited appeal and the member does not request the extension, plan documents include the requirement to give the member prompt oral

notice of the delay. Prompt oral notice requires providing a minimum of three oral attempts to contact the member at various times of the day on different days within two calendar days of **WS**'s decision to extend the time frame.
- Stipulate in plan documents that for member requests for an expedited State fair hearing, **WS** provides to DHHS and the member, upon request within 24 hours, all MCO-held documentation related to the appeal, including, but not limited to, any transcripts, records, or written decisions from participating providers or delegated entities.
- Describe in the notice to members of a terminating provider the procedures for selecting an alternative PCP.
- Include in its transition of care (TOC) policies a documented process to support continuity of care for members when they move from home to foster care placement, from foster care to independent living, return from foster care placement to the community, and when they experience a change in legal status from foster care to adoption.
- Provide any data access or detail records upon written request from DHHS within three business days of the request for any potential FWA investigation, provider or claims audit, or for MCO oversight review.

PIPs

In SFY 2020, DHHS implemented 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 2022, 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 the 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 used 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 through 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 2022 are displayed in Table 3-6.

Table 3-6—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	Completed and achieved all validation criteria. Plan-Do-Study-Act (PDSA) worksheets submitted for review and feedback.	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	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	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 **NHHF**'s PIP activities in SFY 2022 are displayed in Table 3-7.

Table 3-7—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	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	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	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	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 2022 are displayed in Table 3-8.

Table 3-8—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	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	High
	4. PIP Conclusions	Final submission targeted for October 2022.	Confidence level for PIP conclusions to be determined in October 2022.

PIP Topic	Module	Status	Confidence Level
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	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	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-15.

Table 3-9 through Table 3-19 present a summary of the SFY 2022 validation findings for the MCOs' PIPs. For validation of rapid-cycle PIPs, HSAG developed four modules to guide the MCOs in conducting and documenting PIP activities. In SFY 2022, the New Hampshire MCOs continued testing interventions outlined in the validated Module 3s submitted for validation and completed PDSA worksheets through the PIP end date of June 30, 2022. The final outcomes and PIP validation status for each PIP will be reported in the SFY 2023 EQR Technical Report.

ACNH

Table 3-9 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 3-9—ACNH PIP 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 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 the COVID-19 pandemic, 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** did not submit new Module 3s for new interventions. The

MCO continued the same interventions initiated in SFY 2021. 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 was 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, **ACNH** did not submit new Module 3s for new interventions. The MCO continued the same interventions initiated in SFY 2021. The intervention continued from SFY 2021 involved testing the facilitation of timely communication between the **ACNH** TOC coordinator and the hospital discharge planner. The goal of this intervention was to increase the number of targeted inpatient members who had the follow-up visit scheduled prior to being discharged.

Table 3-10 lists the interventions discussed above that **ACNH** tested during SFY 2022.

Table 3-10—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** TOC 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** concluded its intervention testing as of June 30, 2022, and final testing results and PIP outcomes will be reported in the SFY 2023 EQR Technical Report.

NHHF

Table 3-11 presents the PIP title and the 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 3-11—NHHF PIP 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,* **NHHF** aims to increase the percentage of members 18–64 years of age, who reside in Hillsborough County, New Hampshire, are diagnosed with schizophrenia, schizoaffective or bipolar disorder and dispensed an antipsychotic medication and are screened for diabetes, utilizing a glucose or HbA1c test, during the measurement period from 80.8% to 90.0%.

PIP Title	SMART Aim Statement*
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	By June 30, 2021,* **NHHF** will increase the percentage of engagement of alcohol and other drug (AOD) abuse or dependence 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 from 13.45% to 20.0%.

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

For SFY 2022, **NHHF** submitted two new Module 3s for validation for new interventions. The first module submitted involved testing an email campaign. The MCO emailed targeted members information related to smoking cessation and its connection to SUD. The email encouraged members to outreach to their provider for substance misuse treatment or SUD, as well as smoking cessation. The email also included the MCO's contact information for assistance and program information. The goal of this intervention was to have successful outreach through email communication.

The second Module 3 submitted involved testing education to providers at Community Mental Health Clinics (CMHCs) in Rockingham County for members certified with that facility. The education included a letter explaining the *IET* measure, common scenarios of nonadherent members, a Substance Abuse and Mental Health Services Administration (SAMHSA) flyer related to co-occurring diagnoses, and details about assessing and coding SUD. The education also encouraged providers to assess, code, and follow up appropriately for those members with a co-occurring diagnosis of BH disorders and SUDs. The goal of this intervention was to see a decrease in the number of new members certified with a CMHC who are noncompliant for the *IET* measure.

NHHF passed the Module 3s submitted for each new intervention and achieved all validation criteria for both PIPs. **NHHF** concluded its intervention testing as of June 30, 2022, and final testing results and PIP outcomes will be reported in the SFY 2023 EQR Technical Report.

For the first intervention check-in, **NHHF** submitted its PDSA worksheets for Cycles 2 and 3 for the member outreach intervention and Cycles 6 and 7 for the provider outreach intervention. **NHHF** initiated both these interventions in SFY 2021. The results for the *Study* phase of the PDSA cycles are detailed in the table below.

Table 3-12—Member Outreach to Noncompliant Members

Numerator: Total number of members living in Hillsborough County who were successfully reached by telephone.
Denominator: Total number of noncompliant members living in Hillsborough County who were called by health plan staff.

Testing Period	Numerator	Denominator	Percentage
Cycle 1: 01/01/2021–03/31/2021	4	26	15.4
Cycle 2: 04/01/2021–06/30/2021	16	43	37.2
Cycle 3: 07/01/2021–09/24/2021	20	42	47.6

For Cycle 2, **NHHF** reported an increase in the percentage of compliant members following the outreach calls. For Cycle 3, the results showed an increase in the number of members who received the outreach and became compliant for the measure. However, **NHHF** reported that regardless of member outreach and reminders, this intervention did not impact the overall SMART Aim measure. This was determined after multiple cycles and monitoring; therefore, the MCO abandoned the intervention.

Also submitted during this check-in were the results for the *Study* phase for Cycles 6 and 7 for the provider outreach intervention. The results are presented in the table below.

Table 3-13—Outreach to Prescribers

Numerator: Prescribers of antipsychotic medication to select members diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder, living in Hillsborough County, who received an outreach call from the health plan's pharmacy team and confirmed the lab was ordered/documented in the chart during the measurement month.

Denominator: Prescribers of antipsychotic medication to select members, living in Hillsborough County, who have been dispensed an antipsychotic medication, are noncompliant with an annual diabetes screening, and do not have a current diagnosis of diabetes mellitus during the measurement month. These are members who have had either:

- At least one acute inpatient encounter and have the diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder.
- At least two outpatient visits and have the diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder.

Testing Period	Numerator	Denominator	Percentage
Cycle 1: 06/01/2020–07/11/2020	9	49	18.4
Cycle 2: 07/11/2020–08/11/2020	8	52	15.4
Cycle 3: 08/12/2020–09/11/2020	7	52	13.5
Cycle 4: 09/12/2020–12/11/2020	13	47	27.7
Cycle 5: 12/11/2020–03/11/2021	22	58	37.9
Cycle 6: 03/11/2021–06/30/2021	27	50	54.0
Cycle 7: 07/01/2021–09/24/2021	23	49	46.9

The MCO reported that while this intervention showed positive results in educating prescribers and confirming active lab results in medical records, it did not increase/impact the overall SMART Aim measure or address the targeted failure mode; therefore, the intervention was abandoned.

For the March 2022 check-in, **NHHF** submitted its PDSA worksheet for Cycle 1 of the new member outreach intervention. Cycle 1 was from February 1, 2022, to March 1, 2022, and the intervention was carried out as planned.

Table 3-14 displays the member outreach results.

Table 3-14—Member Outreach			
Numerator: Total number of targeted members who were reached by **NHHF** staff to educate regarding diabetes screening recommendations. **Denominator**: Total number of members within Hillsborough County who were noncompliant for diabetes screening as of 2/1/2022 according to the Interpreta tool.			
Testing Period	**Numerator**	**Denominator**	**Percentage**
02/01/2022–03/01/2022	15	35	42.9

NHHF reported that the first round of outreach calls was successful, and that the results were better than expected. The MCO reported that member feedback was positive and final testing results will be reported in the SFY 2023 EQR Technical Report.

For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP, **NHHF** submitted its PDSA worksheets for Cycles 2 and 3 for the provider outreach intervention. **NHHF** initiated this intervention in SFY 2021. The results for the *Study* phase of the PDSA cycles are detailed in the table below.

Table 3-15—PCP Outreach Following Member Acute AOD Event			
Numerator: Total number of providers who had assigned targeted members living in Rockingham County, discharged from an acute visit with an AOD event, and were sent the fax outreach, who also had attributed members engaged in treatment. **Denominator**: The total number of providers who had assigned targeted members living in Rockingham County who were discharged from an acute visit with an AOD event and were sent the fax outreach.			
Testing Period	**Numerator**	**Denominator**	**Percentage**
Cycle 1: 01/18/2021–03/30/2021	3	11	27.3
Cycle 2: 04/01/2021–06/30/2021	8	24	33.3
Cycle 3: 07/01/2021–09/24/2021	13	41	31.7

NHHF indicated that although there was improvement with nine months of testing, this intervention did not impact the overall SMART Aim measure and therefore was abandoned.

For the March 2022 check-in, **NHHF** submitted its PDSA worksheet for Cycle 1 of the member email outreach intervention. This intervention was initiated in SFY 2022, was carried out as planned, and the results for the *Study* phase of the PDSA cycles are detailed in the table below.

Table 3-16—Member Email Outreach			
Numerator: Total number of members 50–64 years of age living in Rockingham County who were emailed educational content and opened it. **Denominator**: Total number of members 50–64 years of age living in Rockingham County who were emailed educational content.			
Testing Period	**Numerator**	**Denominator**	**Percentage**
Cycle 1: 11/24/2021–12/15/2021	0	1	0
Cycle 2: 12/20/2021–12/28/2021	0	0	0

NHHF reported that the minimal number of members who fell into the specifics of the denominator caused this intervention to be ineffective. The intent was to narrow down to a more specific group of members to manage the logistics of the intervention, but the focus was too small. **NHHF** expected to see a higher number of members in the cohort, considering the age range chosen to focus on has historically been the largest age bracket. Without an effective number of members, this intervention could not be analyzed and was abandoned.

Table 3-17 lists the interventions discussed above that **NHHF** tested during SFY 2022.

Table 3-17—NHHF Interventions by PIP Topic

PIP Title	Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Non-compliant member outreach • Outreach to prescribers
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)	• PCP outreach • Member email outreach

WS

Table 3-18 presents the PIP title and the 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 3-18—WS PIP 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,* **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%.

PIP Title	SMART Aim Statement
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 35.6% to 41.0%.**

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

** In May 2021, with approval from DHHS, the baseline data and SMART Aim goal were updated due to the transition from using **WS**'s data to using Beacon's data.

For SFY 2022, **WS** submitted two new Module 3s for validation for new interventions. The first Module 3 involved a provider-focused alternative payment model (APM) member outreach. The goal of this intervention was to see an increase in the number of members who scheduled the required HbA1c screening because of the provider outreach. The second Module 3 submitted was for the *SSD* PIP and involved targeted member outreach calls. This intervention replaced the original cobranded outreach intervention that was never initiated. The goal of this intervention was to see an increase in the number of targeted members who were successfully outreached and scheduled the required HbA1c screening because of the telephonic outreach. The goal of this intervention was to see a decrease in the number of new members certified with a CMHC who are noncompliant for the *IET* measure.

WS passed the Module 3s submitted for each tested intervention and achieved all validation criteria for both PIPs. **WS** concluded its intervention testing as of June 30, 2022, and final testing results and PIP outcomes will be reported in the SFY 2023 EQR Technical Report.

For the first intervention check-in, **WS** submitted its PDSA worksheet for Cycle 1 for the targeted member outreach calls intervention. The intervention was tested and abandoned July 20, 2021. The results for the *Study* phase of the PDSA cycle are detailed in the table below.

Table 3-19—Member Outreach to Noncompliant Members

Numerator: Total number of members from the denominator who were successfully outreached and indicated they were willing to schedule the HbA1c screening during the testing period.
Denominator: Total number of members identified on the HEDIS SSD care gap report who were assigned to selected PHOs and received an outreach call during the testing period.

Testing Period	Numerator	Denominator	Percentage
Cycle 1: 04/12/2021–04/14/2021 Hospital System	0	8	0
Cycle 1: 04/12/2021–04/14/2021 Federally Qualified Health Center (FQHC) System	0	7	0
Total for both systems	0	15	0

WS reported that feedback from members who participate on its Member Advisory Board indicated that members are more likely to respond to calls from their provider or health system as opposed to the health plan. As a result, **WS** abandoned this intervention and developed a new intervention focused on outreach and intervention from the member's provider and/or health system.

For the second check-in, WS submitted its PDSA worksheet for Cycle 1 of the provider focused APM member outreach intervention. In the worksheet, the MCO reported that the intervention was not carried out as planned due to the unforeseen COVID-19 spikes that occurred early in the first quarter of 2022. Due to the COVID-19 spikes, the quality contacts the MCO works with stated they were unable to work on process improvement and outreach for the *SSD* measure. The quality contacts the MCO works with did indicate that they had the bandwidth and would like to resume outreach starting in the second quarter of 2022. The MCO created an implementation plan with an updated outreach listing that was sent the week of April 11, 2022.

For the *Continued Engagement of Opioid Abuse or Dependence Treatment* PIP check-in, WS submitted its PDSA worksheets for the provider telehealth promotion and educational email blast intervention and its provider resource guide educational email.

Telehealth Intervention

WS submitted Cycle 3 for the provider telehealth intervention after adapting the intervention following Cycles 1 and 2. Instead of sending the communication to all mental health and SUD providers, WS sent this third cycle to a targeted group. Based on opioid claims for the WS membership (January–September 2021), the five highest-volume, lowest-telehealth-utilizing sites were selected. WS sent the communication to individual SUD providers at each site and also made a modification to the survey. Instead of asking providers whether they were more likely to use telehealth after receiving the blast, providers were asked how often they use telehealth to provide SUD care. Additionally, WS added a telehealth coding reminder (02 modifier) to the email blast and incorporated a new measure into the measurement strategy that focused on monitoring any increase in telehealth utilization via claims among the targeted provider sites.

Provider Resource Guide Intervention

WS submitted its PDSA worksheet for Cycle 2 and reported that this cycle was an adaptation to the first cycle. Instead of sending the communication to the entire BH and medical provider networks, WS sent this second cycle to a targeted group of five sites with the lowest rates of opioid treatment engagement. WS sent the communication to individual providers at each site. Additionally, to avoid further provider survey fatigue, WS limited the survey to only one question asking the providers if the resource guide was useful.

For the second check-in, WS submitted PDSA worksheets for the medication-assisted treatment (MAT) provider outreach, telehealth, and provider resource guide interventions.

Telehealth Intervention

WS submitted Cycle 3 for the provider telehealth intervention. The MCO reported that the intervention was carried out as planned and documented. While a limited number of providers engaged with the content, the results indicate providers' interest in enhancing their understanding of telehealth standards and procedures. For the survey measure, two providers responded to the survey and indicated that the telehealth resources included in the email were useful. For the question related to frequency of telehealth utilization, both respondents indicated that they do not often use telehealth to provide SUD care. WS also

reported that they collected the telehealth utilization data before and after the email blast. Results showed that there was no increase in telehealth utilization for opioid-related services after the intervention.

The MCO reported that while results produced during this cycle continued to highlight provider interest in telehealth, results also continued to highlight the challenges associated with email-driven educational interventions. Specifically, many of the targeted providers who received the telehealth education email did not open it, leaving a significant portion of the SUD network potentially unaware of the telehealth resources and capabilities available to them. Additionally, there continued to be a very limited collection of qualitative feedback regarding telehealth utilization, which made it difficult to understand provider perceptions of this care modality. Further, results indicated that most of the opioid-related care was being conducted face-to-face and the use of telehealth was very limited. For these reasons, **WS** abandoned the intervention.

Provider Resource Guide Intervention

WS submitted Cycle 2 for the provider resource guide intervention. The MCO reported that the intervention was carried out as planned and results showed that there was no increase or substantial change in the rate of members who were connected to opioid treatment with a targeted provider. For this reason, the intervention was abandoned.

MAT Provider Outreach Intervention

WS submitted Cycle 1 for the MAT provider outreach intervention. At the time of this check-in, the MCO did not have testing results for either intervention effectiveness measure. The results from this intervention testing will be reported in the final PDSA worksheet that will be submitted in October 2022 with Module 4.

Table 3-20 lists the interventions discussed above that **WS** tested during SFY 2022.

Table 3-20—WS Interventions by PIP Topic

PIP Title	Interventions
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Provider-focused APM. Provider outreach to members identified on the HEDIS SSD Care Gap Report • Members identified on the HEDIS SSD Care Gap Report used for MCO outreach
Continued Engagement of Opioid Abuse or Dependence Treatment	• Telehealth education • Provider Resource Guide • MAT provider outreach and education • Project ECHO [Extension for Community Healthcare Outcomes]* provider education

* Project ECHO is an evidence-based method connecting interdisciplinary specialists with community-based practitioners using Web conferencing technology. During ECHO sessions, experts mentor and share their experiences across a virtual network through case-based learning, enabling practices to manage complex conditions in their own communities.

PMV

The following section of the report describes the results of HSAG's SFY 2022 EQR activities specific to the validation of performance measures. This section provides conclusions as to the strengths and areas of opportunity related to the ***quality of care***, ***timeliness of care***, and ***access to care*** provided by the New Hampshire Medicaid MCOs. During SFY 2022, each MCO submitted rates for 13 state-specific measures validated during PMV. Recommendations were offered to each MCO to facilitate continued quality improvement (QI) in the New Hampshire MCM 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 3-21 displays the findings from the PMV activities conducted for each MCO in SFY 2022.

Table 3-21—SFY 2022 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	Acceptable
Appeals data system and process findings	Acceptable	Acceptable	Acceptable
Prior authorization and case management data system and process findings	Acceptable	Acceptable	Acceptable
Performance measure production and reporting findings	Acceptable	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable	Acceptable
Level of Confidence	**High Confidence**	**High Confidence**	**High Confidence**

Conclusions and Recommendations for Improvement

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 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** revise the Initial Credentialing Approval Letter Tracking Standard Operating Procedure (SOP) to include **ACNH**'s resolution process for when discrepancies are observed regarding when the approval letters are sent to the providers.

HSAG recommends that **ACNH** revise the Utilization Management (UM) Timeliness SOP to include processes to ensure data integrity and protect data from manual manipulation.

HSAG recommends that **ACNH** reassess the system capabilities of the web-hosted Cactus system in the ability to capture the date the notice of enrollment letter was sent. **ACNH** is currently manually tracking outside of the software system, which adds another source system for extracting measure-specific data and introduces increased chances of data entry errors as well as oversight of timeliness.

HSAG recommends that **ACNH** formalize a process for ensuring notice of enrollment letters are sent within 45 days of receipt of the application since **ACNH** is currently manually tracking outside of the web-hosted Cactus system. HSAG recommends that the formalized process includes key positions responsible for oversight, frequency of routine review and auditing of timely notice of enrollment letters sent, and the process concerning how discrepancies are noted and resolved.

The Jiva software source system allows the care management episode start date to be manually entered and allows for future and past dates to be entered. HSAG recommends researching the ability to develop field requirements within the Jiva software tool to limit the ability to past date or future date the case management episode start date. If the Jiva software source system is unable to develop these requirements, HSAG recommends that **ACNH** develop an SOP that ensures staff members document rationale for pre- or post-dated case management episode start dates.

HSAG recommends that **ACNH** document the date the discharge progress report is provided to the aftercare provider to ensure the report is sent within seven days of discharge. In addition, **ACNH** should ensure that documentation is stored consistently concerning the sending of the progress notes and receiving confirmation (i.e., successful fax).

NHHF

NHHF used a variety of methods for producing the measure 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 primary source verification (PSV) without issue. HSAG had no concerns with the measure production for any measure under review this year.

HSAG observed source code issues with the SUD.48 measure resulting in **NHHF** updating its source code logic to align with measure specifications. To prevent reoccurrence of this issue and to support future reporting, **NHHF** indicated that it will conduct an additional internal code walkthrough with business owners for future specification changes. 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.

HSAG recommends revising the GRIEVANCE.03 quality assurance process to capture the action plan **NHHF** provided to HSAG relative to mitigating data entry errors and potential data reporting inaccuracies.

HSAG recommends monitoring the implemented action plan noted for the GRIEVANCE.03 measure to ensure **NHHF** mitigates manual data entry errors by conducting adequate oversight and validation.

HSAG also recommends that **NHHF** explore system enhancements to reduce the risk of duplicate data entry for grievances and appeals.

WS

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

WS indicated a Quarter Four code change to the measure calculation for the HRA.08 measure. **WS** indicated that it transitioned outreach calling from in-house to an external vendor, Eliza, in May 2020. **WS** had identified an issue in August through September 2021 with the code used to extract members for outreach and sent to Eliza. Members who had been identified for outreach at the time of their initial enrollment that occurred prior to the transition were not re-identified when it came time for their annual outreach and were not sent to Eliza. A code fix was put in place in August 2021. **WS** noted 52,000 members who were missed for this annual outreach and sent catch-up files to address this issue. HSAG recommends ensuring adequate oversight to confirm completion of outreach calls for the missing 52,000 members as well as monitoring the code to ensure all members who meet criteria are sent to Eliza for outreach. While HSAG identified this as an opportunity, the issue had no impact on the outcome of the HRA.08 rates, as HSAG determined **WS** was compliant with the requirements of the measure.

HSAG recommends that **WS** revise the provisional credentialing process document to define the process for when **WS** would apply the provisional credentialing date as the application date.

WS provided a Microsoft Visio flowchart and steps for validation of the SERVICEAUTH.13 measure. HSAG recommends that **WS** revise the workflow chart to include titles of individuals responsible for each of the validation activities noted in the workflow chart.

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

For SFY 2022, HSAG performed a NAV activity to assess specific aspects of the MCOs' network adequacy. The two key review tasks performed by HSAG during the SFY 2022 NAV included:

- Online directory review of sampled PCPs, specialty providers, and BH providers; and
- Revealed caller telephone surveys to assess the accuracy of the online directory data and appointment availability.

The online directory review compared the provider data files submitted by each MCO to HSAG to the information posted on the required online provider directories for each MCO. This report reflects HSAG's comparisons across 11 indicators including: provider name, provider address, provider suite number, provider city, provider state, provider ZIP Code, provider telephone number, provider type/specialty, provider gender, provider accepting new patients, and provider primary language. HSAG's trained reviewers assessed the number and percentage of sampled cases in which the information matched across MCO provider data files and the online provider directory.

The purpose of comparing the provider-submitted data files to the MCO online directories and then to provider offices via the revealed survey calls was to determine how often the information matched across all three data sources. The frequency of matching data reflected the accuracy of the information available to Medicaid members. Additionally, the survey calls to the provider offices also assessed appointment availability to determine wait times for new and existing member visits. For comparison to the Medicaid MCOs, HSAG assessed appointment availability for individuals with commercial health insurance using the Anthem State Health Employee Plan (Anthem), which is offered in New Hampshire by Anthem BlueCross BlueShield.

Online directory reviews and revealed caller surveys were conducted among a random sample of PCPs; eight different physical health specialty providers, including allergists, otolaryngologists (ear, nose, and throat specialists [ENTs]), gastroenterologists, obstetricians and gynecologists (OB/GYNs), ophthalmologists, orthopedists, pulmonologists, and urologists; and BH providers, including those subcontracted by the MCO.

PCPs

Online Directory Review Findings

In Table 3-22, reviewers identified over 96 percent of sampled cases across all three MCOs in the online provider directories. **ACNH** had the highest percentage of providers identified while **NHHF** had the lowest percentage of providers identified in the online directories at 100 percent and 91.2 percent, respectively. **NHHF** informed HSAG that PCPs could only be displayed with three locations in the online provider directory. This could have contributed to **NHHF** having the lowest match rate. Across the providers identified in the online provider directory for all three MCOs, the locations for 8.2 percent (n = 40) were not corroborated in the online provider directory.

Table 3-22—Summary of Sampled PCPs Located in Online Directories by MCO

MCO	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%**
ACNH	170	170	100	0	0.0	7	4.1
NHHF	170	155	91.2	15	8.8	21	13.5
WS	170	165	97.1	5	2.9	12	7.3
All MCOs*	**510**	**490**	**96.1**	**20**	**3.9**	**40**	**8.2**

* "All MCOs" reflects the aggregate count and rate of matches between the provider data files and the online provider directory across all three MCOs.
** Rate calculated using "Provider Locations Not Found in Directory" as the numerator and "Providers Found in Directory" as the denominator.

Table 3-23 displays, by MCO and study indicator, the percentage of sampled PCP locations identified in the online directories with exact matches between the MCOs' provider data files and the online provider directory information. Of the 11 indicators assessed by reviewers, provider state, provider gender, and provider primary language had the top three match rates across the three MCOs between the online directories and data files submitted by the MCOs at 100 percent, 99.8 percent, and 99.4 percent, respectively. ACNH had the highest percentage of matches with all 11 indicators scoring above 95 percent.

Table 3-23—Percentage of PCP Cases With Exact Matches by MCO and Study Indicator

Indicator	ACNH		NHHF		WS		All MCOs	
	Denom*	%	Denom*	%	Denom*	%	Denom*	%
Provider Name	170	98.2	155	99.4	165	100	490	99.2
Provider Address	170	96.5	155	88.4	165	90.9	490	92.0
Provider Suite Number	170	98.8	155	89.7	165	94.5	490	94.5
Provider City	170	98.2	155	92.3	165	98.8	490	96.5
Provider State	170	100	155	100	165	100	490	100
Provider ZIP Code	170	97.6	155	89.0	165	97.0	490	94.7
Provider Telephone Number	170	97.1	155	67.7	165	95.2	490	87.1
Provider Type/Specialty	170	97.1	155	98.7	165	98.8	490	98.2
Provider Gender	170	99.4	155	100	165	100	490	99.8
Provider Accepting New Patients	170	96.5	155	88.4	165	98.8	490	94.7

Indicator	ACNH		NHHF		WS		All MCOs	
	Denom*	%	Denom*	%	Denom*	%	Denom*	%
Provider Primary Language	170	98.8	155	99.4	165	100	490	99.4

* The denominator for each study indicator includes the number of cases in which the provider was found in the directory.

Telephone Survey Findings

MCO cases were included in the telephone survey if provider data from seven key indicators (i.e., provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty) matched between the online directories and the data files submitted by the MCOs. The HSAG reviewers called provider offices included in the telephone survey to confirm the accuracy of the online directory information posted by the MCOs. As shown in Table 3-24, the statewide response rate was 78.0 percent. **ACNH** had the highest response rate of 81.4 percent of cases, while **WS** had the lowest response rate of 74.1 percent.

Table 3-24—Telephone Survey Response Rate by MCO for PCPs

MCO	Total Number of Cases	Respondents	Response Rate (%)
ACNH	156	127	81.4
NHHF	97	76	78.4
WS	147	109	74.1
Overall*	**400**	**312**	**78.0**

* Use caution when interpreting "Overall" results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table 3-25 displays, by health plan, the number and percentage of cases where the location accepts new patients for each of the MCOs and the commercial insurance, Anthem. The new patient acceptance rate for this table is limited to the sampled cases in the telephone survey that were at the matched location, offered PCP services, and accepted the specified MCO or Anthem. Across all MCOs, 61.0 percent of the respondents reported accepting new patients. **WS** had the highest proportion of respondents state that they accept new patients at 78.0 percent. Conversely, **ACNH** had the lowest proportion of respondents accepting new patients at 47.7 percent. **NHHF** and Anthem had similar rates of 58.8 percent and 59.2 percent of respondents accepting new patients.

Table 3-25—Distribution of Respondents Accepting New Patients by Health Plan

MCO	Denom[1]	Rate (%)
ACNH	107	47.7
NHHF	51	58.8
WS	91	78.0
Overall MCO*	**249**	**61.0**

MCO	Denom[1]	Rate (%)
Anthem**	213	59.2

[1] The denominator includes cases responding to the survey, at the correct location, and accepting the MCO/commercial insurance.
* Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
** Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.

Table 3-26 reflects the median appointment wait time for both new and existing patients for a routine visit across all three MCOs and Anthem. Respondents across all three MCOs and Anthem reported longer appointment wait times for new patients than for existing patients. The median wait time for new patients was 35 calendar days statewide across all MCOs, and the median wait time for existing patients was 14 calendar days statewide. The longest wait time reported by respondents for an MCO was **WS** at 52 calendar days for a new patient visit; however, **WS** also had the shortest waiting period of all the MCOs for an existing patient routine visit. Anthem had a 35-calendar-day wait for a new patient routine visit with a 14-calendar-day wait for an existing patient routine visit.

Table 3-26—Median Appointment Wait Times for PCPs in Calendar Days by Health Plan

MCO	New Patient Routine Visit	Existing Patient Routine Visit
ACNH	32.0	17.0
NHHF	28.0	14.0
WS	52.0	7.0
Overall MCO*	**35.0**	**14.0**
Anthem**	35.0	14.0

* Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
** Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.

Online Directory Review and Telephone Survey Comparative Findings

Table 3-27 displays the comparative findings from the provider data, provider directory, and telephone survey for PCPs. HSAG included cases that matched on seven key indicators (i.e., provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty) in the provider directory and provider data in the telephone survey.

From an original 170 cases per MCO, **ACNH** had 91.8 percent of cases transition to the telephone survey, while **NHHF** and **WS** had 57.1 percent and 86.5 percent of cases transitioning, respectively. When comparing the provider data, provider directory, and telephone survey, **ACNH** matched exactly on the seven key indicators for 43.5 percent of cases, while **NHHF** and **WS** matched on 28.2 percent and 40.6 percent of cases, respectively. Statewide, 37.5 percent of all cases matched on the seven key indicators.

Table 3-27—Distribution of Comparative Findings for PCPs by MCO

MCO	Total Cases	Cases With Exact Match in Directory*	Rate of Cases With Exact Match in Directory**	Cases in Telephone Survey***	Cases Confirmed by Phone Call+	Rate of Cases Confirmed by Phone Call++	Rate of Cases Confirmed Total+++
ACNH	170	156	91.8	156	74	47.4	43.5
NHHF	170	97	57.1	97	48	49.5	28.2
WS	170	147	86.5	147	69	46.9	40.6
Overall$	**510**	**400**	**78.4**	**400**	**191**	**47.8**	**37.5**

* "Cases With Exact Match in Directory" compares the online provider directory to the provider data files provided by the MCO across the following seven indicators: provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty.
** Rate calculated using "Cases With Exact Match in Directory" as the numerator and "Total Cases" as the denominator.
*** "Cases in Telephone Survey" reflects the number of cases with an exact match across all seven indicators in the directory from the "Cases With Exact Match in Directory" column.
+ "Cases Confirmed by Phone Call" reflects the number of cases that confirmed all seven indicators via phone call.
++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Cases in Telephone Survey" as the denominator.
+++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Total Cases" as the denominator.
$ Use caution when interpreting "Overall" results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Specialty Providers

Online Directory Review Findings

Table 3-28 shows the number of sampled specialists found in the provider online directories in relation to the data provided by each MCO for eight specialty provider types. Of the 488 specialty providers sampled, reviewers found 472 in the online provider directories across all three MCOs (96.7 percent). All sampled ENTs contracted with all three MCOs were able to be located in the directory. At least one sampled OB/GYN per MCO was unable to be located in the directory. Pulmonologists contracted with **NHHF** were the most likely to not be found in the directory with 19.0 percent of providers unable to be located. **NHHF** informed HSAG that specialists could only be displayed with five locations in the online provider directory. This could have contributed to **NHHF**'s low match rate. Overall, 9.7 percent of the provider locations were unable to be located in the directory.

Table 3-28—Summary of Sampled Specialty Providers Located in Online Directories by MCO

MCO	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%**
Allergists							
ACNH	17	17	100	0	0.0	3	17.6
NHHF	15	14	93.3	1	6.7	0	0.0
WS	17	17	100	0	0.0	0	0.0
ENTs							
ACNH	21	21	100	0	0.0	5	23.8
NHHF	21	21	100	0	0.0	2	9.5
WS	21	21	100	0	0.0	1	4.8
Gastroenterologists							
ACNH	21	20	95.2	1	4.8	2	10.0
NHHF	21	21	100	0	0.0	2	9.5
WS	21	20	95.2	1	4.8	2	10.0
OB/GYNs							
ACNH	21	20	95.2	1	4.8	2	10.0
NHHF	21	19	90.5	2	9.5	1	5.3
WS	21	20	95.2	1	4.8	2	10.0
Ophthalmologists							
ACNH	19	16	84.2	3	15.8	0	0.0
NHHF	21	21	100	0	0.0	3	14.3
WS	21	21	100	0	0.0	0	0.0
Orthopedists							
ACNH	21	21	100	0	0.0	1	4.8
NHHF	21	20	95.2	1	4.8	1	5.0
WS	21	21	100	0	0.0	1	4.8
Pulmonologists							
ACNH	21	21	100	0	0.0	5	23.8
NHHF	21	17	81.0	4	19.0	4	23.5

MCO	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%**
WS	21	21	100	0	0.0	3	14.3
Urologists							
ACNH	21	21	100	0	0.0	1	4.8
NHHF	21	20	95.2	1	4.8	3	15.0
WS	21	21	100	0	0.0	2	9.5
All MCOs*	**488**	**472**	**96.7**	**16**	**3.3**	**46**	**9.7**

* "All MCOs" reflects the aggregate count and rate of matches between the provider data files and the online provider directory across all three MCOs.
** Rate calculated using "Provider Locations Not Found in Directory" as the numerator and "Providers Found in Directory" as the denominator.

Table 3-29 displays the percentage of sampled providers with exact matches between the provider data and the provider online directory for seven indicators containing contact information and the indicator provider type/specialty. These eight indicators include the seven key indicators used to pass cases from the online directory review to the telephone survey, by specialty provider category and MCO. HSAG located a total of 472 providers in the online provider directory and included them in the online directory review findings. 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 a study indicator, but the online provider directory did not include a data value for the study indicator).

The provider name indicator matched across all sampled providers, for all eight specialties, across all three MCOs. Statewide, 90.0 percent of cases matched on the provider address indicator, 88.1 percent of cases matched on the provider suite number indicator, 98.1 percent of cases matched on the provider city indicator, 99.8 percent of cases matched on the provider state indicator, 96.0 percent of cases matched on the provider ZIP Code indicator, 86.0 percent of cases matched on the provider telephone number indicator, and 98.9 percent of cases matched on the provider type/specialty indicator.

Table 3-29–Percentage of Cases with Exact Matches on Contact Information and Provider Type/Specialty by Specialty Provider Category and MCO

MCO	Provider Name	Provider Address	Provider Suite Number	Provider City	Provider State	Provider ZIP Code	Provider Telephone Number	Provider Type/Specialty
Allergists								
ACNH	100	82.4	82.4	100	100	82.4	100	100
NHHF	100	100	100	100	100	100	78.6	100

MCO	Provider Name	Provider Address	Provider Suite Number	Provider City	Provider State	Provider ZIP Code	Provider Telephone Number	Provider Type/Specialty
WS	100	100	94.1	100	100	100	100	100
ENTs								
ACNH	100	76.2	76.2	90.5	100	81.0	81.0	100
NHHF	100	90.5	90.5	95.2	100	95.2	71.4	95.2
WS	100	95.2	90.5	100	100	100	100	100
Gastroenterologists								
ACNH	100	90.0	90.0	100	100	90.0	95.0	100
NHHF	100	90.5	95.2	95.2	100	95.2	61.9	95.2
WS	100	90.0	100	100	100	100	90.0	100
OB/GYNs								
ACNH	100	90.0	100	100	100	100	100	100
NHHF	100	94.7	94.7	100	100	100	63.2	89.5
WS	100	95.0	65.0	100	100	95.0	95.0	100
Ophthalmologists								
ACNH	100	100	100	100	100	100	100	100
NHHF	100	85.7	85.7	100	100	100	95.2	100
WS	100	90.5	90.5	100	100	100	100	100
Orthopedists								
ACNH	100	95.2	95.2	100	100	95.2	95.2	100
NHHF	100	95.0	100	100	100	100	45.0	100
WS	100	95.2	81.0	100	100	100	95.2	100
Pulmonologists								
ACNH	100	76.2	76.2	100	100	95.2	85.7	100
NHHF	100	76.5	76.5	94.1	100	94.1	64.7	100
WS	100	85.7	76.2	95.2	100	95.2	90.5	95.2
Urologists								
ACNH	100	95.2	81.0	95.2	100	95.2	100	100
NHHF	100	85.0	85.0	95.0	100	95.0	60.0	100
WS	100	90.5	95.2	95.2	95.2	95.2	95.2	100
Overall	**100**	**90.0**	**88.1**	**98.1**	**99.8**	**96.0**	**86.0**	**98.9**

* The denominator for each indicator includes the number of cases in which the provider was found in the directory.

Table 3-30 displays the percentage of sampled providers with exact matches between the provider data and the provider online directory for the three indicators of accepting new patients, provider gender, and

provider primary language, by specialty provider category and MCO. Statewide, 72.2 percent of cases matched on the provider accepting new patients indicator, 99.6 percent of cases matched on the provider gender indicator, and 99.8 percent of cases matched on the provider primary language indicator.

Table 3-30–Percentage of Cases with Exact Matches on Accepting New Patients, Provider Gender, and Provider Primary Language and MCO

MCO	Provider Accepting New Patients	Provider Gender	Provider Primary Language
Allergists			
ACNH	100	100	100
NHHF	100	100	100
WS	11.8	100	100
ENTs			
ACNH	100	100	100
NHHF	95.2	100	100
WS	23.8	100	100
Gastroenterologists			
ACNH	100	100	100
NHHF	85.7	95.2	100
WS	30.0	100	100
OB/GYNs			
ACNH	100	100	100
NHHF	94.7	94.7	100
WS	30.0	100	95.0
Ophthalmologists			
ACNH	100	100	100
NHHF	100	100	100
WS	14.3	100	100
Orthopedists			
ACNH	100	100	100
NHHF	95.0	100	100
WS	14.3	100	100
Pulmonologists			
ACNH	100	100	100
NHHF	94.1	100	100
WS	33.3	100	100

MCO	Provider Accepting New Patients	Provider Gender	Provider Primary Language
Urologists			
ACNH	100	100	100
NHHF	85.0	100	100
WS	42.9	100	100
Overall	**72.2**	**99.6**	**99.8**

Telephone Survey Findings

HSAG included providers in the telephone survey if they could be found in the online provider directory and matched on seven key indicators (i.e., provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty) with the provider data.

If a provider's office completed the survey questions when called, HSAG deemed the case responsive. Table 3-31 presents the response rates by MCO for specialty providers. Statewide, there was a 68.8 percent response rate for all specialty provider types. **NHHF**'s ophthalmologists were the most responsive with 100 percent of all cases' calls completed, while **ACNH**'s ophthalmologists were the least responsive with 43.8 percent of calls completed. Allergists were the only specialty provider type that recorded a response rate of less than 70.0 percent for all three MCOs.

Table 3-31—Telephone Survey Response Rate by MCO for Specialty Providers

MCO	Total Number of Cases	Respondents	Response Rate (%)
Allergists			
ACNH	14	7	50.0
NHHF	11	7	63.6
WS	17	9	52.9
ENTs			
ACNH	16	15	93.8
NHHF	13	10	76.9
WS	20	12	60.0
Gastroenterologists			
ACNH	18	12	66.7
NHHF	11	6	54.5
WS	18	16	88.9

MCO	Total Number of Cases	Respondents	Response Rate (%)
OB/GYNs			
ACNH	18	8	44.4
NHHF	11	7	63.6
WS	18	13	72.2
Ophthalmologists			
ACNH	16	7	43.8
NHHF	18	18	100
WS	19	12	63.2
Orthopedists			
ACNH	20	14	70.0
NHHF	9	7	77.8
WS	20	16	80.0
Pulmonologists			
ACNH	16	12	75.0
NHHF	11	8	72.7
WS	18	10	55.6
Urologists			
ACNH	20	14	70.0
NHHF	10	7	70.0
WS	19	15	78.9
Overall*	**381**	**262**	**68.8**

* Use caution when interpreting "Overall" results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by specialty category, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table 3-32 displays, by specialty provider category and health plan, the number and percentage of cases in which the location accepts new patients for each of the MCOs and the commercial insurance. HSAG limited the new patient acceptance rate to survey respondents at the correct location, accepting the specialty provider category, and accepting the specified health plan. Across all specialty provider types and MCOs, 89.6 percent of all locations stated they were accepting new patients. Across providers accepting all MCOs and Anthem, 100 percent of all pulmonologists and urologists stated that they were accepting new patients. For **WS**, all specialty provider categories, with the exception of gastroenterologists (91.7 percent), also had a 100 percent new patient acceptance rate. **NHHF**'s gastroenterologists reported not accepting any new patients; however, only two providers were included in this portion of the analysis. The lowest non-zero acceptance rate was 57.1 for **ACNH**'s orthopedists.

Table 3-32—Distribution of Respondents Accepting New Patients by Specialty Provider Category and Health Plan

MCO	Denom[1]	Rate (%)
Allergists		
ACNH	6	83.3
NHHF	7	100
WS	7	100
Anthem*	19	94.7
ENTs		
ACNH	10	90.0
NHHF	8	75.0
WS	10	100
Anthem*	26	88.5
Gastroenterologists		
ACNH	7	85.7
NHHF	2	0.0
WS	12	91.7
Anthem*	20	80.0
OB/GYNs		
ACNH	6	83.3
NHHF	7	71.4
WS	8	100
Anthem*	21	85.7

MCO	Denom[1]	Rate (%)
Ophthalmologists		
ACNH	3	66.7
NHHF	17	82.4
WS	10	100
Anthem*	26	84.6
Orthopedists		
ACNH	7	57.1
NHHF	5	80.0
WS	5	100
Anthem*	19	78.9
Pulmonologists		
ACNH	6	100
NHHF	7	100
WS	6	100
Anthem*	19	100
Urologists		
ACNH	8	100
NHHF	7	100
WS	11	100
Anthem*	24	100
Overall MCO**	**182**	**89.6**

[1] The denominator includes cases responding to the survey, at the correct location, and accepting the MCO/commercial insurance.
* Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.
** Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by specialty provider category, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table 3-33 displays the median wait time by appointment type and health plan to reflect differences in appointment availability. Instances when long appointment wait times are comparable across the MCOs and Anthem suggest that concerns about timely appointments are not limited solely to Medicaid patients. All specialty provider types for each MCO and Anthem had a longer median wait time for new patients compared to existing patients with the exception of **WS**'s OB/GYNs, ophthalmologists, and orthopedists; and **ACNH**'s urologists, where the median wait times were identical. Statewide, the median wait time was 55.0 calendar days for new patients and 42.5 calendar days for existing patients.

Table 3-33—Median Appointment Wait Times in Calendar Days by Specialty Provider Category and Health Plan

MCO	New Patient Routine Visit	Existing Patient Routine Visit
Allergists		
ACNH	50.0	41.0
NHHF	55.03	14.0
WS	59.5	34.5
Anthem*	56.0	32.0
ENTs		
ACNH	85.0	61.5
NHHF	66.0	50.0
WS	17.0	16.0
Anthem*	65.0	42.5
Gastroenterologists		
ACNH	90.0	69.0
NHHF+	NA	NA
WS	48.0	29.5
Anthem*	71.0	58.0
OB/GYNs		
ACNH	36.0	31.5
NHHF	35.0	19.0
WS	14.0	14.0
Anthem*	31.0	21.0
Ophthalmologists		
ACNH	72.0	50.0
NHHF	89.0	63.0
WS	42.5	42.5
Anthem*	72.5	57.0

MCO	New Patient Routine Visit	Existing Patient Routine Visit
Orthopedists		
ACNH	20.0	14.0
NHHF	23.0	9.0
WS	6.0	6.0
Anthem*	14.0	9.0
Pulmonologists		
ACNH	31.0	9.0
NHHF	62.0	22.0
WS	75.0	46.5
Anthem*	49.0	22.0
Urologists		
ACNH	50.0	50.0
NHHF	68.0	54.0
WS	48.0	46.0
Anthem*	53.0	50.5
Overall MCO**	**55.0**	**42.5**

+ NA, or Not Applicable, denotes there were no cases that proceeded to this section of the telephone survey.
* Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.
** Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Online Directory Review and Telephone Survey Comparative Findings

Table 3-34 shows the distribution of providers' information that matched on seven key indicators (i.e., provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty) in the provider data, online provider directory, and telephone survey. Statewide, 78.1 percent of all specialty provider cases matched on seven key indicators during the online directory review and were included in the telephone survey. **WS**'s allergists had the highest percentage of cases match during the online directory review with 100 percent of cases. **WS** had at least 85.7 percent of cases match during the online directory review for all eight specialty provider types, while **NHHF** had a maximum of 85.7 cases match. There was a match rate of 32.4 percent for all specialty provider types and MCOs when comparing the provider data, online provider directory, and data obtained from the telephone survey. Individually, each specialty provider type and MCO combination had a match rate of 47.6 or lower when comparing the provider data, online provider directory, and data obtained from the telephone survey with the exception of **NHHF**'s ophthalmologists, which matched in 71.4 percent of cases.

Table 3-34—Distribution of Comparative Findings by Specialty Provider Category and MCO

MCO	Total Cases	Cases With Exact Match in Directory*	Rate of Cases With Exact Match in Directory**	Cases in Telephone Survey***	Cases Confirmed by Phone Call+	Rate of Cases Confirmed by Phone Call++	Rate of Cases Confirmed Total+++
Allergists							
ACNH	17	14	82.4	14	6	42.9	35.3
NHHF	15	11	73.3	11	7	63.6	46.7
WS	17	17	100	17	6	35.3	35.3
ENTs							
ACNH	21	16	76.2	16	10	62.5	47.6
NHHF	21	13	61.9	13	7	53.8	33.3
WS	21	20	95.2	20	9	45.0	42.9
Gastroenterologists							
ACNH	21	18	85.7	18	7	38.9	33.3
NHHF	21	11	52.4	11	0	0.0	0.0
WS	21	18	85.7	18	8	44.4	38.1
OB/GYNs							
ACNH	21	18	85.7	18	6	33.3	28.6
NHHF	21	11	52.4	11	4	36.4	19.0
WS	21	18	85.7	18	4	22.2	19.0
Ophthalmologists							
ACNH	19	16	84.2	16	3	18.8	15.8
NHHF	21	18	85.7	18	15	83.3	71.4
WS	21	19	90.5	19	9	47.4	42.9
Orthopedists							
ACNH	21	20	95.2	20	7	35.0	33.3
NHHF	21	9	42.9	9	4	44.4	19.0
WS	21	20	95.2	20	5	25.0	23.8

MCO	Total Cases	Cases With Exact Match in Directory*	Rate of Cases With Exact Match in Directory**	Cases in Telephone Survey***	Cases Confirmed by Phone Call+	Rate of Cases Confirmed by Phone Call++	Rate of Cases Confirmed Total+++
Pulmonologists							
ACNH	21	16	76.2	16	6	37.5	28.6
NHHF	21	11	52.4	11	6	54.5	28.6
WS	21	18	85.7	18	6	33.3	28.6
Urologists							
ACNH	21	20	95.2	20	7	35.0	33.3
NHHF	21	10	47.6	10	7	70.0	33.3
WS	21	19	90.5	19	9	47.4	42.9
Overall$	**488**	**381**	**78.1**	**381**	**158**	**41.5**	**32.4**

* "Cases With Exact Match in Directory" compares the online provider directory to the provider data files provided by the MCO across the following seven indicators: provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty.
** Rate calculated using "Cases With Exact Match in Directory" as the numerator and "Total Cases" as the denominator.
*** "Cases in Telephone Survey" reflects the number of cases with an exact match across all seven indicators in the directory from the "Cases With Exact Match in Directory" column.
+ "Cases Confirmed by Phone Call" reflects the number of cases that confirmed all seven indicators via phone call.
++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Cases in Telephone Survey" as the denominator.
+++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Total Cases" as the denominator.
$ Use caution when interpreting "Overall" results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by specialty provider category, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Behavioral Health Providers

Online Directory Review Findings

Table 3-35 displays BH providers that HSAG reviewers located in the MCOs' online directories with matching data files provided by the MCO. Overall, HSAG located 90 percent of providers in the directory across all MCOs with **ACNH** having the highest amount of BH providers found in the directory at 92.4 percent and **NHHF** with the lowest percentage of providers found in the online directory at 85.9 percent. **NHHF** informed HSAG that specialists could only be displayed with five locations in the online provider directory. This could have contributed to **NHHF**'s low match rate.

Table 3-35—Summary of Sampled BH Providers Located in Online Directories by MCO

MCO	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%**
ACNH	170	157	92.4	13	7.6	12	7.6
NHHF	170	146	85.9	24	14.1	6	4.1
WS	170	156	91.8	14	8.2	1	0.6
All MCOs*	**510**	**459**	**90.0**	**51**	**10.0**	**19**	**4.1**

* "All MCOs" reflects the aggregate count and rate of matches between the provider data files and the online provider directory across all three MCOs.
** Rate calculated using "Provider Locations Not Found in Directory" as the numerator and "Providers Found in Directory" as the denominator.

Table 3-36 reflects exact matches between provider online directories and the provider data files submitted by the MCOs for BH providers. Reviewers identified the provider name with the highest percentage of cases matched across all three MCOs at 100 percent. Eight indicators (i.e., provider suite number, provider city, provider state, provider ZIP Code, provider type/specialty, gender, provider accepting new patients, provider primary language) matched cases at 95.5 percent or above across all three MCOs. ACNH and WS had exact matches above 90 percent for all 11 indicators, while NHHF had exact matches for above 90 percent for 10 of the 11 indicators.

Table 3-36—Percentage of Cases With Exact Matches by MCO and Study Indicator for BH Providers

Indicator	ACNH		NHHF		WS		All MCOs	
	Denom*	%	Denom*	%	Denom*	%	Denom*	%
Provider Name	157	100	146	100	156	100	459	100
Provider Address	157	90.4	146	95.9	156	98.7	459	95.0
Provider Suite Number	157	95.5	146	95.9	156	98.1	459	96.5
Provider City	157	99.4	146	99.3	156	99.4	459	99.3
Provider State	157	99.4	146	100	156	100	459	99.8
Provider ZIP Code	157	97.5	146	97.9	156	99.4	459	98.3
Provider Telephone Number	157	98.7	146	76.0	156	98.1	459	91.3
Provider Type/Specialty	157	98.7	146	99.3	156	98.7	459	98.9
Provider Gender	157	99.4	146	91.8	156	100	459	97.2
Provider Accepting New Patients	157	100	146	95.9	156	99.4	459	98.5

Indicator	ACNH		NHHF		WS		All MCOs	
	Denom*	%	Denom*	%	Denom*	%	Denom*	%
Provider Primary Language	157	100	146	98.6	156	97.4	459	98.7

* The denominator for each indicator includes the number of cases in which the provider was found in the directory.

Telephone Survey Findings

Table 3-37 portrays the telephone survey response rate by MCO for BH providers. Overall, the response rate among all three MCOs was 46.7 percent. **ACNH** had the highest response rate at 59.0 percent. The lowest response rate was among providers from **WS** at 37.6 percent.

Table 3-37—Telephone Survey Response Rate for BH Providers by MCO

MCO	Total Number of Cases	Respondents	Response Rate (%)
ACNH	139	82	59.0
NHHF	106	46	43.4
WS	149	56	37.6
Overall*	**394**	**184**	**46.7**

* Use caution when interpreting "Overall" results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Table 3-38 displays, by health plan, the number and percentage of cases where the location accepts new patients for each of the MCOs and the commercial insurance. HSAG limited the new patient acceptance rate to survey respondents at the correct location, offering BH services, and accepting the specified health plan. Across the three MCOs, 74.5 percent of all respondents accepted new patients. **WS** had the highest proportion of respondents state that they accept new patients at 81.8 percent. Conversely, **NHHF** had the lowest proportion of respondents accepting new patients at 66.7 percent. **ACNH** and Anthem had rates of 71.4 percent and 74.1 percent of respondents, respectively, accepting new patients.

Table 3-38—Distribution of BH Providers Accepting New Patients by Health Plan

MCO	Denom[1]	Rate (%)
ACNH	42	71.4
NHHF	24	66.7
WS	44	81.8
Overall MCO*	**110**	**74.5**

MCO	Denom[1]	Rate (%)
Anthem**	85	74.1

[1] The denominator includes cases responding to the survey, at the correct location, and accepting the MCO/commercial insurance.
* Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
** Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.

Table 3-39 presents the median appointment wait times by health plan to illustrate differences in appointment availability. Instances in which long appointment wait times are comparable across the four health plans suggest that concerns about timely appointments are not limited to providers serving Medicaid members. Across the three MCOs, the new patient routine visit wait time was 30.0 calendar days, while the existing patient routine visit was 11.0 calendar days. **NHHF** had the longest wait time for a new patient routine visit at 47.0 calendar days, while **WS** had the shortest wait time at 22.5 calendar days. **WS** also had the shortest wait time for an existing patient routine visit at 7.0 calendar days, while **ACNH** had the longest at 12.0 calendar days.

Table 3-39—Median Appointment Wait Times for BH Services in Calendar Days by Health Plan

MCO	New Patient Routine Visit	Existing Patient Routine Visit
ACNH	33.5	12.0
NHHF	47.0	11.0
WS	22.5	7.0
Overall MCO*	**30.0**	**11.0**
Anthem**	40.5	11.0

* Use caution when interpreting Overall MCO results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).
** Results for Anthem are limited to cases that reported accepting Medicaid and Anthem and do not reflect a separate, random sample of provider locations contracted with Anthem.

Online Directory Review and Telephone Survey Comparative Findings

Table 3-40 shows the distribution of providers' names that matched on seven key indicators (i.e., provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty) between the provider data, online provider directory, and telephone survey. Statewide, the total rate of cases confirmed was 17.8 percent with **ACNH** displaying the highest rate at 22.9 percent and **NHHF** displaying the lowest rate at 12.9 percent.

Table 3-40—Distribution of Comparative Findings for BH Providers by MCO

MCO	Total Cases	Cases With Exact Match in Directory*	Rate of Cases With Exact Match in Directory**	Cases in Telephone Survey***	Cases Confirmed by Phone Call+	Rate of Cases Confirmed by Phone Call++	Rate of Cases Confirmed Total+++
ACNH	170	139	81.8	139	39	28.1	22.9
NHHF	170	106	62.4	106	22	20.8	12.9
WS	170	149	87.6	149	30	20.1	17.6
Overall$	**510**	**394**	**77.3**	**394**	**91**	**23.1**	**17.8**

* "Cases With Exact Match in Directory" compares the online provider directory to the provider data files provided by the MCO across the following seven indicators: provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty.
** Rate calculated using "Cases With Exact Match in Directory" as the numerator and "Total Cases" as the denominator.
*** "Cases in Telephone Survey" reflects the number of cases with an exact match across all seven indicators in the directory from the "Cases With Exact Match in Directory" column.
+ "Cases Confirmed by Phone Call" reflects the number of cases that confirmed all seven indicators via phone call.
++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Cases in Telephone Survey" as the denominator.
+++ Rate calculated using "Cases Confirmed by Phone Call" as the numerator and "Total Cases" as the denominator.
$ Use caution when interpreting Overall results, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations. Survey calls were placed by provider domain, telephone number, and address; survey responses are unique to the sampled location (i.e., case).

Health Plan-Specific Conclusions and Recommendations

Drawing from the results of the SFY 2022 NAV, HSAG is providing the following health plan-specific conclusions and recommendations for consideration by the MCOs. Additional opportunities for improvement are provided in Section 4 for each MCO.

ACNH

- After receiving the data files from the NAV study showing the provider address, suite number, and provider telephone numbers that did not match between the online directory and telephone survey, **ACNH** needs to correct the information.
- In the **ACNH** online provider directory, nearly one-quarter (23.8 percent) of the provider locations submitted with the MCO's provider data files for both ENTs and pulmonologists could not be

located. **ACNH** should consider review of the processes used to ensure that provider data are updated and maintained in an accurate and timely manner.

- The telephone survey with **ACNH**'s PCPs revealed that 47.7 percent of the providers accepted new patients. **ACNH** should evaluate the number of PCPs accepting new patients to ensure that there is adequate capacity to accommodate the needs of its members.

NHHF

- After receiving the data files from the NAV study showing the provider address, suite number, ZIP code, provider telephone numbers, and providers accepting new patients that did not match between the online directory and telephone survey, **NHHF** needs to correct the information.
- A total of 19.0 percent of pulmonologists and 14.1 percent of BH providers sampled could not be found in the online provider directory. Among the providers who were found, nearly one-quarter (23.5 percent) of the pulmonologist office locations could not be identified in the online provider directory. **NHHF** informed HSAG that specialists could only be displayed with five locations in the online provider directory. This could have contributed to the low match rates. Since HSAG cannot determine if the limitation of locations affected these two rates, **NHHF** should consider review of the processes used to ensure that provider data are updated and maintained in an accurate and timely manner.
- **NHHF**'s sampled PCP locations reported accepting new patients in 58.8 percent of the cases surveyed, while the online provider directory and MCO data file match rate indicated 88.4 percent were accepting new patients. Sampled BH providers reported accepting new patients in 66.7 percent of the cases surveyed, while the online provider directory and MCO data file match rate indicated 95.9 percent were accepting new patients. **NHHF** should consider reviewing PCP panel capacities and the availability of BH providers to accept new patients relative to the **NHHF** membership to determine whether additional provider contracts should be executed.

WS

- After receiving the data files from the NAV study showing the provider address, suite number, and providers accepting new patients that did not match between the online directory and telephone survey, **WS** needs to correct the information.
- In the **WS** online provider directory, 14.3 percent of pulmonologist cases sampled did not match on the office location when compared to the submitted provider data. Among specialty providers sampled in the online provider directory, the provider accepting new patients indicator matched the submitted provider data in 11.8 percent to 42.9 percent of cases. **WS** should consider a review of the processes used to ensure that provider data are updated and maintained for office locations and providers accepting new patients.
- **WS**'s sampled PCPs had a median wait time for an appointment for a new patient of 52.0 calendar days. While this finding does not mean that appointments were not available within the 45-calendar-day appointment standard defined by DHHS, it does indicate that half of the PCP provider locations surveyed indicated having new patient appointment wait times that were longer than 52 calendar days. **WS** should consider reviewing the appointment wait time standards with its contracted PCP

providers and identifying whether additional PCP provider capacity is necessary to reduce overall wait times to a shorter period of time.

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.[3-8]

The CAHPS 5.1H Surveys include a set of standardized items including four global ratings and four composite scores.[3-9] The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, 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 3-41 and Table 3-42. 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 3-41 contains the adult Medicaid CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to the NCQA national averages.

3-8 National Committee for Quality Assurance. *HEDIS® Measurement Year 2021*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2021.

3-9 For this report, the 2022 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).

Table 3-41—ACNH, NHHF, and WS Adult Medicaid CAHPS Results

CAHPS Measure	2022 Adult Medicaid Positive Rates	2021 National Average Comparison*	2022 Adult Medicaid Positive Rates	2021 National Average Comparison*	2022 Adult Medicaid Positive Rates	2021 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**82.5%**	—	**78.8%**	—	**81.7%**	—
Rating of All Health Care	**78.8%**	—	**78.9%**	—	**79.3%**	—
Rating of Personal Doctor	**81.2%**	—	**79.5%**	—	**78.7%**	↓
Rating of Specialist Seen Most Often	**88.6%**	—	**85.6%**	—	**83.3%**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**85.1%**	—	**83.6%**	—	**84.1%**	—
Getting Care Quickly	**86.3%**	—	**77.7%**	—	**84.8%**	—
How Well Doctors Communicate	**94.8%**	—	**90.9%**	—	**93.4%**	—
Customer Service	**91.9%+**	—	**86.0%+**	—	**91.1%**	—

* The 2021 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 lower than the national average.
— Indicates the measure rate is neither statistically significantly higher nor lower than the national average.

Table 3-42 contains the general child CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to NCQA national averages.

Table 3-42—ACNH, NHHF, and WS Child Medicaid CAHPS Results

CAHPS Measure	2022 Child Medicaid Positive Rates	2021 National Average Comparison*	2022 Child Medicaid Positive Rates	2021 National Average Comparison*	2022 Child Medicaid Positive Rates	2021 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**82.0%**	↓	**84.5%**	—	**87.9%**	—
Rating of All Health Care	**87.9%**	—	**86.2%**	—	**91.3%**	—
Rating of Personal Doctor	**90.0%**	—	**88.2%**	—	**90.5%**	—
Rating of Specialist Seen Most Often	**76.3%+**	↓	**87.3%+**	—	**89.3%**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**85.7%**	—	**90.2%**	—	**89.0%**	—
Getting Care Quickly	**89.0%**	—	**90.3%**	—	**90.9%**	↑
How Well Doctors Communicate	**96.4%**	↑	**94.8%**	—	**96.3%**	↑
Customer Service	**87.6%+**	—	**92.0%+**	—	**93.0%+**	↑

* The 2021 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 statistically significantly lower 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 2022, and members returned 226 completed surveys. After excluding ineligible members, the response rate was 11.3 percent. In 2022, 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 14.7 percent. Figure 3-1 and Figure 3-2 show **ACNH**'s adult Medicaid 2022 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.

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

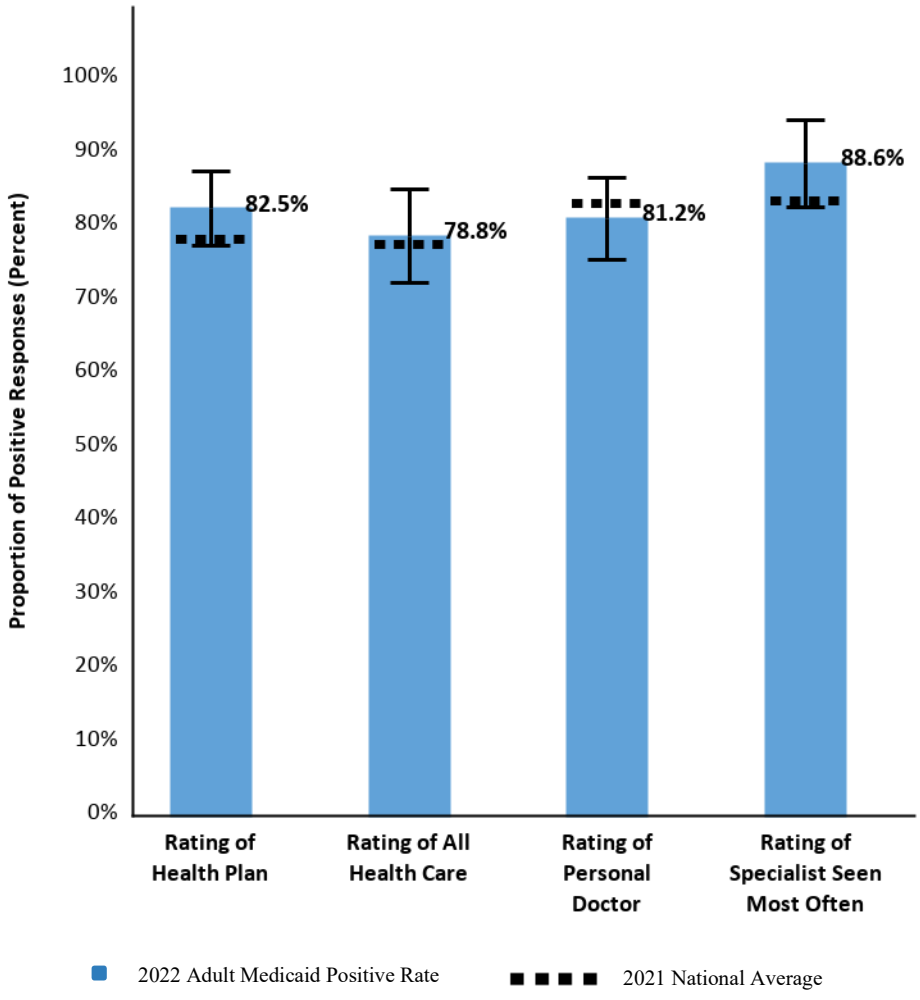
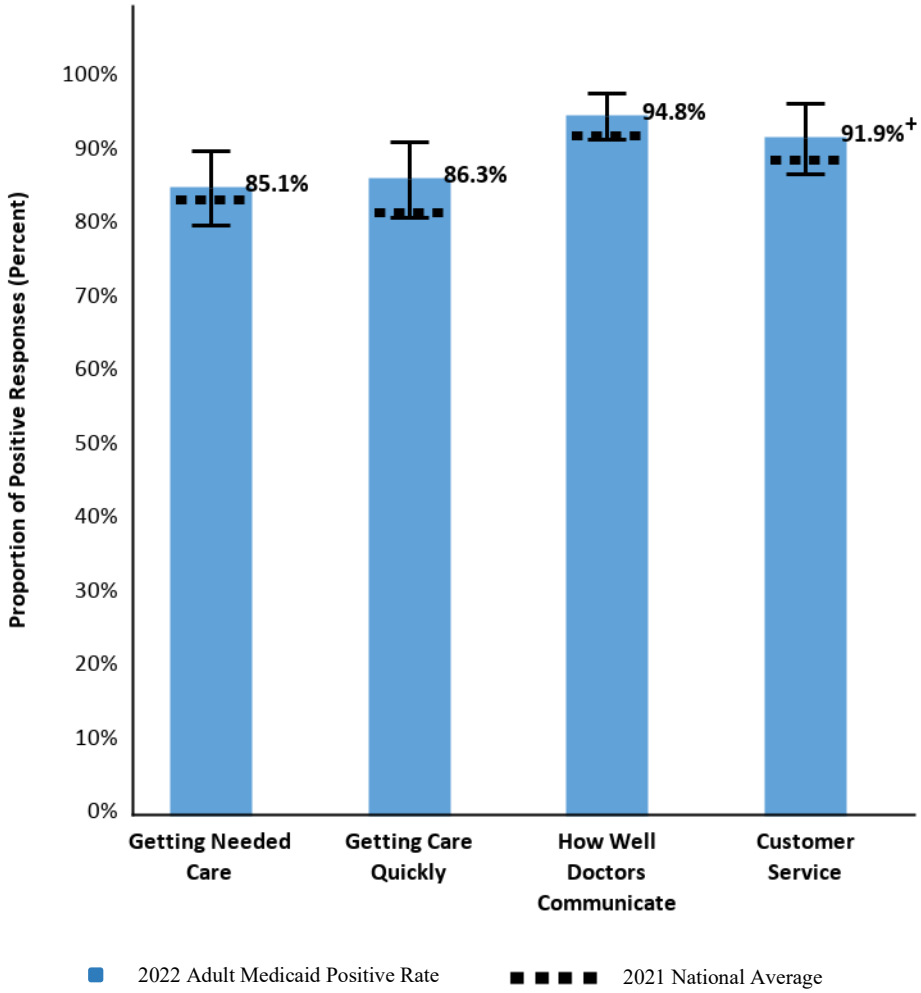


Figure 3-2—ACNH Adult Medicaid CAHPS Results: Composite Measures

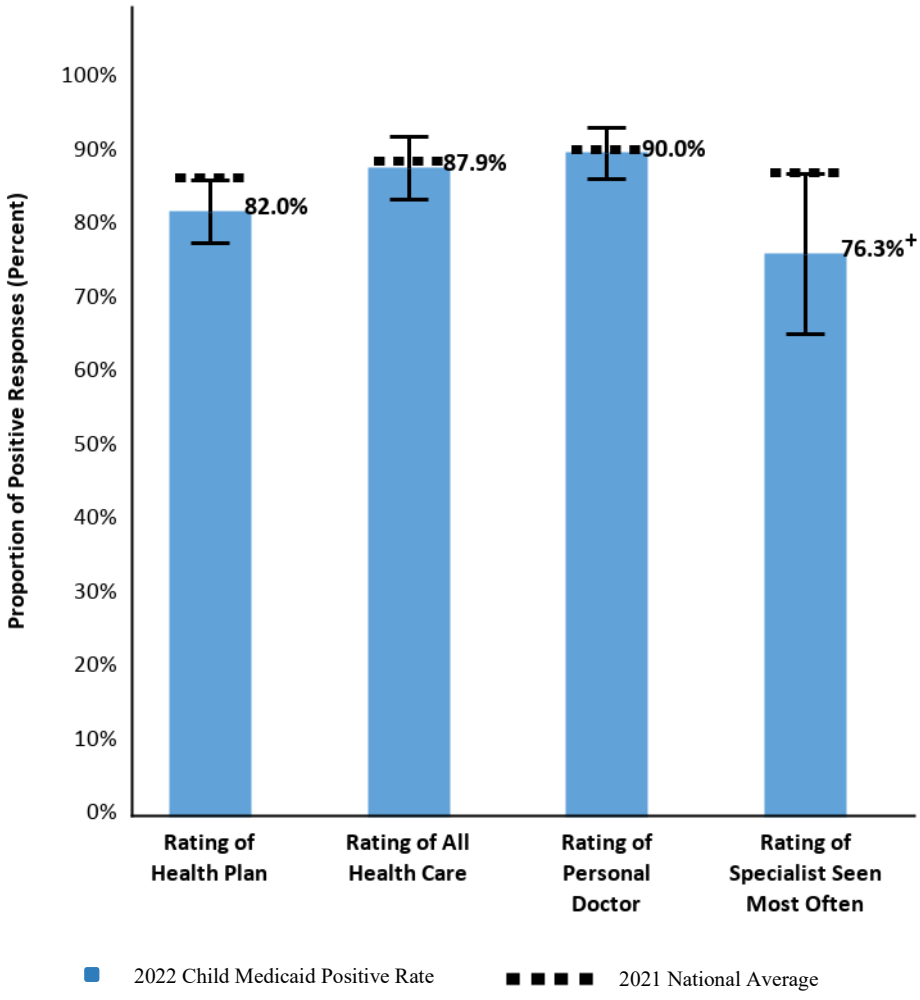


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **ACNH**'s adult Medicaid population, seven rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2021 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

ACNH surveyed 3,399 general child Medicaid members in 2022, and parents/caretakers of child members returned 321 completed surveys. After excluding ineligible members, the response rate was 9.5 percent. In 2022, 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 16.4 percent.[3-10] Figure 3-3 and Figure 3-4 show **ACNH**'s general child Medicaid 2022 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.[3-11]

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

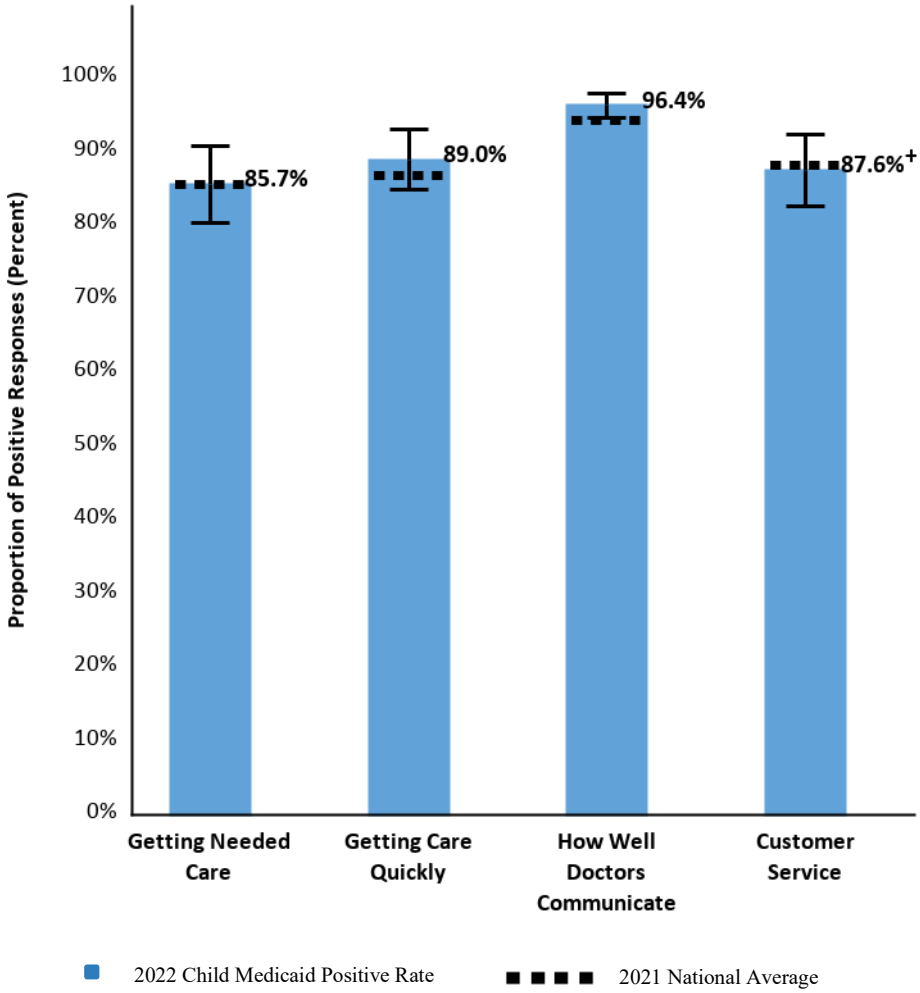


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[3-10] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid members in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

[3-11] The 2022 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



+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **ACNH**'s general child Medicaid population, three rates, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*, exceeded NCQA's 2021 Medicaid national averages. The measure rate for *How Well Doctors Communicate* was statistically significantly higher than the national average, while measure rates for *Rating of Health Plan* and *Rating of Specialist Seen Most Often* were statistically significantly lower than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and child Medicaid populations' 2022 CAHPS survey results to the 2021 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Two of the 2022 measure rates for the child Medicaid population were statistically significantly lower than the 2021 NCQA Medicaid national averages; therefore, HSAG recommends that **ACNH** focus ***quality of care*** improvement efforts on the *Rating of Health Plan* and

Rating of Specialist Seen Most Often measures for the child population. Caution should be exercised when evaluating the results from *Rating of Specialist Seen Most Often*, however, since the survey generated fewer than 100 responses for this measure. In addition, HSAG recommends that **ACNH** focus ***quality of care***, ***timeliness of care***, and ***access to care*** improvement efforts on the *Rating of All Health Care*, *Rating of Personal Doctor*, 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 specific information concerning areas for improvement.

The rates for *Customer Service* could be improved by conducting an evaluation of current MCO call center hours and practices to determine if the hours and resources meet members' needs. **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 ***quality of care***, ***timeliness of care***, and ***access to 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** also could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

NHHF

NHHF surveyed 2,376 adult Medicaid members in 2022, and members returned 248 completed surveys. After excluding ineligible members, the response rate was 10.5 percent. In 2022, 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 14.7 percent. Figure 3-5 and Figure 3-6 show **NHHF**'s adult Medicaid 2022 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.

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

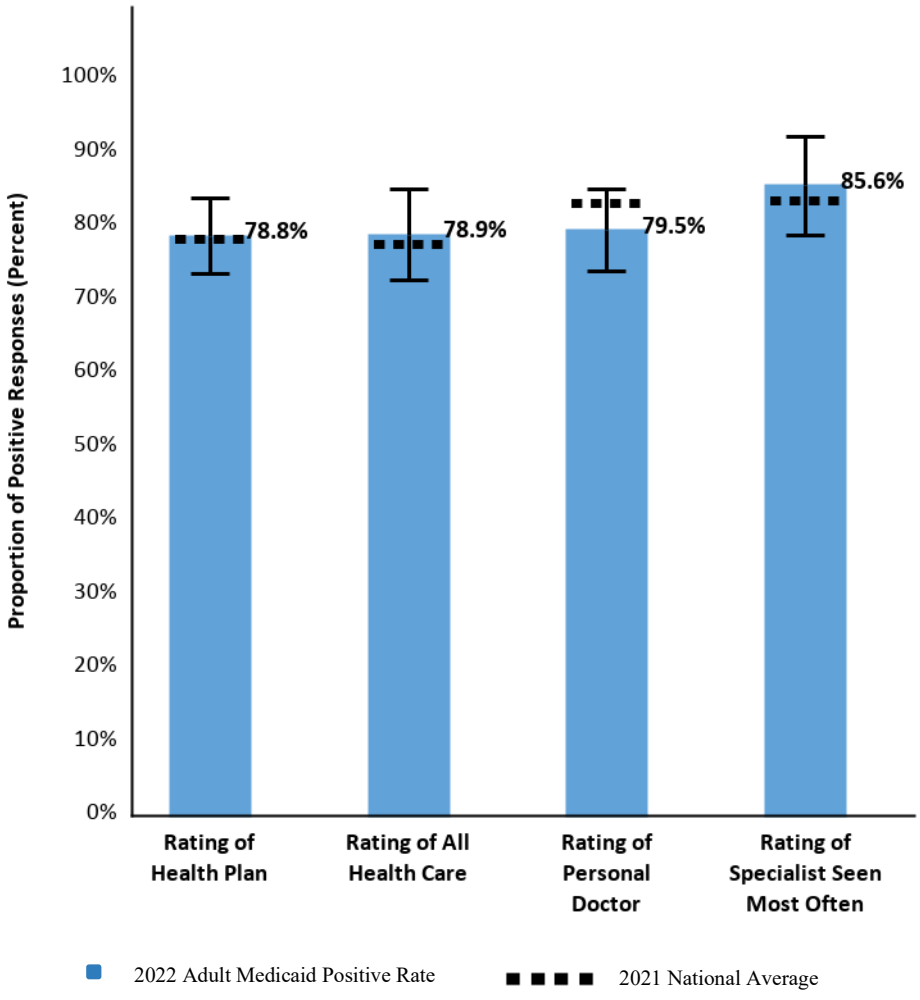
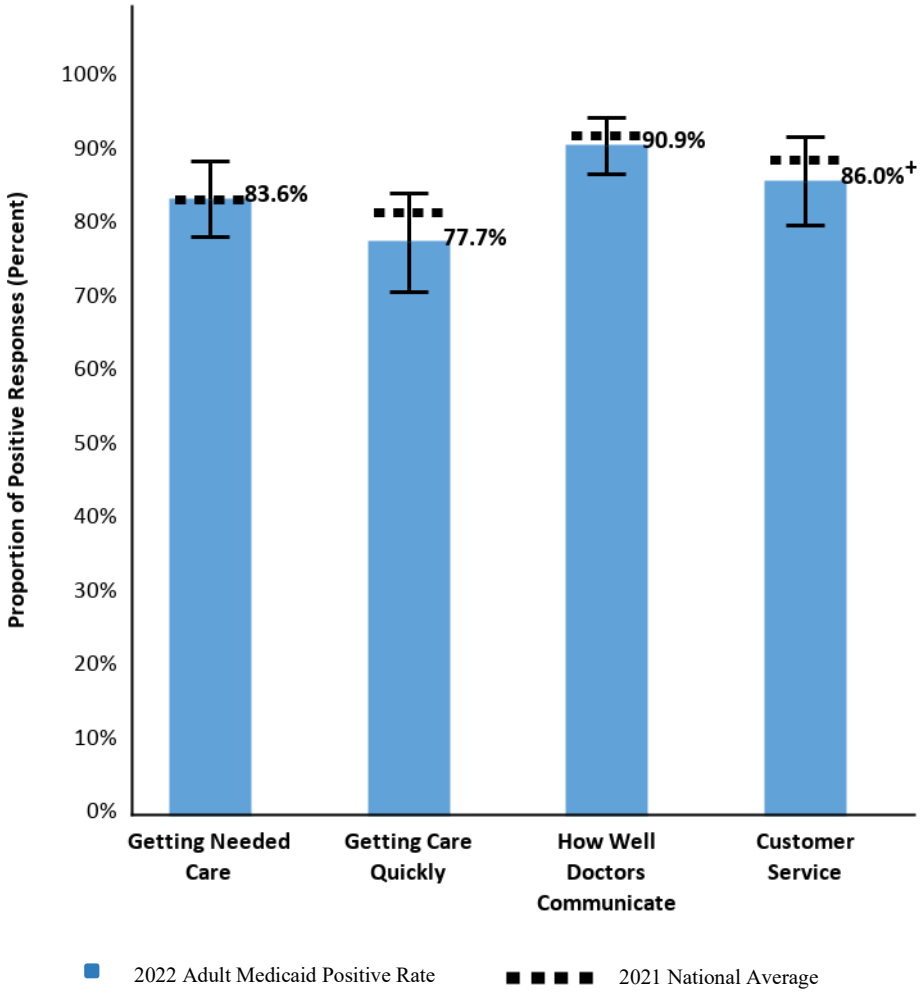


Figure 3-6—NHHF Adult Medicaid CAHPS Results: Composite Measures

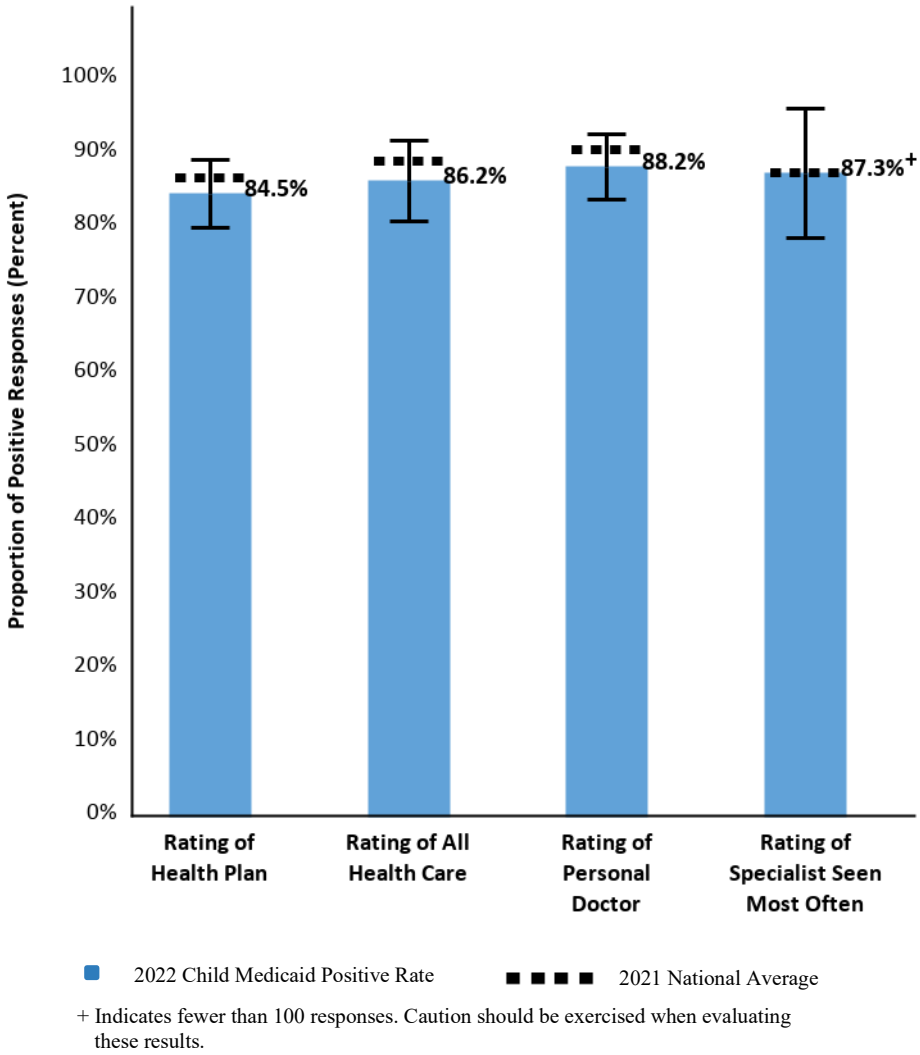


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **NHHF**'s adult Medicaid population, four rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*, exceeded NCQA's 2021 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages.

NHHF surveyed 2,640 general child Medicaid members in 2022, and parents/caretakers of child members returned 236 completed surveys. After excluding ineligible members, the response rate was 8.9 percent. In 2022, 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 16.4 percent.[3-12] Figure 3-7 and Figure 3-8 show **NHHF**'s general child Medicaid 2022 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.[3-13]

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

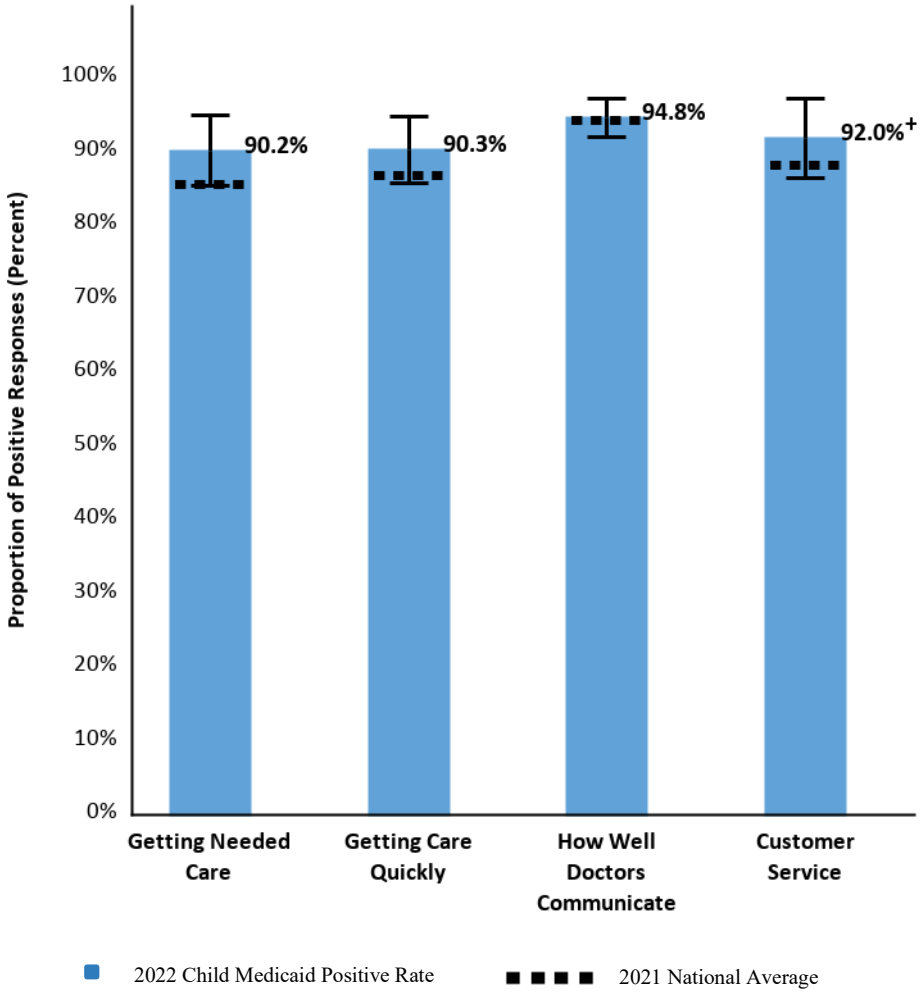


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[3-12] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid members in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

[3-13] The 2022 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



+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **NHHF**'s general child Medicaid population, four rates, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2021 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' 2022 CAHPS survey results to the 2021 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2022 measure rates for the adult or child Medicaid populations were statistically significantly lower than the 2021 NCQA Medicaid national averages, HSAG recommends that **NHHF** focus ***quality of care***, ***timeliness of care***, and ***access to care*** improvement efforts on *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* for the adult population as these rates fell below the national averages. In addition, HSAG recommends that

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

The rates for *Rating of Health Plan*, *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** also could consider obtaining feedback from patients on their recent office visit, such as a follow-up call or email, to gather more specific 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 direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible 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 of care***, and ***access to care***. 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.

The rates for *How Well Doctors Communicate* could be improved by providing literature to doctors and other clinicians containing guidelines for how they can ensure they explain things in a way that is easy for the member to understand and that they spend enough time with the member. The literature also could furnish advice concerning the importance of listening carefully to members and how clinicians can show respect for what the member has to say. Providers may not be communicating well with members or parents/caretakers of child members or spending adequate time with the member to provide the quality of care the member anticipates or expects to meet their or their child's healthcare needs. Improvement in interpersonal skills and doctor communication will positively impact ***quality of care***. **NHHF** could consider publishing brochures (mail or electronic), provider bulletins, or trainings that aim to improve the way doctors communicate with members, which could help facilitate positive perceptions of its members related to how their doctor communicates with them.

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 ***quality of care***, ***timeliness of care***, and ***access to 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 discuss and refine existing service standards to enhance staff interactions with members.

WS

WS surveyed 3,375 adult Medicaid members in 2022, and members returned 387 completed surveys. After excluding ineligible members, the response rate was 11.6 percent. In 2022, 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 14.7 percent. Figure 3-9 and Figure 3-10 show **WS**'s adult Medicaid 2022 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.

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

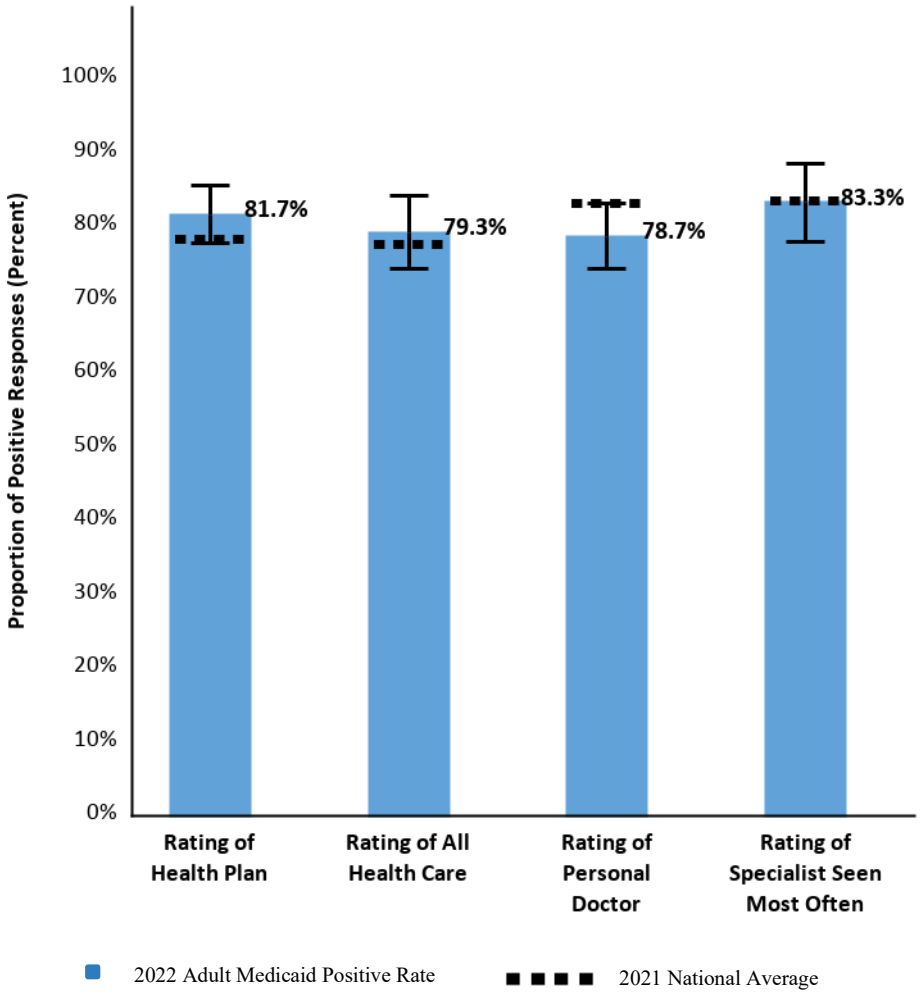
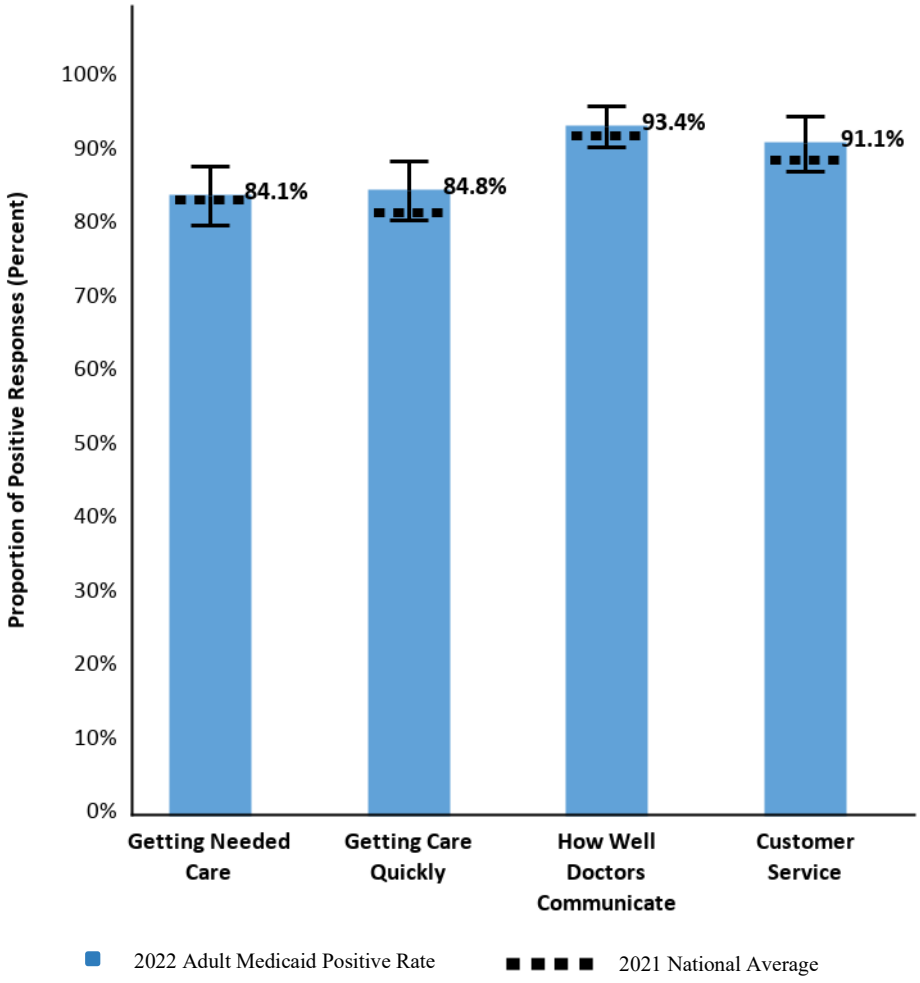


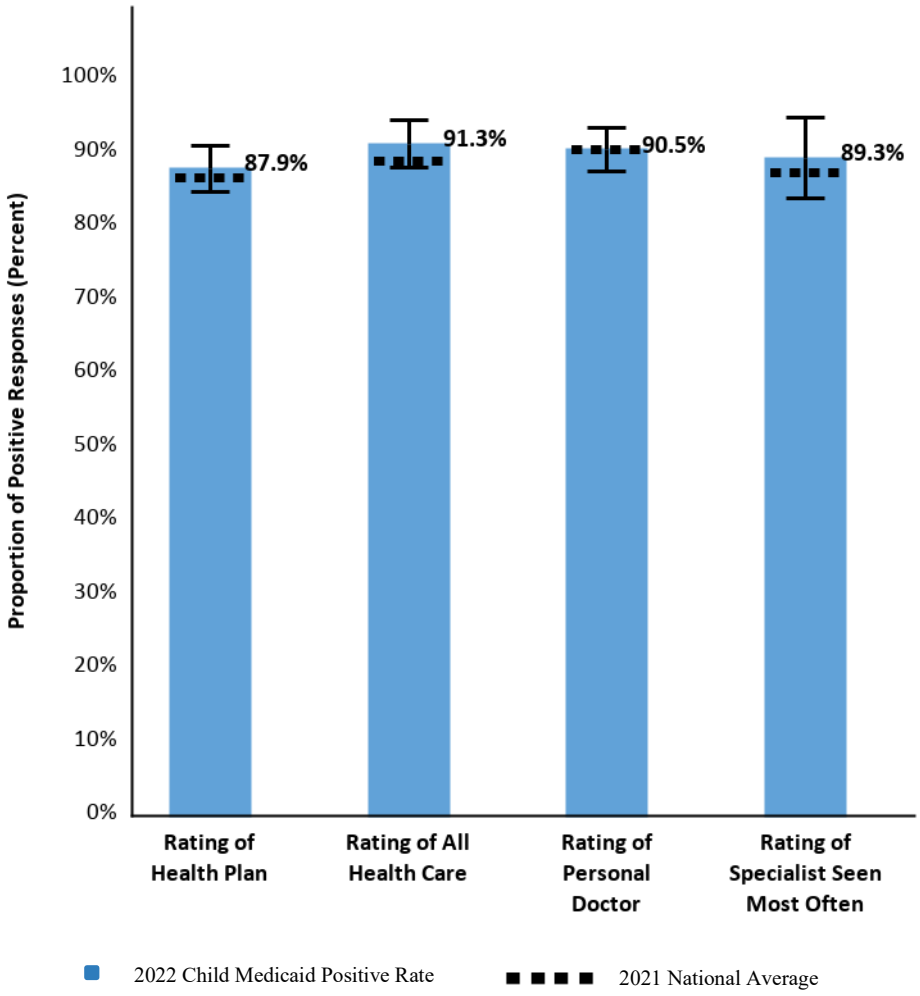
Figure 3-10—WS Adult Medicaid CAHPS Results: Composite Measures



For **WS**'s adult Medicaid population, six rates, *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2021 Medicaid national averages. However, no measure rates were statistically significantly higher than the national averages. The measure rate for *Rating of Personal Doctor* was statistically significantly lower than the national average.

WS surveyed 4,124 general child Medicaid members in 2022, and parents/caretakers of child members returned 424 completed surveys. After excluding ineligible members, the response rate was 10.4 percent. In 2022, the WS 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 16.4 percent.[3-14] Figure 3-11 and Figure 3-12 show WS's general child Medicaid 2022 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.[3-15]

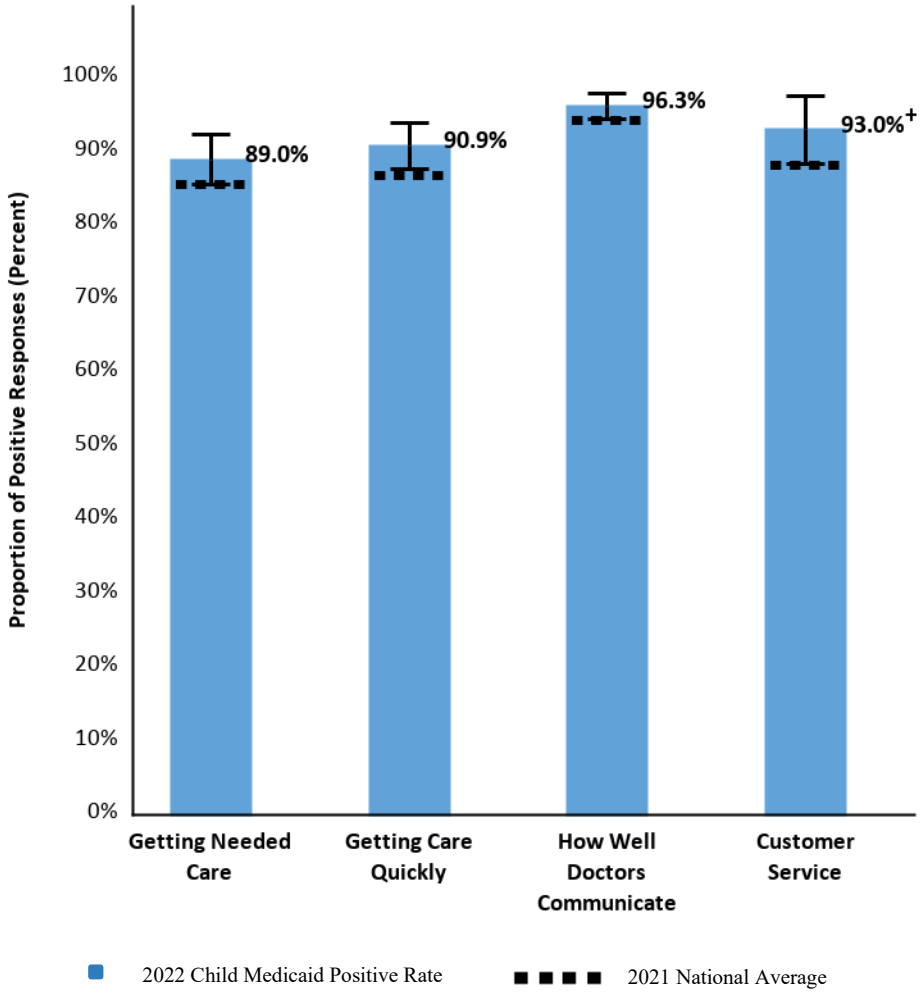
Figure 3-11—WS Child Medicaid CAHPS Results: Global Ratings



[3-14] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid members in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

[3-15] The 2022 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



+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **WS**'s general child Medicaid population, seven rates, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2021 Medicaid national averages. The measure rates for *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* were statistically significantly higher than the national averages.

Conclusions and Recommendations for Improvement

HSAG performed a comparison of the adult and child Medicaid populations' 2022 CAHPS survey results to the 2021 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. The 2022 measure rate for *Rating of Personal Doctor* for the adult Medicaid population was statistically significantly lower than the 2021 NCQA Medicaid national average; therefore, HSAG recommends that **WS** focus on ***quality of care*** improvement efforts for the

Rating of Personal Doctor measure for the adult population. In addition, HSAG recommends that **WS** focus on ***quality of care***, ***timeliness of care***, and ***access to care*** improvement efforts on the *Rating of Specialist Seen Most Often* for the adult population and the *Rating of Personal Doctor* measure for the child population, since these rates fell below the national averages.

To improve CAHPS rates, **WS** could consider involving MCO staff members at every level to assist in improving *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* rates. To improve the rates for these measures, **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 specific information concerning areas for improvement. Improving these rates will positively affect ***quality of care***, ***timeliness of care***, and ***access to care***.

For additional information concerning HSAG's methodology for evaluating CAHPS results, see Appendix B. Methodologies for Conducting EQR Activities, page B-24.

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.[3-16] **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 the 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), IS compliance tools, and the interactive data submission system (IDSS) files approved by an NCQA-licensed organization (LO).

[3-16] 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: Sept 14, 2022.

The 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.
- 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-validated data resulting from the data aggregator validation (DAV) program 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) 2021 HEDIS rates for the three MCOs and provided a statewide average.

For three measures, *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), Comprehensive Diabetes Care—HbA1c Poor Control (CDC),* and *Ambulatory Care—Emergency Department (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 2021 rates to national benchmarks that are based on NCQA's Quality Compass[3-17] national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2021 representing MY 2020, the most recent benchmarks available for comparison.

[3-17] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Table 3-43 displays the HEDIS 2022 rates representing MY 2021 rates for the MCOs, the statewide average rate, and the HEDIS MY 2021 statewide average percentile ranking.

Table 3-43—HEDIS MY 2021 Health Plan Comparison Table

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
Prevention					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total	74.75%	78.34%	78.41%	77.67%	25th–49th Percentile
Breast Cancer Screening (BCS)					
Breast Cancer Screening	52.69%	53.52%	47.88%	50.97%	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	54.20%	55.87%	56.20%	55.69%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	70.21%	76.80%	75.02%	75.58%	50th–74th Percentile
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	65.66%	67.07%	65.93%	66.38%	≥90th Percentile
12–17 Years	56.34%	58.16%	58.02%	57.97%	75th–89th Percentile
18–21 Years	29.29%	34.41%	32.88%	33.28%	75th–89th Percentile
Total	55.85%	58.38%	58.56%	58.29%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body-Mass Index (BMI) Percentile—Total	69.34%	69.59%	71.74%	70.66%	25th–49th Percentile
Counseling for Nutrition—Total[1]	69.59%	67.40%	69.78%	68.74%	25th–49th Percentile

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
Counseling for Physical Activity—Total	66.91%	62.04%	66.34%	64.53%	25th–49th Percentile
Childhood Immunization Status (CIS)					
Combination 3 (diphtheria/tetanus/acellular pertussis [DTaP], polio [IPV], measles/mumps/ rubella [MMR], haemophilus influenzae type B [HIB], hepatitis B [HepB], varicella [VZV], pneumococcal conjugate [PCV])	66.18%	69.34%	66.42%	67.62%	25th–49th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	41.12%	42.34%	44.28%	43.13%	50th–74th Percentile
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	61.69%	73.97%	75.18%	73.97%	<25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	25.00%	28.95%	30.90%	29.75%	<25th Percentile
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening	46.23%	57.66%	61.71%	57.27%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.00%	0.09%	0.22%	0.14%	75th–89th Percentile
Chlamydia Screening in Women (CHL)					
16–20 Years	47.26%	44.37%	44.72%	44.73%	25th–49th Percentile
21–24 Years	60.60%	52.89%	54.03%	54.86%	25th–49th Percentile

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
Total	55.42%	47.15%	47.63%	48.31%	25th–49th Percentile
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	82.73%	80.78%	83.04%	82.14%	25th–49th Percentile
Postpartum Care	80.78%	76.89%	79.82%	78.97%	50th–74th Percentile
Lead Screening in Children (LSC)					
Total	79.08%	72.67%	73.24%	73.62%	50th–74th Percentile
Acute and Chronic Care					
Appropriate Testing for Children with Pharyngitis (CWP)					
Total	78.49%	78.81%	80.87%	79.77%	50th–74th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)					
Appropriate Treatment for Upper Respiratory Infection	96.23%	96.74%	96.83%	96.73%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Bronchodilator	73.17%	84.88%	93.49%	86.05%	50th–74th Percentile
Systemic Corticosteroid	78.05%	78.49%	94.08%	84.63%	≥90th Percentile
Comprehensive Diabetes Care (CDC)					
HbA1c Testing	88.32%	87.35%	84.91%	86.52%	75th–89th Percentile
HbA1c Poor Control (>9.0%)*	49.15%	39.90%	44.04%	43.14%	50th–74th Percentile
HbA1c Control (<8.0%)	41.12%	47.45%	45.74%	45.69%	25th–49th Percentile
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	52.07%	59.37%	56.45%	56.97%	50th–74th Percentile

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain	74.66%	75.10%	70.80%	73.13%	25th–49th Percentile
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	12.20%	10.78%	11.35%	11.24%	<25th Percentile
Asthma Medication Ratio (AMR)					
Total	58.42%	60.09%	62.55%	61.26%	25th–49th Percentile
Ambulatory Care—Total (AMB)***					
*Emergency Department (ED) Visits—Total**	44.83	37.58	39.96	39.87	50th–74th Percentile
Antibiotic Utilization—Total (ABX)					
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	32.91%	34.00%	35.29%	34.43%	75th–89th Percentile
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	59.31%	61.07%	59.97%	60.21%	≥90th Percentile
30-Day Follow-Up—Total	73.70%	76.41%	73.91%	74.74%	≥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***	82.49%	77.31%	74.68%	77.00%	50th–74th Percentile
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People with Diabetes and Schizophrenia	NA	61.11%	64.18%	65.15%	50th–74th Percentile

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	66.67%	72.01%	74.27%	72.22%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose Testing—Total	44.74%	58.58%	55.27%	56.44%	75th–89th Percentile
Cholesterol Testing—Total	21.05%	39.23%	34.20%	36.08%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	21.05%	38.32%	33.06%	35.08%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
Total	NA	74.18%	60.33%	65.46%	50th–74th Percentile
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	70.62%	65.66%	62.48%	65.16%	75th–89th Percentile
Effective Continuation Phase Treatment	60.51%	48.72%	46.73%	50.00%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	40.82%	52.04%	37.63%	43.70%	25th–49th Percentile
Continuation and Maintenance Phase	NA	56.68%	39.53%	46.49%	25th–49th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment—Total	61.85%	52.87%	47.19%	52.83%	75th–89th Percentile

Performance Measure HEDIS MY 2021	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2021 Statewide Average Percentile
*Engagement of AOD Treatment—Total***	31.10%	22.84%	22.60%	24.80%	≥90th Percentile
Identification of Alcohol and Other Drug Services (IAD)					
Any Service—Total	15.46%	8.63%	10.41%	10.58%	75th–89th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	71.51%	70.16%	66.50%	68.83%	≥90th Percentile
30-Day Follow-Up—Total	79.23%	79.48%	76.18%	78.01%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	30.62%	26.78%	31.80%	29.91%	≥90th Percentile
30-Day Follow-Up—Total	45.40%	37.34%	44.65%	42.56%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)					
Total	34.25%	29.30%	29.04%	30.10%	25th–49th Percentile

* For this indicator, a lower rate indicates better performance.
** This measure is also a PIP topic for the three MCOs.
***This utilization rate is expressed as the rate per 1,000 members.
NA indicates that a rate could not be reported due to a small denominator.

Table 3-44 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 2021 representing MY 2020.

Table 3-44—Summary of the NH MCM Program Statewide Scores for MY 2021 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	1	4	5	11	2	**23**
Acute and Chronic Care	2	2	5	3	1	**13**
Behavioral Health	7	6	5	3	0	**21**
All Domains	**10**	**12**	**15**	**17**	**3**	**57**
Percentage	**17.54%**	**21.05%**	**26.32%**	**29.82%**	**5.26%**	**100%**

The New Hampshire statewide Medicaid rates ranked at or above the 50th percentile for 37 measures (64.91 percent), with 10 of these measures (17.54 percent) meeting or exceeding the 90th percentile. A total of 20 measures (35.09 percent) fell below the 50th percentile.

The following statewide average rates met or exceeded the HEDIS MY 2021 statewide average 90th percentile:

- One Prevention measure indicator rate: *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*
- Two Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- Seven BH measure indicator rates: *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*, *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 2021 statewide average 25th percentile:

- Two Prevention measure indicator rates: *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- One Acute and Chronic Care measure indicator rate: *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*

ACNH

Table 3-45 below contains **ACNH**'s HEDIS MY 2021 performance measure rates and **ACNH**'s HEDIS MY 2021 percentile ranking as compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2021 representing MY 2020. **ACNH** operations in New Hampshire began September 1, 2019; therefore, no HEDIS data were available prior to MY 2020. The percentile rankings in the < 25th percentile and the 25th–49th percentile are shown in **red font**, the percentile rankings in the 50th–74th percentile are in **brown font**, and the 75th–89th percentile and the rates at or above the 90th percentile are in **green font**.

Table 3-45—ACNH HEDIS MY 2020 and MY 2021 Rates, and MY 2021 Percentile Rankings

ACNH HEDIS Rates	HEDIS 2021 (MY 2020 Rate)	HEDIS 2022 (MY 2021 Rate)	HEDIS 2022 (MY 2021) Percentile Ranking
Prevention			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Total	74.64%	74.75%	25th–49th Percentile
Breast Cancer Screening (BCS)			
Breast Cancer Screening	NA	52.69%	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	43.21%	54.20%	25th–49th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	NA	70.21%	25th–49th Percentile
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	54.34%	65.66%	75th–89th Percentile
12–17 Years	44.71%	56.34%	75th–89th Percentile
18–21 Years	23.75%	29.29%	50th–74th Percentile
Total	45.58%	55.85%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	55.47%	69.34%	25th–49th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020 Rate)	HEDIS 2022 (MY 2021 Rate)	HEDIS 2022 (MY 2021) Percentile Ranking
Counseling for Nutrition—Total	61.31%	69.59%	25th–49th Percentile
Counseling for Physical Activity—Total	55.23%	66.91%	50th–74th Percentile
Childhood Immunization Status (CIS)			
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)	***	66.18%	25th–49th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	24.39%	41.12%	50th–74th Percentile
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	NA	61.69%	<25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	NA	25.00%	<25th Percentile
Cervical Cancer Screening (CCS)			
Cervical Cancer Screening	36.98%	46.23%	<25th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)			
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.32%	0.00%	≥90th Percentile
Chlamydia Screening in Women (CHL)			
16–20 Years	43.64%	47.26%	25th–49th Percentile
21–24 Years	50.89%	60.60%	25th–49th Percentile
Total	48.21%	55.42%	50th–74th Percentile
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	80.94%	82.73%	25th–49th Percentile
Postpartum Care	75.25%	80.78%	75th–89th Percentile
Lead Screening in Children (LSC)			
Total	***	79.08%	75th–89th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020 Rate)	HEDIS 2022 (MY 2021 Rate)	HEDIS 2022 (MY 2021) Percentile Ranking
Acute and Chronic Care			
Appropriate Testing for Children with Pharyngitis (CWP)			
Total	78.05%	78.49%	50th–74th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)			
Appropriate Treatment for Upper Respiratory Infection	93.78%	96.23%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Bronchodilator	72.73%	73.17%	<25th Percentile
Systemic Corticosteroid	72.73%	78.05%	75th–89th Percentile
Comprehensive Diabetes Care (CDC)			
HbA1c Testing	87.14%	88.32%	≥90th Percentile
*HbA1c Poor Control (>9.0%)**	44.00%	49.15%	25th–49th Percentile
HbA1c Control (<8.0%)	44.86%	41.12%	25th–49th Percentile
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	52.90%	52.07%	25th–49th Percentile
Use of Imaging Studies for Low Back Pain (LBP)			
Use of Imaging Studies for Low Back Pain	80.16%	74.66%	25th–49th Percentile
Plan All-Cause Readmissions (PCR)			
Observed Readmissions—Total	NA	12.20%	<25th Percentile
Asthma Medication Ratio (AMR)			
Total	NA	58.42%	<25th Percentile
Ambulatory Care—Total (AMB)*			
*ED Visits—Total**	42.99	44.83	25th–49th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020 Rate)	HEDIS 2022 (MY 2021 Rate)	HEDIS 2022 (MY 2021) Percentile Ranking
Antibiotic Utilization—Total (ABX)			
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	34.48%	32.91%	75th–89th Percentile
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up—Total	51.47%	59.31%	≥90th Percentile
30-Day Follow-Up—Total	68.14%	73.70%	≥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%	82.49%	75th–89th Percentile
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)			
Diabetes Monitoring for People with Diabetes and Schizophrenia	NA	NA	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.85%	66.67%	50th–74th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing—Total	NA	44.74%	25th–49th Percentile
Cholesterol Testing—Total	NA	21.05%	<25th Percentile
Blood Glucose and Cholesterol Testing—Total	NA	21.05%	<25th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Total	NA	NA	NC
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	74.66%	70.62%	≥90th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020 Rate)	HEDIS 2022 (MY 2021 Rate)	HEDIS 2022 (MY 2021) Percentile Ranking
Effective Continuation Phase Treatment	64.38%	60.51%	≥90th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	NA	40.82%	25th–49th Percentile
Continuation and Maintenance Phase	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	59.03%	61.85%	≥90th Percentile
*Engagement of AOD Treatment—Total***	29.74%	31.10%	≥90th Percentile
Identification of Alcohol and Other Drug Services (IAD)			
Any Service—Total	17.86%	15.46%	≥90th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
7-Day Follow-Up—Total	71.51%	71.51%	≥90th Percentile
30-Day Follow-Up—Total	78.21%	79.23%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
7-Day Follow-Up—Total	36.92%	30.62%	≥90th Percentile
30-Day Follow-Up—Total	50.54%	45.40%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)			
Total	***	34.25%	50th–74th Percentile

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

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

*** This measure was not displayed in the previous year.

****This utilization rate is expressed as the rate per 1,000 members.

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 because HEDIS MY 2021 is the first year this measure is being reported.

Conclusions

ACNH was fully compliant with all NCQA-defined IS standards for HEDIS MY 2021.

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 Prevention measure indicator rate: *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Two Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Comprehensive Diabetes Care (CDC)— HbA1c Testing*
- Eleven BH measure indicator rates: *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 Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*, *Identification of Alcohol and Other Drug Services (IAD)—Any Service—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**:

- Three Prevention measure indicator rates: *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*, and *Cervical Cancer Screening (CCS)*
- Three Acute and Chronic Care measure indicator rates: *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*, *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*, and *Asthma Medication Ratio (AMR)—Total*
- Two BH measure indicator rates: *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Cholesterol Testing–Total* and *Blood Glucose and Cholesterol Testing—Total*

Recommendations

With 25 of 54 rates (46.30 percent) falling below the 50th percentile, **ACNH** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care (i.e., emergency

department [ED] visits), timely prenatal care, comprehensive diabetes care, pharmacotherapy management of COPD exacerbation using bronchodilators, breast cancer screening, and cervical cancer screening. **ACNH** also should focus on ensuring young women are appropriately screened for chlamydia. Additional areas of focus for **ACNH** include weight assessment and counseling for BMI and nutrition for children and adolescents, well-child visits in the first 15 and 30 months of life, controlling high blood pressure, immunizations for children and adolescents, asthma medication ratio, plan all-cause readmissions, and follow-up care for children prescribed ADHD medication. **ACNH** should also work to improve rates for imaging studies for low back pain and metabolic monitoring for children and adolescents on antipsychotics. Improving these rates will impact the ***timeliness of care***, ***access to care***, and ***quality of care*** for **ACNH**'s members in the New Hampshire MCM program.

NHHF

Table 3-46 displays **NHHF**'s HEDIS MY 2019, HEDIS MY 2020, and HEDIS MY 2021 performance measure rates, and **NHHF**'s HEDIS MY 2021 percentile ranking. The HEDIS MY 2021 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2021 representing MY 2020. The percentile rankings in the < 25th percentile and the 25th–49th percentile are shown in **red font**, the percentile rankings in the 50th–74th percentile are in **brown font**, and the 75th–89th percentile and the rates at or above the 90th percentile are in **green font**.

Table 3-46—NHHF HEDIS MY 2019, MY 2020, and MY 2021 Rates, and MY 2021 Percentile Rankings

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	81.56%	78.42%	78.34%	50th–74th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening[1]	58.74%	53.73%	53.52%	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%	55.87%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	81.91%	76.80%	75th–89th Percentile
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years[2]	—	63.67%	67.07%	≥90th Percentile

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
12–17 Years[2]	—	54.20%	58.16%	75th–89th Percentile
18–21 Years [2]	—	33.20%	34.41%	75th–89th Percentile
Total [2]	—	55.76%	58.38%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	75.67%	72.75%	69.59%	25th–49th Percentile
Counseling for Nutrition—Total[1]	72.75%	70.80%	67.40%	25th–49th Percentile
Counseling for Physical Activity—Total[1]	67.88%	66.18%	62.04%	25th–49th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)	***	***	69.34%	50th–74th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	48.18%	51.58%	42.34%	50th–74th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.10%	76.89%	73.97%	<25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	32.36%	34.55%	28.95%	<25th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening[1]	54.99%	59.37%	57.66%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.13%	0.17%	0.09%	≥90th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	47.99%	43.16%	44.37%	<25th Percentile

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
21–24 Years	51.63%	52.38%	52.89%	<25th Percentile
Total	49.10%	46.13%	47.15%	<25th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care[1]	88.56%	81.75%	80.78%	25th–49th Percentile
Postpartum Care[1]	82.00%	74.21%	76.89%	50th–74th Percentile
Lead Screening in Children (LSC)				
Total	***	***	72.67%	50th–74th Percentile
Acute and Chronic Care				
Appropriate Testing for Children with Pharyngitis (CWP)				
Total[1]	86.14%	84.11%	78.81%	50th–74th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Appropriate Treatment for Upper Respiratory Infection	93.33%	93.70%	96.74%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	85.85%	86.49%	84.88%	25th–49th Percentile
Systemic Corticosteroid	81.76%	70.81%	78.49%	75th–89th Percentile
Comprehensive Diabetes Care (CDC)				
HbA1c Testing	92.21%	85.40%	87.35%	75th–89th Percentile
HbA1c Poor Control (>9.0%)[1,*]	31.14%	38.93%	39.90%	50th–74th Percentile
HbA1c Control (<8.0%)	53.77%	51.34%	47.45%	50th–74th Percentile

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure[2]	—	58.88%	59.37%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain	74.59%	75.51%	75.10%	25th–49th Percentile
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	11.26%	10.91%	10.78%	25th–49th Percentile
Asthma Medication Ratio (AMR)				
Total	67.24%	59.89%	60.09%	25th–49th Percentile
Ambulatory Care—Total (AMB)****				
*ED Visits—Total**	45.76	34.87	37.58	50th–74th Percentile
Antibiotic Utilization—Total (ABX)				
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	36.29%	35.23%	34.00%	75th–89th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total[1]	55.38%	62.28%	61.07%	≥90th Percentile
30-Day Follow-Up—Total[1]	75.13%	76.78%	76.41%	≥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***	82.61%	76.62%	77.31%	50th–74th Percentile
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	68.75%	61.82%	61.11%	25th–49th Percentile

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	78.01%	77.70%	72.01%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	56.12%	53.19%	58.58%	75th–89th Percentile
Cholesterol Testing—Total	37.64%	34.66%	39.23%	75th–89th Percentile
Blood Glucose and Cholesterol Testing—Total	36.53%	33.86%	38.32%	75th–89th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	74.07%	66.45%	74.18%	75th–89th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	61.92%	63.53%	65.66%	75th–89th Percentile
Effective Continuation Phase Treatment	45.90%	48.17%	48.72%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase[1]	53.77%	55.99%	52.04%	75th–89th Percentile
Continuation and Maintenance Phase[1]	58.74%	67.34%	56.68%	50th–74th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment—Total[2]	48.65%	53.16%	52.87%	75th–89th Percentile
Engagement of AOD Treatment—Total[2, **]	18.86%	22.83%	22.84%	≥90th Percentile

NHHF HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Identification of Alcohol and Other Drug Services (IAD)				
Any Service—Total[2]	10.11%	9.14%	8.63%	50th–74th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total[1]	74.34%	72.41%	70.16%	≥90th Percentile
30-Day Follow-Up—Total[1]	81.45%	80.77%	79.48%	≥90th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total[2]	26.03%	23.92%	26.78%	≥90th Percentile
30-Day Follow-Up—Total[2]	37.06%	37.52%	37.34%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	***	***	29.30%	25th–49th Percentile

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

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

*** This measure was not displayed in the previous year.

****This utilization rate is expressed as the rate per 1,000 members.

[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.

Conclusions

NHHF was fully compliant with all NCQA-defined IS standards for HEDIS MY 2021.

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 its 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 Prevention measure indicator rates: *Child and Adolescent Well-Care Visits (WCV)—3–11 Years* and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- One Acute and Chronic Care measure indicator rate: *Appropriate Treatment for Upper Respiratory Infection (URI)*
- Seven BH measure indicator rates: *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*, *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 **NHHF**:

- Five Prevention measure indicator rates: *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*, and *Chlamydia Screening in Women (CHL)—16–20 Years*, *21–24 Years*, and *Total*

Recommendations

With 17 of 57 rates (29.82 percent) falling below the 50th percentile, **NHHF** should consider focusing efforts on ensuring women are screened for breast cancer, cervical cancer, chlamydia, and have access to timely prenatal care. **NHHF** also should focus on ensuring that members are appropriately screened for weight assessment and counseling for BMI/nutrition/physical activity for children and adolescents, pharmacotherapy management of COPD exacerbation using bronchodilators, immunizations for adolescents, and plan all cause readmissions. The focus for improving BH measures should be on diabetes monitoring for people with diabetes and schizophrenia, and pharmacotherapy for opioid use. Additionally, **NHHF** should also focus on improving imaging for low back pain and asthma medication ratio rates. Improving these rates will impact the ***timeliness of care***, ***access to care***, and ***quality of care*** for **NHHF**'s members in the New Hampshire MCM program.

WS

Table 3-47 displays **WS**'s HEDIS MY 2019, HEDIS MY 2020, and HEDIS MY 2021 performance measure rates, and **WS**'s HEDIS MY 2021 percentile ranking. HEDIS MY 2021 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2021 representing MY 2020. The percentile rankings in the < 25th percentile and the 25th–49th percentile are shown in **red font**, the percentile rankings in the 50th–74th percentile are in **brown font**, and the 75th–89th percentile and the rates at or above the 90th percentile are in **green font**.

Table 3-47—WS HEDIS MY 2019, MY 2020, and MY 2021 Rates, and MY 2021 Percentile Rankings

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	80.78%	78.87%	78.41%	50th–74th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening[1]	54.70%	50.09%	47.88%	<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%	56.20%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	—	79.86%	75.02%	50th–74th Percentile
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years [2]	—	62.49%	65.93%	75th–89th Percentile
12–17 Years [2]	—	52.78%	58.02%	75th–89th Percentile
18–21 Years [2]	—	31.08%	32.88%	75th–89th Percentile
Total [2]	—	55.53%	58.56%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	67.68%	57.11%	71.74%	25th–49th Percentile

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Counseling for Nutrition—Total[1]	66.16%	62.11%	69.78%	25th–49th Percentile
Counseling for Physical Activity—Total[1]	64.63%	55.79%	66.34%	50th–74th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)	***	***	66.42%	25th–49th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	41.61%	33.58%	44.28%	50th–74th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.35%	72.26%	75.18%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	33.82%	28.71%	30.90%	25th–49th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening[1]	60.94%	52.66%	61.71%	50th–74th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.10%	0.18%	0.22%	75th–89th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	48.16%	43.26%	44.72%	25th–49th Percentile
21–24 Years	57.63%	53.97%	54.03%	<25th Percentile
Total	51.09%	46.54%	47.63%	<25th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care[1]	86.62%	72.02%	83.04%	25th–49th Percentile
Postpartum Care[1]	76.40%	71.53%	79.82%	75th–89th Percentile
Lead Screening in Children (LSC)				
Total	***	***	73.24%	50th–74th Percentile

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Acute and Chronic Care				
Appropriate Testing for Children with Pharyngitis (CWP)				
Total[1]	84.98%	83.99%	80.87%	50th–74th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Appropriate Treatment for Upper Respiratory Infection	93.52%	93.66%	96.83%	≥90th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	92.48%	85.39%	93.49%	≥90th Percentile
Systemic Corticosteroid	86.73%	79.78%	94.08%	≥90th Percentile
Comprehensive Diabetes Care (CDC)				
HbA1c Testing	89.54%	82.24%	84.91%	50th–74th Percentile
HbA1c Poor Control (>9.0%)[1, *]	40.39%	59.37%	44.04%	25th–49th Percentile
HbA1c Control (<8.0%)	49.39%	33.58%	45.74%	25th–49th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure[2]	—	45.99%	56.45%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain	76.31%	76.73%	70.80%	<25th Percentile
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	12.79%	10.71%	11.35%	<25th Percentile
Asthma Medication Ratio (AMR)				
Total	63.18%	61.50%	62.55%	25th–49th Percentile

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Ambulatory Care—Total (AMB)****				
*ED Visits—Total**	49.13	37.12	39.96	50th–74th Percentile
Antibiotic Utilization—Total (ABX)				
Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	36.54%	35.03%	35.29%	50th–74th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total[1]	52.04%	58.15%	59.97%	≥90th Percentile
30-Day Follow-Up—Total[1]	71.14%	73.30%	73.91%	≥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***	82.80%	75.14%	74.68%	25th–49th Percentile
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People with Diabetes and Schizophrenia	68.09%	58.33%	64.18%	25th–49th Percentile
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	75.17%	68.51%	74.27%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	56.77%	51.66%	55.27%	75th–89th Percentile
Cholesterol Testing—Total	34.80%	28.48%	34.20%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	33.74%	27.32%	33.06%	50th–74th Percentile

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	76.58%	60.10%	60.33%	25th–49th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	59.89%	57.79%	62.48%	75th–89th Percentile
Effective Continuation Phase Treatment	46.74%	43.06%	46.73%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase[1]	44.35%	42.36%	37.63%	<25th Percentile
Continuation and Maintenance Phase[1]	52.14%	44.10%	39.53%	<25th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment—Total[2]	48.87%	46.14%	47.19%	50th–74th Percentile
Engagement of AOD Treatment—Total[2,] **	24.55%	20.91%	22.60%	75th–89th Percentile
Identification of Alcohol and Other Drug Services (IAD)				
Any Service—Total[2]	12.35%	11.10%	10.41%	75th–89th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total[1]	71.12%	68.80%	66.50%	≥90th Percentile
30-Day Follow-Up—Total[1]	80.95%	76.16%	76.18%	≥90th Percentile

WS HEDIS Rates	HEDIS 2020 (MY 2019) Rate	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021 Rate)	HEDIS MY 2021 Percentile Rankings
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total[2]	26.81%	31.05%	31.80%	≥90th Percentile
30-Day Follow-Up—Total[2]	42.07%	45.13%	44.65%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	***	***	29.04%	25th–49th Percentile

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

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

*** This measure was not displayed in the previous year.

****This utilization rate is expressed as the rate per 1,000 members.

[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.

Conclusions

WS was fully compliant with all NCQA-defined IS standards for HEDIS MY 2021.

The HEDIS audits confirmed that **WS** 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. **WS** demonstrated the accuracy and completeness of its primary databases, which contained claims and encounters, membership and enrollment, and provider credentialing data. **WS** 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 **WS**:

- Three Acute and Chronic Care measure indicator rates: *Appropriate Treatment for Upper Respiratory Infection (URI)* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and *Systemic Corticosteroid*
- Seven BH measure indicator 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*, and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*

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

- Three Prevention measure indicator rates: *Breast Cancer Screening (BCS)* and *Chlamydia Screening in Women (CHL)—21–24 Years* and *Total*
- Two Acute and Chronic Care measure indicator rates: *Use of Imaging for Low Back Pain (LBP)* and *Plan All Cause Readmissions—Observed Readmissions—Total*
- Two BH measure indicator rates: *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

Recommendations

With 21 of 57 rates (36.84 percent) falling below the 50th percentile, **WS** should consider focusing efforts on ensuring women have access to timely prenatal care, breast cancer screening, and chlamydia screening. **WS** should also focus on ensuring that children and adolescents are appropriately screened for weight assessment and counseling for BMI and nutrition, immunizations for children and adolescents, comprehensive diabetes care, plan all-cause readmissions, asthma medication ratios, pharmacotherapy for opioid use disorders, and the use of imaging studies for low back pain. **WS** could improve additional BH rates by focusing efforts on diabetes screenings for people with schizophrenia or bipolar disorder who are using antipsychotic medications, diabetes monitoring for people with diabetes and schizophrenia, use of first-line psychosocial care for children and adolescents on antipsychotics, and follow-up care for children on ADHD medications. Improving these rates will impact the ***timeliness of care***, ***access to care***, and ***quality of care*** for **WS**'s members in the New Hampshire MCM program.

EDV

During SFY 2022, DHHS contracted HSAG to conduct an EDV study. In alignment with CMS' EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019 (EQR Protocol 5),[3-18] HSAG conducted the following three core evaluation activities for the EDV activity:

- IS review—assessment of the MCOs' IS and processes. Of note, DHHS does not currently require MCOs to submit encounters for value-added services (e.g., dental and food services) to its Medicaid Management Information System (MMIS); therefore, encounters for value-added services were out of scope for the IS review.
- Ongoing encounter data quality reports—assess completeness, accuracy, and timeliness of MCOs' encounter data files submitted to DHHS on a monthly/quarterly basis.
- 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.

While the ongoing encounter data quality reports evaluated encounters submitted to DHHS between July 1, 2021, and June 30, 2022, HSAG included encounter data with dates of service between July 1, 2020, and June 30, 2021, in the comparative analysis.

IS Review

Health Plan Comparisons

The IS review component of the EDV study provided self-reported qualitative information from all three MCOs regarding the data quality checks performed by the MCOs' subcontractors and the MCOs. Of note, encounters for value-added services (e.g., dental and food services) were out of scope for the IS review. Based on the MCOs' responses, below are key findings:

- All MCOs' subcontractors performed at least one data quality check before and/or after submitting encounters to the MCOs/DHHS. However, the types of quality checks varied across subcontractors.
- All MCOs performed at least one data quality check before and/or after submitting encounters to DHHS except for **WS**'s NEMT and vision encounters. The quality checks generally included, but were not limited to, electronic data interchange (EDI) compliance edits, field-level completeness and validity, timeliness, reconciliation with financial reports, and claim volume by submission month. **WS** did not note quality checks evaluating whether the payment fields in the encounters align with any financial reports.

[3-18] 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 9, 2022.

- All MCOs submitted all required types of claims/encounters to DHHS.
- **WS** noted challenges with DHHS' denied response file edits for its encounter data; however, DHHS clarified that the denied response file edits were intended only as a warning, not as rejections. **WS** should work with DHHS to clarify the confusion regarding the purpose of the denied response files.

Health Plan-Specific Conclusions and Recommendations

Based on the IS review activity, HSAG has the following recommendation for **WS** only:

- **WS** should perform quality checks on the NEMT and vision encounters before and/or after submitting encounters to DHHS.
- **WS** should add quality checks to evaluate whether the payment fields in the encounters align with the financial reports.
- **WS** should work with DHHS to clarify the confusion regarding the purpose of the denied response files and then determine an effective, efficient way to review these files, if appropriate.

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 on a monthly/quarterly basis, Table 3-48 displays aggregate compliance rates for each MCO in relation to the five standards within Exhibit A of the MCO contract. The aggregate results are for encounters submitted to DHHS between July 1, 2021, and June 30, 2022. 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 10.0 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 10.0 percentage points. In addition, the values in the **green shaded** cells indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points, and values in the **red shaded** cells indicate rates that decreased from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

Table 3-48—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
X12 EDI Compliance Edits	98.0%	ACNH	100%		100%		NA	
		NHHF	100%		100%		NA	
		WS	100%		100%		NA	
Validity of Member Identification Number*	100%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	99.9%	100%	99.8%	100%	100%

Evaluation Area	Standard	MCO	837P (Professional) Encounters		837I (Institutional) Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
Validity of Billing Provider Information*	98.0%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	100%	100%	100%	100%	100%
Validity of Servicing Provider Information*	98.0%	ACNH	100%	100%	100%	100%	NA	
		NHHF	100%	100%	100%	100%	NA	
		WS	100%	100%	100%	100%	NA	
Initial Submission Within 14 Days of Claim Payment*	100%	ACNH	100%		100%		100%	
		NHHF	82.8%		100%		99.8%	
		WS	97.9%		99.8%		91.1%*	

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

* Because WS's new pharmacy subcontractor went through a production implementation between July and October 2021, the rate displayed in the table is for pharmacy encounters received between November 2021 and June 2022.

Green text indicates rates meeting the standards.

Red text indicates rates that fell below the standards by more than 10.0 percentage points.

= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

= Indicate rates that decreased from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

The list below includes the findings for each standard:

- **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 HSAG assessed these values, all MCOs either met the percent accurate standard of 100 percent or fell slightly below the standard by no more than 0.2 percentage points. Compared to the results in the SFY 2021 EDV Aggregate Report, the difference for all results was no more than 0.2 percentage point higher 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 2021 EDV Aggregate Report, all results were the same 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 2021 EDV Aggregate Report, all results were the same for all MCOs.
- **Initial Submission Within 14 Days of Claim Payment:** The percentage of encounters initially submitted to DHHS within 14 calendar days of claim payment dates met the standard of 100 percent for all ACNH's encounter types and NHHF's institutional encounters. The only rate that was below

the standard by more than 10.0 percentage points was from **NHHF**'s professional encounters due to its transportation subcontractor. The remaining rates were all above 91.0 percent (i.e., the lowest rate was for **WS**'s pharmacy encounters primarily due to encounters submitted within 15 to 18 days of claim payment date). Compared to the results in the SFY 2021 EDV Aggregate Report, **NHHF** improved its rate for pharmacy encounters by more than 10.0 percentage points while lowering its rate for the 837P encounters by more than 10.0 percentage points.

Currently there are no standards for the measures in the quarterly reports; therefore, no findings from the quarterly reports are listed in this section.

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 all encounter types.

HSAG has no recommendations for **ACNH**.

NHHF

NHHF'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 its 837I encounters.

HSAG recommends that **NHHF** continues to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for professional and pharmacy encounters, especially professional encounters.

WS

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

HSAG recommends that **WS** focus on two areas to improve its encounter data submissions: 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 all encounter types, especially 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, and the values in the **green shaded** cells indicate a rate that improved from the SFY 2021 EDV study by more than 10.0 percentage points. In addition, **lower rates indicate better performance for omission and surplus rates while higher rates indicate better performance for accuracy rates**.

Record Completeness

Table 3-49 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).

Table 3-49—Record Omission and Surplus Rates by MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
ACNH	4.7%	0.3%	0.4%	1.3%	6.9%	0.1%
NHHF	1.9%	0.4%	11.4%	2.6%	5.5%	0.2%
WS	0.3%	0.9%	0.6%	2.3%	0.1%	4.4%

Red text indicates rates needing the MCOs' attention.
= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

For both **ACNH** and **NHHF**, two rates needed attention. As for **WS**, one pharmacy encounter rate needed attention. In addition, **ACNH** had two rates and **WS** had one rate that improved by more than 10.0 percentage points from the SFY 2021 EDV study.

Element Omission and Surplus

Table 3-50 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 3-50—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 identification (ID)	<0.1%	0.0%	<0.1%	<0.1%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Rendering Provider Number/NPI	<0.1%	0.0%	<0.1%	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%
Referring Provider Number/NPI	<0.1%	1.8%	<0.1%	0.0%	0.0%	0.0%	57.0%	62.1%	72.8%
Primary Diagnosis Code	0.0%	<0.1%	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%
Secondary Diagnosis Code	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	51.6%	53.4%	61.1%
Procedure Code	<0.1%	<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%	<0.1%	56.6%	54.2%	57.3%
Header Paid Amount	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	<0.1%	0.0%	<0.1%	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%

Red text indicates rates needing the MCOs' attention.

= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

For **WS**, one rate needed attention. In addition, **ACNH** had one rate and **NHHF** had two rates that improved by more than 10.0 percentage points from the SFY 2021 EDV study, respectively.

Table 3-51 displays the element omission, element surplus, and element missing values results for each key data element from the institutional encounters.

Table 3-51—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%	<0.1%	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%	<0.1%	0.0%	0.0%	0.0%	0.0%

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Attending Provider Number/NPI	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	<0.1%	5.5%
Referring Provider Number/NPI	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%	84.1%	85.4%	84.1%
Primary Diagnosis Code	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Secondary Diagnosis Code	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	21.4%	22.0%	23.1%
Procedure Code	0.1%	0.4%	0.1%	0.1%	0.1%	0.0%	17.3%	15.8%	13.7%
Procedure Code Modifier	0.1%	0.4%	<0.1%	0.1%	0.5%	0.0%	84.2%	82.4%	83.2%
Primary Surgical Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	92.2%	93.0%	96.3%
Secondary Surgical Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	95.2%	95.7%	97.7%
Revenue Code	<0.1%	<0.1%	0.0%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
Diagnosis Related Group (DRG)	0.2%	0.1%	<0.1%	0.8%	0.3%	0.0%	89.0%	89.6%	94.4%
Header Paid Amount	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	<0.1%	<0.1%	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%

= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

ACNH had two rates and **NHHF** had one rate that improved by more than 10.0 percentage points from the SFY 2021 EDV study.

Table 3-52 displays the element omission, element surplus, and element missing values results for each key data element from the pharmacy encounters.

Table 3-52—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%

	Element Omission			Element Surplus			Element Missing Values		
Key Data Element	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Prescribing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%
National Drug Code (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; therefore, none of the rates needed the MCOs' attention.

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 3-53 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.

Table 3-53—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%	99.8%
Billing Provider Number/NPI	>99.9%	>99.9%	100%
Rendering Provider Number/NPI	100%	>99.9%	99.9%
Referring Provider Number/NPI	100%	>99.9%	100%
Primary Diagnosis Code	100%	>99.9%	99.8%
Secondary Diagnosis Code	100%	>99.9%	100%
Procedure Code	99.9%	99.9%	>99.9%

Key Data Element	ACNH	NHHF	WS
Procedure Code Modifier	>99.9%	>99.9%	100%
Header Paid Amount	99.7%	98.8%	99.9%
Detail Paid Amount	99.9%	99.0%	>99.9%
MCO Carrier ID	100%	100%	100%

= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

The element accuracy rates for all data elements for all MCOs were at least 98.8 percent; therefore, none of the rates needed the MCOs' attention. **ACNH** and **NHHF** each had one rate that improved by more than 10.0 percentage points from the SFY 2021 EDV study.

Table 3-54 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 3-54—Data Element Percent of Accuracy by MCO: Institutional Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	>99.9%
Header Service From Date	>99.9%	>99.9%	>99.9%
Header Service To Date	>99.9%	100%	>99.9%
Billing Provider Number/NPI	100%	>99.9%	100%
Attending Provider Number/NPI	100%	100%	100%
Referring Provider Number/NPI	100%	100%	100%
Primary Diagnosis Code	100%	>99.9%	100%
Secondary Diagnosis Code	>99.9%	>99.9%	100%
Procedure Code	98.3%	93.5%	100%
Procedure Code Modifier	99.8%	93.1%	100%
Primary Surgical Procedure Code	100%	100%	100%
Secondary Surgical Procedure Code	100%	99.7%	100%
Revenue Code	99.1%	97.2%	>99.9%
DRG	97.3%	99.9%	100%
Header Paid Amount	>99.9%	99.0%	>99.9%
Detail Paid Amount	98.3%	92.7%	100%

Key Data Element	ACNH	NHHF	WS
MCO Carrier ID	100%	100%	100%

Red text indicates rates needing the MCOs' attention.
= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

While no rates needed **ACNH**'s and **WS**'s attention, **NHHF** needed to take action for three rates. **WS** had one rate that improved from the SFY 2021 EDV study by more than 10.0 percentage points.

Table 3-55 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.

Table 3-55—Data Element Percent of Accuracy by MCO: Pharmacy Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	100%
Header Service From Date	100%	100%	100%
Billing Provider Number/NPI	>99.9%	100%	100%
Prescribing Provider Number/NPI	>99.9%	>99.9%	99.9%
NDC	>99.9%	99.9%	100%
Drug Quantity	>99.9%	99.9%	>99.9%
Header Paid Amount	100%	100%	>99.9%
MCO Carrier ID	100%	100%	100%

= Indicate rates that improved from the SFY 2021 EDV Aggregate Report by more than 10.0 percentage points.

The element accuracy rates for all data elements for all MCOs were at least 99.9 percent; therefore, none of the rates needed the MCOs' attention. In addition, **NHHF** had one rate that improved from the SFY 2021 EDV study by more than 10.0 percentage points.

Health Plan-Specific Conclusions and Recommendations

ACNH

Among the 158 rates listed in the comparative analysis section, **ACNH** needed to take action for two 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 3-56 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-56—Results Needing Action from ACNH

Measure	Claim Type	Rate
Record Omission	Professional	4.7%
Record Omission	Pharmacy	6.9%

NHHF

Among the 158 rates listed in the comparative analysis section, **NHHF** needed to take action for five 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 3-57 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-57—Results Needing Action from NHHF

Measure	Claim Type	Data Element	Rate
Record Omission	Institutional	Not applicable	11.4%
Record Omission	Pharmacy	Not applicable	5.5%
Element Accuracy	Institutional	Procedure Code	93.5%
Element Accuracy	Institutional	Procedure Code Modifier	93.1%
Element Accuracy	Institutional	Detail Paid Amount	92.7%

WS

Among the 158 rates listed in the comparative analysis section, **WS** needed to take action for five rates. Of note, two rates needing actions were based on the comparative analysis results and three were from HSAG's file review process.

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 3-58 to ensure that complete and accurate encounter data have been submitted to DHHS.

Table 3-58—Results Needing Action From WS

Measure	Claim Type	Data Element	Reason	Rate
Record Surplus	Pharmacy	Not applicable	Rate	4.4%
Element Missing	Professional (BH, DME, and Vision)	Referring Provider Number/NPI	Rate and File Review	72.8%
Element Missing	Professional (Vision)	Secondary Diagnosis Code	File Review	NA
Element Missing	Professional (Vision)	Procedure Code Modifier	File Review	NA
Element Missing	Institutional (BH)	Referring Provider Number/NPI and Attending Provider Number/NPI	File Review	NA

Other EQR Activities

Semi-Structured Qualitative Interviews

Fall Semi-Structured Interviews

The New Hampshire DHHS conducted an independent qualitative study of MCM program adult beneficiaries who had an inpatient stay with a primary mental health diagnosis and were discharged from New Hampshire Hospital or other facility between March 1, 2021, and July 9, 2021. Some members may have had more than one discharge in the time period. Between September 8, 2021, and October 4, 2021, Horn Research interviewed 30 members, including four family members responding on behalf of a beneficiary. The study used four points of inquiry: description of participants, access to information and services, mental health self-management education and support programs, and physical health.

While participants reported consistent connection with a PCP, they were less likely to report having a mental healthcare provider who they saw regularly. Turnover in providers appeared to be an important issue to consider for this population with over a third of participants reporting they had changed their PCP and/or their mental health provider in the past year. In addition to provider turnover, participants mentioned transportation, a lack of providers and services, long wait times for appointments, issues with quality of care, and difficulty navigating the mental health system as their main challenges in getting the care and support needed for their mental health.

When asked what their goals were with respect to their mental health, participants mentioned achieving emotional self-regulation; maintaining stability in their mental health, housing, and employment; having a happy life; ensuring they have adequate mental health support; handling medications and care self-management; and working through trauma treatment successfully.

Participants said communication challenges, not knowing how to navigate the system, a lack of care options, and stigma were the primary barriers to getting their questions answered about mental health and mental health services. The bulk of participants had used telehealth for mental health services in the past, and most agreed that it improved their access to care. Participants were split with respect to whether telehealth care was as effective as in-person care.

A small, but significant, number of participants said they did not currently have access to a medication provider. Participants mentioned their inability to speak directly to their psychiatrist, a lack of information about pre-authorization, their PCP's minimal knowledge of psychiatric medications, and transition periods between providers as key challenges in getting their medication questions answered. Nearly half of all participants said there had been some challenge in accessing their medications. Delays due to prior authorization were the most frequently noted challenge. Other challenges included the gap between leaving hospitalization and getting psychiatric care, transportation, coverage of their medication by their MCO's formulary, and forgetting to get a prescription filled. Nearly half of participants said they experienced some kind of challenge when taking their medications. The difficulties articulated by participants included not remembering to take their medications, needing to keep medications safe to prevent overdose, and side effects. About a third of participants said their provider had not described the potential side effects of their medication.

Nearly two-thirds of participants said they had difficulty accessing services after ED visits or hospitalization. Participants reported thinking they had been released too soon, a lack of communication with ongoing providers about hospitalization, and unhelpful discharge planning.

The most frequently mentioned barriers to staying physically healthy included injury and pain that limited exercise, a lack of funds to pay for a gym membership, poor quality medical care, and poor mental health.

Recommendations

Recommendations generated from the interviews included:

Proactive and ongoing case management for people at high risk for hospitalization

While the data were not statistically significant, participants who reported having access to a case manager also reported greater connection with mental health providers, and somewhat better after-hospitalization care. Offering proactive case management may help ensure that people with mental health diagnoses could successfully navigate what can be a confusing and overwhelming mental healthcare system. This navigation support should help patients find providers, housing, employment, transportation, and other services that could help stabilize vulnerable individuals.

Improve coordination between hospital providers and ongoing providers

Participants frequently remarked about the disconnect between the diagnosis and care they received during hospitalization and the diagnosis and care they received from their ongoing mental health providers. Better, and more frequent, communication between providers may improve patient experience and outcomes.

Improve discharge planning for post-emergency room visits and post-hospitalization

Over half of participants said the discharge planning offered after both emergency room visits and hospitalization was ineffective and frequently resulted in re-hospitalization. Creating a more robust and proactive discharge planning system that is consistently connected with patients' regular providers and their MCO could improve patient outcomes and reduce re-hospitalizations. For patients who do not have regular providers, discharge support that definitively identifies and schedules follow-up care also could improve after-hospitalization outcomes.

Increase access to psychiatrists and other mental health providers

In the qualitative interviews, one of the most frequently mentioned barriers to mental healthcare was a lack of mental health providers accepting Medicaid, which lead to long wait lists and inconsistent care. Improving incentives for providers to accept Medicaid beneficiaries could help to ameliorate these challenges.

Continue to encourage providers to offer telehealth options

The bulk of participants said telehealth options made it easier for them to access mental health providers. With New Hampshire permanently extending telehealth coverage, continued efforts to encourage telehealth services could assist people with mental health diagnoses in obtaining greater access to providers.

Encourage medication management strategies

Participants frequently said they had difficulty managing their medication. Encouraging providers, pharmacies, and patients to use medication support systems could improve medication compliance, improve patient outcomes, and reduce the risk of re-hospitalization. Some strategies may include in-person support for taking medication, pre-packaged medication or pill packs, auto-refill of prescriptions, and delivery options.

Spring Semi-Structured Qualitative Study

The New Hampshire DHHS conducted an independent qualitative study of women in the MCM program who gave birth between October 2020 and October 2021. Horn Research interviewed 30 members between June 6, 2022, and July 12, 2022. The study used seven points of inquiry: description of participants, access to prenatal care, quality of prenatal care, access to and quality of postpartum care, access to information, experience with Medicaid managed care, and suggestions for improvement.

Overall, participants said they had sufficient and early access to pregnancy testing and prenatal care. The vast majority of participants said they received prenatal care within the first trimester of pregnancy. About a third of participants said there were not enough providers available through their MCO, but that the choices available for hospitals or birthing centers were sufficient. All participants who received specialist care during their pregnancy reported ease of access and good care. Participants universally reported having access to prenatal vitamins and medications, but a handful noted they were unaware that their MCO would have paid for the vitamins.

Participants reported high satisfaction with the quality of their prenatal provider. Participants reported being routinely asked about their tobacco use, substance use, and mental health. A quarter of participants said they used tobacco and were either aware of or offered cessation support, but only one accepted. All participants who had experience with substance use were being treated and not in need of additional support. Over half of participants said they were offered mental health support during their pregnancy, the bulk of whom accepted. Most participants said the mental health supports they received were excellent. A handful of participants said they did not receive needed mental health support during pregnancy. Nearly all participants discussed birth control options with their prenatal provider. Nearly equal numbers of participants reported receiving an intrauterine device (IUD) or contraceptive implant, having a tubal ligation, and using condoms as birth control methods. A small minority said they were not using any birth control.

Only a third of participants reported receiving a home visit from a nurse after their baby was born, the bulk of whom said it was a helpful experience. Nearly all participants went for a postpartum appointment. Overall, participants said their postpartum care was satisfactory, but a noteworthy number said the amount of postpartum care they received was insufficient and that referrals for pelvic floor therapy were generally unavailable. Participants reported being asked about tobacco use, substance use, and mental health during their postpartum appointments. None of the participants reported accepting tobacco cessation or substance use counseling postpartum. Despite screening positive for postpartum mood disorders, some participants reported not being offered, or not accepting, mental health services. Challenges reported by participants included not experiencing mental health difficulties until several months after postpartum care ended, not being able to find a counselor, and not being satisfied with the medication-only option presented to them.

Participants described using a mix of resources to find information about pregnancy and postpartum care. Participants most often said they asked medical providers, family and friends, and used the internet for information. Overall, participants reported receiving limited amounts of information from their MCO and said it was generally not very helpful. A third of participants said they had not received any services or supports from their MCOs' program for pregnant women. Of note, the handful of participants who received case management services reported satisfaction with the support they received. A number of participants enrolled with **WS** expressed dissatisfaction with their MCOs' rewards program and described not receiving benefits despite completing the required activities. None of the participants reported receiving breastfeeding support from their MCO, instead getting support from other entities such as Women, Infants & Children (WIC), hospital lactation specialists, and medical providers.

Recommendations

Recommendations generated from the interviews included:

Review and improve the MCOs' rewards programs

A substantial number of participants reported not receiving any of the supports and services available through their MCOs' program for pregnant women. Some participants expressed frustration that they completed the required activities but had not received any of the rewards. Participants mentioned that their medical providers were unaware of the programs and did not successfully send the confirmation to the MCO. The MCOs should consider reviewing the process used to track activities to ensure they are robust enough to universally capture successful completion of tasks and provide rewards as promised.

In addition, an examination of the types of requirements that are being rewarded should be conducted to tie activities more effectively to rewards. For example, nearly all interview participants received prenatal care. Some participants volunteered that they would have gone to their prenatal appointments regardless of the rewards program. In contrast, a quarter of participants reported using tobacco products, but had not agreed to accept cessation support. A rewards program that motivates pregnant women to stop smoking during pregnancy and continue to refrain from smoking during their postpartum period may be a more effective incentive for the MCOs to consider.

Enhanced information and support for postpartum pelvic floor complications

Participants reported not having access to information about and services to address postpartum pelvic floor issues. Providing information during pregnancy focused on preventive exercises and allowing access to physical therapy and other services during postpartum could reduce complications.

Connecting mothers with resources and support

Text messages, rather than telephone calls, may be a more effective method to inform beneficiaries of available resources. In addition, participants noted a desire for connection with other new and more experienced mothers. The MCOs could consider sponsoring support groups to facilitate these connections and interactions.

Enhancing and expanding postpartum appointment schedule

The bulk of participants said they had only one postpartum appointment scheduled six weeks after birth. Additional postpartum appointments stretched out further beyond birth could improve participants' access to and acceptance of needed mental health services and identify potential physical complications due to pregnancy. Participants frequently reported a need for more postpartum support to check in with new mothers and provide support and connection to mental health services. Postpartum depression and anxiety symptoms can be delayed and occur after the end of postpartum medical appointments.

Reveal Caller Telephone Survey

The New Hampshire DHHS contracted with HSAG to conduct a reveal caller telephone survey among provider locations contracted with the Medicaid MCOs and specializing in one of five physical health specialties (e.g., Cardiology, Dermatology, Endocrinology, Hematology/Oncology, and Neurology). Per the MCOs' contracts with DHHS, each MCO is required to maintain provider network capacity to ensure the following available appointment wait times from the member's PCP or another provider:

- Non-symptomatic office visits (i.e., preventive care): within 45 calendar days
- Non-urgent, symptomatic office visits (i.e., routine care): within 10 calendar days
- Urgent, symptomatic office visits: within 48 hours

The purpose of the survey was to evaluate New Hampshire's Medicaid managed care network of physical health specialty locations and the availability of appointments for non-urgent routine care. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to specialists. Specific survey objectives included the following:

- Determine whether specialty locations accept patients enrolled with a Medicaid MCO
- Determine whether specialty locations accept new patients
- Determine appointment availability with the sampled specialty locations for non-urgent services

HSAG called providers in November 2021 and sought to determine appointment availability, by specialty category, for non-urgent services for Medicaid managed care members served by at least one of the following MCOs:

- **ACNH**
- **NHHF**
- **WS**

For comparison to the Medicaid MCOs, HSAG also assessed appointment availability for individuals with commercial health insurance, using Anthem, offered in New Hampshire by Anthem BlueCross BlueShield.

Provider Locations Included in the Study

HSAG attempted to contact 869 provider locations, with a 38.3 percent response rate. Due to the revealed caller nature of the study, there were provider locations (i.e., "cases") where the provider's office ended the caller's conversation without offering responses for all survey elements. More than 97.0 percent of applicable survey respondents indicated that the provider location accepted new patients and these results were similar for all three MCOs. However, more than 74.0 percent indicated that they only served adult members.

Table 3-59 summarizes the number of survey cases and potential outcomes by health plan.

Table 3-59—Summary of Survey Case Outcomes by Health Plan

Health Plan	Total Survey Cases	Cases With Correct Location and Specialty	Providers Offering Services for Children	Providers Confirming Enrollment With Medicaid	Providers Confirming Enrollment With Health Plan	Accepting New Patients
ACNH	202	87	22	75	69	67
NHHF	393	137	31	118	113	111
WS	274	109	27	93	85	85
Anthem*				184	151	149

* Total survey cases, cases with correct location and specialty, and providers offering services for children are not displayed for Anthem because cases were not sampled separately for Anthem. Survey questions related to Anthem were asked if the ACNH, NHHF, and/or WS cases were reached and accepting the MCO.

Results

The physical health specialty provider telephone survey results indicated that while most sampled provider locations serve new patients with New Hampshire Medicaid MCOs and/or commercial insurance, provider data deficiencies may create challenges for Medicaid members seeking to contact specialty providers. The following key findings support this conclusion:

- HSAG was unable to reach more than 55 percent of sampled cases for each MCO. The reasons that cases were not reached included leaving voice mails without a return response, being placed on an extended hold greater than five minutes, the address being verified by HSAG did not exist or the location contacted was different than the sampled location, the location did not provide the requested physical specialty service, the phone number was disconnected, the telephone number in the sample did not reach a medical office, or the telephone number reached a fax machine tone or busy signal during all call attempts.
- HSAG achieved overall survey response rates of 43.1 percent, 34.9 percent, and 39.8 percent for ACNH, NHHF, and WS, respectively. Response rates varied by provider specialty and MCO, with differences up to 30 percentage points between the specialties with the lowest and highest response rates for each MCO.
- Among ACNH, NHHF, and WS provider locations that confirmed offering the sampled specialty, more than 74 percent of cases indicated that they only served adult members. Results varied by provider specialty and MCO, and most specialties more frequently indicated that they did not offer services for pediatric patients.
  - Approximately 25 percent of ACNH's respondent cases reported accepting children for the sampled specialty services.
  - Fewer than 25 percent of NHHF's and WS's respondent cases reported accepting children for the sampled specialty services.

  - Findings related to provider locations accepting adults and/or children are informational, as the survey's sampling approach does not support the application of such findings to the overall population of specialty providers or anticipated member needs.

- More than 90 percent of applicable survey respondents indicated that the provider location was contracted to serve the MCO's members, with acceptance rates of 92.0 percent for **ACNH**, 95.8 percent for **NHHF**, and 91.4 percent for **WS**. Overall, 82.1 percent of the **ACNH**, **NHHF**, and/or **WS** cases indicated the provider location also accepted patients enrolled with Anthem.
- More than 97 percent of applicable survey respondents indicated that the provider location was accepting new patients, and these results were similar for all four health plans (i.e., the Medicaid MCOs and Anthem).
- In general, appointments for existing patients were available sooner than appointments for new Medicaid patients. The average wait time for all MCOs was more than 56.0 days for new patients and approximately 43.0 days for existing patients, except for **ACNH**, which averaged wait times of 52.0 days.
  - Selected findings suggest limited appointment availability with certain types of specialists, regardless of a patient's health insurance. Dermatology had the highest median wait times across most health plans for new patients, while neurology had the highest median wait times across most health plans for existing patients.
  - Median wait times for new patient routine visits varied by provider specialty with **WS** having the longest median wait times for cardiology services. **ACNH** had the longest median wait times for dermatology, endocrinology, and neurology services, and **NHHF** had the longest median wait times for hematology and oncology services.
  - The median wait times across the health plans for existing patient routine visits were relatively consistent for dermatology, endocrinology, and hematology and oncology. However, cardiology and neurology showed the largest variability among median wait times. Median wait times for cardiology ranged from 11 days (**ACNH**) to 21.5 days (**WS**). Median wait times for neurology ranged from 56.0 days (**WS**) to 79.5 days (**ACNH**).

Study Limitations

Due to the nature of the survey methodology and script, the following limitations should be considered when generalizing survey results across physical health specialty providers contracted with each New Hampshire Medicaid MCO:

- HSAG conducted survey calls approximately one month following receipt of the MCO's provider data, resulting in the possibility that provider locations updated their contact information with the MCO prior to HSAG's survey calls.
- HSAG compiled survey findings from self-reported responses supplied to HSAG's callers by physical health specialty providers' office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., the MCO's online provider directory).

  - The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
  - Appointments may have taken longer to schedule during the COVID-19 pandemic due to a variety of reasons, including staffing shortages, backlog of appointments, and enhanced cleaning procedures.
- Since this survey required callers to indicate that they were conducting a survey on behalf of DHHS, responses may not accurately reflect members' experiences when seeking an appointment. Of note, 12.2 percent of **ACNH**'s locations, 11.7 percent of **NHHF**'s locations, and 12.7 percent of **WS**'s locations declined to participate in the survey. Additionally, 1.3 percent of **ACNH**'s locations, 2.0 percent of **NHHF**'s locations, and 2.4 percent of **WS**'s locations failed to return survey calls or voicemails, an outcome that may differ for prospective patients.
- Due to the nature of the survey script, respondents may have ended the caller's conversation without answering all survey elements by transferring the caller to another respondent to collect different survey elements. For example, billing staff may have supplied information concerning MCO acceptance, then transferred the caller to scheduling staff for appointment availability. As such, HSAG did not collect all survey elements for all respondent cases.
- The MCOs are responsible for ensuring that members have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of each MCO's processes for aiding members who require timely appointments.
- HSAG based survey results for the time to the first available appointment on appointments requested at the sampled location and counted cases as being unable to offer an appointment if the survey respondent offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Medicaid members are willing travel to an alternate location.

Recommendations

Based on the survey findings and the case-level survey data files sent to the MCOs, HSAG offers the following recommendations to evaluate and address potential MCO provider data quality and/or access to care concerns:

- HSAG was unable to reach more than 55 percent of sampled cases for each MCO, and a key non-response reason was call attempts in which the provider location reached was not the address noted in the provider data.
  - Since the MCOs supplied HSAG with the provider data used for this survey, DHHS should supply each MCO with the case-level survey data files and a defined timeline by which each MCO will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers, addresses, and/or provider specialty information that does not correspond to the sampled provider location).

- The MCOs' provider data included a provider type and specialty indicator. However, HSAG's survey results identified cases in which the survey respondent noted that the sampled location did not provide the requested specialty services. DHHS should consider conducting an independent provider directory review to verify that the MCOs' publicly available provider data accurately represent the provider data supplied to members.
- Per the MCOs' contracts with DHHS, each MCO is required to maintain provider network capacity to ensure the following available non-urgent appointment wait times from the member's PCP or another provider:
  - Non-symptomatic office visits (i.e., preventive care): within 45 calendar days
  - Non-urgent, symptomatic office visits (i.e., routine care): within 10 calendar days

  Overall survey results for average appointment wait times exceeded 57 days for new patients and 42 days for existing patients across all MCOs and Anthem. Therefore, DHHS should request that each MCO supply copies of its documentation regarding the MCO's processes for monitoring and evaluating members' ability to access care in a timely manner, including both geographic access and timely access to care.

  DHHS could also consider reviewing the current appointment timeliness standards to determine whether the State should establish separate timeliness standards for visits with PCPs versus physical health specialty providers for both non-symptomatic and non-urgent symptomatic visits. Per CMS' *Promoting Access in Medicaid and CHIP Managed Care*, states may allow physical health specialists to have timeliness standards with longer appointment wait times than the wait times expected for a similar visit with a PCP-type provider.[3-19] For example, the MCOs may be allowed 15 calendar days for a non-urgent symptomatic appointment with a specialist, but only 10 calendar days for the same type of appointment with a PCP.

  Improvement in the information concerning provider locations and the availability of appointment wait times will improve ***quality of care***, ***timeliness of care***, and ***access to care*** for New Hampshire MCM program members.

Quality Study

At the end of SFY 2022, DHHS and HSAG were discussing topics for the quality study. The information concerning that study will be included in the SFY 2023 New Hampshire External Quality Review Technical Report.

[3-19] Lipson DJ, Libersky J, Bradley K, et. al. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability. Baltimore, MD: Division of Managed Care Plans, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services. Available at: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf. Accessed on Nov 22, 2022.

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 of care, 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 PCCM entity in §438.364(a)(1).[4-4] HSAG follows a three-step process to aggregate and analyze data

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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 9, 2022.

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 9, 2022.

4-4 Ibid.

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.

AmeriHealth Caritas New Hampshire

MCO Contractual Compliance

This was the third year that **ACNH** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 99.2 percent on the review. Of the seven standards reviewed that included 256 applicable elements, **ACNH** achieved a 100 percent score in Emergency and Post-Stabilization Care, Wellness/Prevention/Member Education, Cultural and Accessibility Considerations, Grievances and Appeals Systems, and Health IS. 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 strength in the administration of emergency and post-stabilization care by ensuring coverage and payment for emergency services regardless of whether the provider that furnished the services was a participating provider. **ACNH** did not limit what constituted an emergency medical condition on the basis of lists of diagnoses or symptoms and did not hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. **ACNH** provided coverage and payment of emergency services until the attending physician, or the provider actually treating the member, determined that the member was sufficiently stabilized for transfer or discharge. By not holding members who have an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient, **ACNH** improved the overall ***quality of care*** received by those members. Complying with the requirements for emergency and post-stabilization care also assisted members in receiving ***timeliness of care*** and ***access to care***.

ACNH demonstrated strength in Wellness/Prevention/Member Education by presenting the Population Health Management Strategy Document, which described the wellness and prevention programs offered to members. The programs included Bright Start Maternity, Living Beyond Pain, and Emergency Room (ER) Diversion; and the Pediatric Preventive Health Care intervention. These programs contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in Cultural and Accessibility Considerations by ensuring that all members received equitable and effective service and treatment in a culturally and linguistically appropriate manner, regardless of members' ability to speak English or of their disabilities, gender, sexual orientation, or gender identity. The Physician Provider Agreement template required providers to furnish physical access, reasonable accommodations, and accessible equipment for members with physical or behavioral disabilities. All linguists assigned to perform services for **ACNH** were properly trained and qualified to provide the services requested, had an understanding of the cultural issues involved, and were briefed on the required protocols to follow when providing translation services. Complying with the Cultural and Accessibility Considerations requirements could assist in improving the ***quality of care***, ***timeliness of care***, and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in the Grievances and Appeals Systems standard by developing policies and procedures that included detailed information pertaining to the MCO's grievance system, appeal process, and access to the State fair hearing system. **ACNH** assisted members in completing the forms required for filing a grievance, appeal, or State fair hearing; furnished interpreter services to include American Sign Language; ensured that, concerning grievances and appeals, decision makers and their subordinates were not involved in previous levels of review or decision making; and followed the timelines for resolution as required by State and federal requirements. File reviews confirmed that **ACNH** followed the established time frames for processing grievances and appeals, and HSAG's review of the acknowledgement letters and notices of disposition confirmed inclusion of the required information. By correctly processing grievances and appeals, **ACNH** assisted members in improving ***quality of care***, ***timeliness of care***, and ***access to care***.

ACNH demonstrated strength in the Health IS standard by maintaining a system that collected, analyzed, integrated, and reported data for New Hampshire Medicaid members. HSAG also reviewed **ACNH**'s health IS during the 2022 PMV virtual review, and the information received during the compliance review continued to confirm the MCO's ability to collect provider and member information and ensure that data are accurate and complete. **ACNH**'s submission of accurate and complete encounter data assisted the MCO and DHHS in determining ***timeliness of care*** and ***access to care*** for members, and encounter data were also used to determine health outcomes, which represent ***quality of care*** for **ACNH**'s members.

To improve the Access standard, **ACNH** must ensure that providers are aware of the requirement to consult with the DCYF regarding medical and psychiatric matters for members who are children in State custody/guardianship. Improving consultations between providers and DCYF may result in better ***quality of care*** for **ACNH**'s members.

After finalization of the SFY 2022 Compliance Review Report in July 2022, **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 2022 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2022 Compliance Review CAP items during the SFY 2023 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 2022, **ACNH** demonstrated the following strengths that positively impacted the ***quality of care*** and ***access to care***:

- Continued testing interventions using incremental PDSA cycles.

During SFY 2022, 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. Each PDSA cycle (Cycle 1, Cycle 2, etc.) should have its own independent start and stop date and completed worksheet.
- **ACNH** should ensure each PDSA cycle worksheet reflects the data and intervention testing results for the intervention effectiveness measure(s) that were validated and approved in Module 3.
- If intervention testing results do not produce positive results in a timely manner, **ACNH** should revisit its key driver diagram and identified failure modes in the failure modes and effects analysis (FMEA) table to determine new member, provider, or system-focused interventions to test rather than continuing to test interventions not producing the desired outcomes. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing (PDSA cycle) results.
- **ACNH** should address HSAG's feedback provided in intervention testing check-in reviews and technical assistance summaries.
- **ACNH** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

PMV

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

- Revise the Initial Credentialing Approval Letter Tracking SOP to include **ACNH**'s resolution process for when discrepancies are observed regarding when the approval letters are sent to the providers. Improving this requirement will facilitate ***access to care***.

- Revise the Utilization Management (UM) Timeliness SOP to include processes to ensure data integrity and protect data from manual manipulation. Improving this requirement will facilitate ***timeliness of care*** and data quality, which in turn will improve the ***quality of care***.
- Reassess the system capabilities of the web-hosted Cactus system concerning the ability to capture the date the notice of enrollment letter was sent. **ACNH** is currently manually tracking outside of the software system, which adds another source system for extracting measure-specific data and introduces increased chances of data entry errors as well as oversight of timeliness. Improving this requirement will facilitate ***access to care***.
- Formalize a process for ensuring that notice of enrollment letters to providers are sent within 45 days of receipt of the application since **ACNH** is currently manually tracking outside of the web-hosted Cactus system. HSAG recommends that the formalized process includes key positions responsible for oversight, frequency of routine review and auditing of timely notice of enrollment letters sent, and the process for how discrepancies are noted and resolved. Improving this requirement will improve ***access to care***.
- Research the ability to develop field requirements within the Jiva software tool to limit the ability to past date or future date the case management episode start date. If the Jiva software source system is unable to develop these requirements, **ACNH** should develop a SOP that ensures staff members document rationale for pre- or post-dated care management episode start dates. It was noted during the review that the Jiva software source system allows the care management episode start date to be manually entered and allows for future and past dates to be entered. Improving this requirement will facilitate ***quality of care*** and ***access to care***.
- Document the date of when the discharge progress report is provided to the aftercare provider within seven days of discharge. In addition, **ACNH** should ensure documentation confirming the date the discharge progress report is sent to a provider is stored consistently with the progress notes and receipt of confirmation (i.e., successful fax). Improving this requirement will facilitate ***quality of care*** and ***timeliness of care***.

NAV

The following sections provide information concerning **ACNH**'s strengths identified during the NAV study and opportunities for improvement.

Strengths

- Reviewers were able to locate the provider information for the vast majority of **ACNH** providers sampled in the NAV. This included locating 100 percent of PCPs, between 84.2 percent and 100 percent of all specialty providers, and 92.4 percent of BH providers. Based on these findings, members' ***access to care*** is robust with respect to being able to find the majority of **ACNH**'s network in the online directory.
- Reviewers were able to confirm that provider contact information, specialties, and other key data indicators in the online provider directories matched with the data files submitted by **ACNH** for 95 percent of cases or more per key indicator for PCPs and 90 percent of cases per key indicator for

BH providers. These findings indicate that members' ***access to care*** is robust with respect to their ability to find accurate information for contacting PCPs and BH providers.

- The median wait time for appointments with **ACNH** pulmonologists for existing patients was 9.0 calendar days, while for new patients the median wait time for an appointment was 31.0 calendar days. For both new and existing patients, the median wait times for this specialty provider type was substantially shorter than for other MCOs. This indicates a substantial advantage to the ***timeliness of care*** for members with pulmonology needs who are enrolled in **ACNH**.

Opportunities for Improvement

- Unlike PCPs and BH providers, the contact information for **ACNH**'s specialty providers was not as robust. Address information was incorrect for nearly 17.6 percent of allergists and 23.8 percent for ENTs and pulmonologists. For members wanting to contact these providers, ***access to care*** is limited by incorrect information, which will necessitate additional effort by members to contact the desired provider.
- In the online provider directory, **ACNH** providers were identified as accepting new patients across all specialty and BH providers, as well as among 96.5 percent of PCPs. Upon calling providers in the telephone survey, however, **ACNH** PCP offices reported accepting new patients in 47.7 percent of cases. For specialty providers, the corresponding new patient acceptance rate was less than 90 percent for five of eight specialty provider types; and for BH providers, the new patient acceptance rate was 71.4 percent. The disagreement between data provided in the online directory and those obtained directly from providers' offices indicate that members' ***access to care*** may be limited by an additional hurdle of finding a provider who is accepting new patients. Depending on the provider type, less than half of providers may be taking on new patients, requiring additional effort by members to locate a provider for care. Such delays could result in extended delays in the ***timeliness of care*** if members must put in significant effort to contact many providers to obtain an appointment.
- The median appointment wait time for **ACNH** providers was substantially longer than the median appointment wait time for other plans across specialty providers. Comparatively, across MCOs the results indicate that the ***timeliness of care*** in appointment wait times might be reduced to a level commensurate with other plans. When combining the results of median appointment wait times with the percentage of providers accepting new patients, **ACNH** may need to add more providers to its network to accommodate its membership and improve the ***timeliness of care***.
- Across the three data sources reviewed, the provider contact information and specialty provider types agreed in only 43.5 percent of PCP cases, 15.8 to 47.6 percent of specialty providers, and 22.9 percent of BH providers. This finding indicates that while **ANCH**'s internal databases and online provider directories may be largely in alignment, providers' offices indicate that the information is often incorrect. For members, the data inaccuracies in the online directories result in reduced ***access to care*** and, potentially, reduced ***timeliness of care***.

CAHPS

Two of the 2022 measure rates representing the ***quality of care*** domain (i.e., *Rating of Health Plan* and *Rating of Specialist Seen Most Often*) for **ACNH**'s child Medicaid population were statistically significantly lower than the 2021 NCQA child Medicaid national averages. The 2022 measure rates representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains for **ACNH**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2021 NCQA adult Medicaid national averages.

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.

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.

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 2021 representing MY 2020.

Table 4-1—Summary of ACNH's Scores for MY 2021 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	1	5	4	10	3	**23**
Acute and Chronic Care	2	2	1	5	3	**13**

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
BH	11	1	2	2	2	**18**
All Domains	**14**	**8**	**7**	**17**	**8**	**54**
Percentage	**25.93%**	**14.81%**	**12.96%**	**31.48%**	**14.81%**	**100%**

ACNH's rates ranked at or above the 50th percentile for 29 measures (53.70 percent), with 14 of these measures (25.93 percent) meeting or exceeding the 90th percentile. The rates for 25 measures (46.30 percent) fell below the 50th percentile.

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. The following HEDIS measure results reflect all three domains of care—***quality of care***, ***timeliness of care***, and ***access to care***.

ACNH demonstrated strength for measures related to ***quality of care***, meeting or exceeding the 50th percentile for 28 of the 50 (56.00 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):

- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*, *12–17 Years*, and *Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *Lead Screening in Children (LSC)*
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *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)—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:

- *Breast Cancer Screening (BCS)*
- *Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months—Six or More Visits* and *15 Months–30 Months—Two or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total and Counseling for Nutrition—Total*
- *Childhood Immunization Status (CIS)—Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)*
- *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* and *21–24 Years*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*†
- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%),* and *HbA1c Control (<8.0%)*
- *Controlling High Blood Pressure (CBP)*
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *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*†
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*

To improve ***quality of care***, **ACNH** should educate members to help them understand the importance of receiving preventive care and screenings. **ACNH** should remind providers to review preventive care measures for every patient, including children and adolescents, 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; controlling blood pressure; immunizations for adolescents; and weight assessment, counseling for nutrition, and physical activity for children and adolescents. Adopting clinical practice guidelines (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 12 of the 17 (70.59 percent) measure 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):

- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *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**
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *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:

- *Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months—Six or More Visits* and *15 Months–30 Months—Two or More Visits*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*†
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*

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 their babies. Additionally, **ACNH** also could inform members of the importance of well-child visits and immunizations to ensure children are healthy and developing properly. 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 12 of the 17 (70.59 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):

- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*, *12–17 Years*, and *Total*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

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*
- *Well-Child Visits in the First 30 Months of Life (W30)—First 15 Months—Six or More Visits* and *15 Months–30 Months—Two or More Visits*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*

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 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 well-child visits for promoting healthy child development and follow-up care for children prescribed ADHD medications.

EDV

In the IS review activity, **ACNH** subcontractors performed at least one data quality check before and/or after submitting encounters to **ACNH**. However, the types of quality checks varied across subcontractors. **ACNH** performed at least one data quality check before and/or after submitting encounters to DHHS. The quality checks generally included, but were not limited to, EDI compliance edits, field-level completeness and validity, timeliness, reconciliation with financial reports, and claim volume by submission month. **ACNH** also submitted all required types of claims/encounters to DHHS.

ACNH demonstrated strength by meeting 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 all encounter types.

ACNH has two 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***.

Aggregate Conclusions for ACNH

The following tables include aggregated conclusions concerning strengths and weaknesses for **ACNH** in the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

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

Quality	Access	Timeliness	Strengths
✓	✓		**ACNH** continued HSAG's rapid-cycle PIP approach for two PIP topics in SFY 2022. The PIPs were also HEDIS measures in SFY 2022: *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*. The *IET* PIP achieved a HEDIS percentile rating of equal to or greater than the 90th percentile, and the *SSD* PIP achieved the 75th–89th percentile. The PIP activities positively impacted the HEDIS rate for those two measures.
✓	✓		**ACNH** met the requirements for the CLAIM.23—*Timely Processing of All Clean Provider Claims: Thirty Days of Receipt* performance measure included in the PMV activity. The findings from the PMV activity correlate with the 100 percent scores achieved by **ACNH** in the EDV Health Plan Comparisons activity that evaluated initial submissions within 14 days of claims payment for professional and institutional encounters. The findings from the PMV and EDV activities support the finding of timely claims processing for **ACNH**.
✓	✓	✓	The compliance review determined that **ACNH** demonstrated strength by maintaining a health IS that accurately and completely collected, analyzed, integrated, and reported data for New Hampshire Medicaid members. HSAG also reviewed **ACNH**'s health IS during the SFY 2022 PMV review and the HEDIS IS review. All three system reviews confirmed the MCO's ability to collect provider and member information and ensure that data are accurate and complete.
✓			Another measure showing strong performance for **ACNH** during the PMV activity was GRIEVANCE.03: *Member Grievances Received.* The SFY 2022 compliance review included HSAG's review of 10 grievance files, and the results of that review confirmed that **ACNH** sent 10 acknowledgement letters as required confirming the receipt of those grievances with the member. The findings from the PMV and the compliance review activities confirm that **ACNH** is receiving grievance files and sending acknowledgement letters for those files as required by State and federal regulations.

Quality	Access	Timeliness	Strengths
	✓	✓	**ACNH** received an *Acceptable* score during the PMV audit on the APPEALS.03: *Resolution of Expedited Appeals Within 72 Hours* performance measure. During the compliance activity, HSAG reviewed 10 appeal files, and the file review also indicated that **ACNH** processed expedited appeals within the established timelines. The findings from the PMV and the compliance review activities confirm that **ACNH** is receiving appeals files and processing those files as required by State and federal regulations.

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

Quality	Access	Timeliness	Weaknesses
	✓		In the NAV study, the online provider directory indicated that providers accepted new patients for 96.5 percent of PCPs. After calling providers in the telephone survey, however, HSAG learned that **ACNH**'s PCP offices reported accepting new patients in 47.7 percent of cases. With less than half of the **ACNH** PCPs contacted during the study accepting new patients, **ACNH** may have experienced an access to care issue that affected the HEDIS rates, especially for preventive care measures scoring under the 50th percentile. **Recommendation: ACNH** should contact PCP offices to determine which offices are accepting new patients and correct the information in the provider files and the online provider directory.
	✓	✓	During the NAV study, HSAG found that the data files submitted by **ACNH** did not match provider location information in **ACNH**'s online directory for 23.8 percent of the pulmonologists. The incorrect information could have contributed to members not finding pulmonologists in their geographic area, which in turn may have impacted the low percentile rankings (i.e., less than the 25th percentile) for *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*. **Recommendation: ACNH** should review the information in the online provider directory to ensure that complete and accurate information is included concerning the location of pulmonologists.

New Hampshire Healthy Families

MCO Contractual Compliance

This was the ninth year that **NHHF** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 99.6 percent on the review. Of the seven standards reviewed that included 258 applicable elements, **NHHF** achieved a 100 percent score in Emergency and Post-Stabilization Care, Wellness/Prevention/Member Education, Cultural and Accessibility Considerations, Grievances and Appeals Systems, and Health IS. 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 did not limit what constituted an emergency medical condition on the basis of lists of diagnoses or symptoms. The MCO covered payment for emergency services at a rate that was no less than the equivalent DHHS FFS rate and ensured payment regardless of whether the provider was a participating provider or an out-of-network provider. **NHHF** also covered post-stabilization services and considered the attending emergency physician or the provider actually treating the member as the person responsible for determining when the member was sufficiently stabilized for transfer or discharge. By not holding members who have an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient, **NHHF** improved the overall ***quality of care*** received by those members. Complying with the requirements for emergency and post-stabilization care also assisted members in receiving ***timeliness of care*** and ***access to care***.

NHHF demonstrated strengths in wellness and prevention by enhancing care management to include wellness and prevention programs for childhood and adult obesity, smoking cessation, and other topics related to wellness and prevention programs in consultation with the State. Interviews with staff members confirmed that **NHHF** also had implemented weight management and smoking cessation programs as part of its disease management program. **NHHF** presented evidence of incentives and other programs to encourage healthy behaviors, such as the maternity rewards program, flu shot promotional materials, and the Healthy Kids Club program. **NHHF** also developed multiple website links for members to access health and wellness information and other educational resources and encouraged members to actively participate in decisions concerning their healthcare. These programs contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NHHF**'s members.

NHHF demonstrated strengths in cultural considerations by developing a Cultural Competency Plan to promote the delivery of healthcare services in a culturally and linguistically competent manner to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. **NHHF** established and followed quality standards in delivering language assistance services, including using only qualified bilingual/multilingual staff, qualified interpreters for members with a disability, qualified interpreters for members with LEP, and qualified translators. **NHHF** monitored participating providers to ensure that members had physical access and the accommodations and equipment necessary to treat members with physical or behavioral disabilities. Encouraging all members, especially members with

LEP, to receive healthcare services, ensuring physical access to accommodations and equipment, and following quality standards in delivering language assistance services improved ***quality of care***, ***timeliness of care***, and ***access to care*** for New Hampshire Medicaid beneficiaries.

NHHF demonstrated strengths in its grievances and appeals systems by submitting documents with detailed information about the grievance process, appeal process, and members' access to the State fair hearing system. During the contracting process, **NHHF** also furnished information about the grievance and appeal system to all providers and subcontractors. Grievance, appeal, and State fair hearing documents contained the correct requirements concerning the timelines for resolution and extensions. File reviews confirmed that **NHHF** followed the established time frames for processing grievances and appeals, and HSAG's review of the acknowledgement letters and notices of disposition confirmed inclusion of the required information. By correctly processing grievances and appeals, **NHHF** assisted members in improving ***quality of care***, ***timeliness of care***, and ***access to care***.

NHHF demonstrated strength in its health IS by confirming its capabilities to collect, analyze, integrate, and report data needed to maintain information concerning the New Hampshire Medicaid beneficiaries. HSAG also reviewed **NHHF**'s health IS during the 2022 PMV virtual review, and the information received during the compliance review continued to confirm the MCO's ability to collect provider and member information and ensure that data are accurate and complete. **NHHF**'s submission of accurate and complete encounter data assisted the MCO and DHHS in determining ***timeliness of care*** and ***access to care*** for members, and encounter data were also used to determine health outcomes, which represent ***quality of care*** for **NHHF**'s members.

To improve ***timeliness of care*** and ***access to care*** for the Availability of Services standard, **NHHF** must provide the notice of termination of a contracted provider to members 30 calendar days prior to the effective date of the termination.

FWA could be improved by creating documentation requiring the MCO and its subcontractors to provide any data access or detail records upon written request from DHHS within three business days of the request for any potential FWA investigation, provider or claims audit, or for MCO oversight reviews.

After finalization of the SFY 2022 Compliance Review Report in July 2022, **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 2022 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2022 Compliance Review CAP items during the SFY 2023 compliance audit.

PIPs

NHHF collaborated with DHHS and the other MCOs to select the topics for the two PIPs that were initiated in SFY 2020. During SFY 2022, 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***:

- Determined new targeted interventions to test and developed sound intervention effectiveness measures.
- Tested interventions using incremental PDSA cycles and making data-driven decisions based on testing results.

During SFY 2022, 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. The testing methodology should allow the MCO 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 ensure that the intervention developed and tested has the potential to impact the overall goal of the project.
- **NHHF** should revisit its key driver diagram and identified failure modes to determine new interventions to test once an intervention is abandoned.
- **NHHF** should consider addressing identified lessons learned with an intervention.
- **NHHF** should apply lessons learned and knowledge gained throughout the PIP to future PIPs and quality improvement activities.

PMV

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

- Regularly communicate with the measure-producing staff members to ensure any changes to measures are captured and reported accurately. HSAG observed source code issues with the SUD.48 measure resulting in **NHHF** updating its source code logic to align with measure specifications. To prevent reoccurrence of this issue and to support future reporting, **NHHF** indicated that it will conduct an additional internal code walkthrough with business owners for future specification changes. Improving this requirement will facilitate ***quality of care*** and ***access to care***.
- Revise the GRIEVANCE.03 quality assurance process to capture the action plan **NHHF** provided to HSAG relative to mitigating data entry errors and potential data reporting inaccuracies. Improving this requirement will facilitate ***quality of care***.
- Monitor the implemented action plan noted for the GRIEVANCE.03 measure to ensure **NHHF** mitigates manual data entry errors by conducting adequate oversight and validation. Improving this requirement will facilitate ***quality of care***.
- Explore system enhancements to reduce the risk of duplicate data entry for grievances and appeals. Improving this requirement will facilitate ***quality of care***.

NAV

The following sections provide information concerning **NHHF**'s strengths identified during the NAV study and opportunities for improvement.

Strengths

- Reviewers were able to locate the provider information for the vast majority of **NHHF** providers sampled in the NAV. This included locating 91.2 percent of PCPs, between 81.0 percent and 100 percent of all specialty providers, and 85.9 percent of BH providers. Based on these findings, members' ***access to care*** is robust with respect to being able to find the majority of **NHHF**'s PCP network and many specialty providers in the online directory.
- **NHHF**'s allergists, pulmonologists, and urologists all reported accepting new patient in 100 percent of cases. For these providers, **NHHF** members enjoy a robust network of providers that are able to provide ***access to care*** with excess capacity to accept new patients. These new patient acceptance rates also exceed the rate of new patient acceptance identified in **NHHF**'s online provider directory.
- **NHHF** had the shortest median wait time for new patients for PCPs at 28.0 calendar days. Median wait times for appointments for existing patients with specialty providers were 14.0 calendar days for allergists, 19.0 calendar days for OB/GYNs, 9.0 calendar days for orthopedists, and 11.0 calendar days for BH providers. Among these provider types, **NHHF** members enjoy robust ***timeliness of care***.

Opportunities for Improvement

- Reviewers were not able to confirm that provider contact information in the online provider directories matched with the data files submitted by **NHHF** for at least 95 percent of cases. Specifically, while many key indicators matched at nearly the 90 percent level, **NHHF** telephone numbers matched between the MCO-submitted data and the online provider directory in 67.7 percent of cases for PCPs, between 45.0 and 95.2 percent of cases for specialty providers, and 76.0 percent of cases for BH providers. Even if provider names and address information were correct, since the telephone is a primary mode of contact for members to make appointments, inaccurate phone numbers are likely to produce reduced ***access to care*** and potentially poorer ***timeliness of care***.
- **NHHF**'s PCPs reported accepting new patients in 58.8 percent of telephone survey cases. This is substantially lower than the 88.4 percent indicated on the **NHHF** online provider directory, and indicates reduced ***access to care*** for **NHHF** members, which could also lead to reductions in the ***timeliness of care***. HSAG also identified similar results across BH providers with **NHHF**. Among BH providers, the telephone survey indicated 66.7 percent of providers accepting new patients, whereas the **NHHF** online provider directory indicated 95.9 percent accepting new patients.
- Across the three data sources reviewed, the provider contact information and specialty types agreed in only 28.2 percent of PCP cases, 0.0 to 71.4 percent of specialty providers, and 12.9 percent of BH providers. This finding indicates that while **NHHF**'s internal databases and online provider directories may be largely in alignment, providers' offices indicate that the information is often incorrect. For members, the data inaccuracies in the online directories result in reduced ***access to care*** and, potentially, reduced ***timeliness of care***.

CAHPS

None of the 2022 measure rates representing the ***quality of care*** or ***timeliness of care*** domains for **NHHF**'s adult and child Medicaid populations were statistically significantly higher or lower than the 2021 NCQA adult and child Medicaid national averages.

Although none of **NHHF**'s adult and child Medicaid populations' rates were statistically significantly higher or lower than the 2021 NCQA adult and child Medicaid national averages, there were some measures that performed below the 2021 NCQA adult and child Medicaid national averages. To improve CAHPS rates on these measures, **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*** 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 the Internet 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 2021 representing MY 2020.

Table 4-4—Summary of NHHF's Scores for MY 2021 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	2	4	6	6	5	**23**
Acute and Chronic Care	1	3	5	4	0	**13**
BH	7	9	3	2	0	**21**
All Domains	**10**	**16**	**14**	**12**	**5**	**57**
Percentage	**17.54%**	**28.07%**	**24.56%**	**21.05%**	**8.77%**	**100%**

NHHF's rates ranked at or above the 50th percentile for 40 measures (70.18 percent), with 10 of these measures (17.54 percent) meeting or exceeding the 90th percentile. The rates for 17 measures (29.82 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 36 of the 53 (67.92 percent) measures related to ***quality***. The following measures related to ***quality of care*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the First 30 Months of Life (W30)—15 Months–30 Months—Two or More Visits*
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years**, *12–17 Years*, *18–21 Years*, and *Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing*
- *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)*
- *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*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug 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*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*
- *Asthma Medication Ratio (AMR)—Total*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*
- *Pharmacotherapy for Opioid Use Disorder (POD)—Total*

To improve ***quality of care***, **NHHF** should educate members to help them understand the importance of receiving preventive care and remind providers to review preventive care measures for every patient, including children and adolescents, 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, well-child visits, cervical cancer, and chlamydia screenings. 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)* measure. **NHHF** also could furnish information in provider newsletters and perform targeted provider mailings concerning asthma medications and immunizations for adolescents.

NHHF demonstrated strength in measure indicators related to ***timeliness of care***, meeting or exceeding the 50th percentile for 15 of the 19 (78.95 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):

- *Well-Child Visits in the First 30 Months of Life (W30)—15 Months–30 Months—Two or More Visits*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug 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 for the following measures:

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*
- *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*
- *Pharmacotherapy for Opioid Use Disorder (POD)—Total*

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 17 of the 19 (89.47 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):

- *Well-Child Visits in the First 30 Months of Life (W30)—15 Months–30 Months—Two or More Visits*
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years**, *12–17 Years*, *18–21 Years*, and *Total*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Initiation and Engagement of Alcohol and Other Drug 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 for the following measures:

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*

To improve ***access to care***, **NHHF** could consider focusing its efforts on 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 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 diabetes and schizophrenia.

EDV

In the IS review activity, **NHHF** subcontractors performed at least one data quality check before and/or after submitting encounters to **NHHF**. However, the types of quality checks varied across subcontractors. **NHHF** performed at least one data quality check after submitting encounters to DHHS. The quality checks generally included, but were not limited to, EDI compliance edits, field-level completeness and validity, timeliness, reconciliation with financial reports, and claim volume by submission month. **NHHF** also submitted all required types of claims/encounters to DHHS.

NHHF met the standards for the X12 EDI compliance edits, the accuracy for member identification numbers, the accuracy for billing and servicing providers in all applicable encounter types, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for its 837I encounters. **NHHF** should continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for professional and pharmacy encounters, especially professional encounters. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the ***timeliness of care*** issues.

NHHF has five 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. 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***.

Aggregate Conclusions for NHHF

The following tables include aggregated conclusions concerning strengths and weaknesses for **NHHF** in the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

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

Quality	Access	Timeliness	Strengths
✓	✓		**NHHF** continued HSAG's rapid-cycle PIP approach for the PIP topic *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total* in SFY 2022. In the results section for the HEDIS measures, the *IET* PIP achieved a percentile rating of equal to or greater than the 90th percentile indicating that the PIP activities positively impacted the HEDIS rate for that measure.
✓	✓		**NHHF** met the requirements for the CLAIM.23—*Timely Processing of All Clean Provider Claims: Thirty Days of Receipt* performance measure included in the PMV activity. The finding from the PMV activity correlates with the 100 percent score achieved by **NHHF** in the EDV Health Plan Comparisons activity that evaluated initial submissions within 14 days of claims payment for institutional encounters.

Quality	Access	Timeliness	Strengths
✓	✓		The compliance review determined that **NHHF** demonstrated strength by maintaining a health IS that accurately and completely collected, analyzed, integrated, and reported data for New Hampshire Medicaid members. HSAG also reviewed **NHHF**'s health IS during the SFY 2022 PMV review and the HEDIS IS review. All three system reviews confirmed the MCO's ability to collect provider and member information and ensure that data are accurate and complete.
✓			Another measure showing strong performance for **NHHF** during the PMV activity was GRIEVANCE.03: *Member Grievances Received.* The SFY 2022 compliance review included HSAG's review of 10 grievance files, and the results of that review confirmed that **NHHF** sent 10 acknowledgement letters as required, confirming the receipt of those grievances with the member.
	✓	✓	**NHHF** received an *Acceptable* score during the PMV audit on the APPEALS.03: *Resolution of Expedited Appeals Within 72 Hours* performance measure. During the compliance activity, HSAG reviewed 10 appeal files, and the file review also confirmed that **NHHF** processed expedited appeals within the established timelines.

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

Quality	Access	Timeliness	Weaknesses
	✓		In the online provider directory, **NHHF** providers were identified as accepting new patients for 88.4 percent of PCPs. After calling providers in the telephone survey, however, HSAG found that **NHHF**'s PCP offices reported accepting new patients in 58.8 percent of offices. With just more than half of the **NHHF** PCPs contacted during the study accepting new patients, **NHHF** may have experienced an access to care issue that affected the HEDIS rates, especially for preventive care measures scoring less than the 25th percentile or between the 25th and 49th percentile. **Recommendation:** **NHHF** should contact PCP offices to determine which offices are accepting new patients and correct the information in the provider files and the online provider directory.
	✓		During the NAV study, HSAG found that information obtained during the telephone survey did not match the contact information (i.e., name, address, city, state, ZIP Code, telephone number, and specialty) found in **NHHF**'s online directory for 71.4 percent of the pulmonologists. The incorrect information could have contributed to members not finding pulmonologists in their geographic area, which in turn may have impacted the low percentile ranking (i.e., 25th–49th percentile) for *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*. **Recommendation:** **NHHF** should review the information in the online provider directory to ensure that complete and accurate information is included concerning the contact information for pulmonologists.

Well Sense Health Plan

MCO Contractual Compliance

This was the ninth year that **WS** completed a compliance review in New Hampshire, and the MCO achieved an overall score of 98.8 percent on the review. Of the seven standards reviewed that included 255 applicable elements, **WS** achieved a 100 percent score in Emergency and Post-Stabilization Care, Wellness/Prevention/Member Education, Cultural and Accessibility Considerations, and Health IS. 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.

WS demonstrated strengths in the administration of emergency care by ensuring that it paid for emergency services regardless of whether the provider furnishing the services is a participating provider and ensuring that it did not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Interviews with staff members confirmed that the attending emergency physician or provider treating the member was responsible for determining when the member was sufficiently stabilized for transfer or discharge. By not holding members who have an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient, **WS** improved the overall ***quality of care*** received by those members. Complying with the requirements for emergency and post-stabilization care also assisted members in receiving ***timeliness of care*** and ***access to care***.

WS demonstrated strengths in wellness and prevention by offering members an array of quality wellness services that included innovative solutions to managing health status. Multiple documents submitted by **WS** demonstrated that the MCO offered incentives and rewards for members who engaged in personal responsibility and self-management of their healthcare. Interviews with staff members confirmed that **WS** used the Member Advisory Board to obtain feedback regarding the development of wellness programs, and staff members also confirmed that **WS** care managers used a variety of outreach methods to engage members who were difficult to contact. These programs and activities contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **WS**'s members.

WS demonstrated strengths in cultural considerations by offering language assistance to individuals with LEP and/or other communication needs, at no cost to members, to facilitate timely access to all healthcare and services. The member handbook and provider manual also contained information about how **WS** participated in these efforts by including requirements for provider and employee training. **WS** provided written information for members in English and Spanish and would provide documents in additional languages if the MCO received a request for the information. Encouraging all members, especially members with LEP, to receive healthcare services, ensuring physical access to accommodations and equipment, and following quality standards in delivering language assistance services improved ***quality of care***, ***timeliness of care***, and ***access to care*** for New Hampshire Medicaid beneficiaries.

WS demonstrated strength in its health IS by documenting, maintaining, and discussing a system that collects, analyzes, integrates, and reports data for the New Hampshire Medicaid program. The health IS contained a claims processing and retrieval system that collected data elements necessary to support the mechanized claims processing and information retrieval systems operated by the State. **WS** demonstrated its ability to collect and maintain sufficient member encounter data to submit the information to DHHS and meet the level of detail required for DHHS' reporting to CMS. **WS**'s submission of accurate and complete encounter data assisted the MCO and DHHS in determining ***timeliness of care*** and ***access to care*** for members, and encounter data were also used to determine health outcomes, which represented ***quality of care*** for **WS**'s members.

To improve the Grievances and Appeals Systems standard, **WS** must ensure that if it extends the time frame for an expedited appeal, and the member does not request the extension, plan documents include the requirement to give the member prompt oral notice of the delay. Prompt oral notice requires providing a minimum of three oral attempts to contact the member at various times of the day on different days within two calendar days of **WS**'s decision to extend the time frame. For member requests for an expedited State fair hearing, **WS** must provide to DHHS and the member, upon request within 24 hours, all MCO-held documentation related to the appeal, including, but not limited to, any transcripts, records, or written decisions from participating providers or delegated entities.

To improve the Access standard, **WS** must include in its TOC policies a documented process to support continuity of care for members when they move from home to foster care placement, from foster care to independent living, return from foster care placement to the community, and when they experience a change in legal status from foster care to adoption. **WS** also must describe in the notice to members the procedures for selecting an alternative PCP when the member's PCP terminates. Improvements in these requirements will assist in improving ***quality of care***, ***timeliness of care***, and ***access to care***.

To improve the FWA standard, **WS** must provide any data access or detail records upon written request from DHHS within three business days of the request for any potential FWA investigation, provider or claims audit, or for MCO oversight review.

After finalization of the SFY 2022 Compliance Review Report in July 2022, **WS** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be *Partially Met* or *Not Met* during the compliance review. **WS** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2022 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2022 Compliance Review CAP items during the SFY 2023 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 2022, 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***:

- Determined new targeted interventions to test and developed sound intervention effectiveness measures.
- Tested interventions using thoughtful and incremental PDSA cycles and making data-driven decisions based on testing results.

During SFY 2022, 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 apply lessons learned and knowledge gained throughout the PIPs to future PIPs and QI activities.

PMV

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

- Ensure adequate oversight to confirm completion of outreach calls for the missing 52,000 members as well as monitor the code to ensure all members who meet criteria are sent to Eliza for outreach. **WS** indicated a Quarter Four code change to the measure calculation for the HRA.08 measure. **WS** indicated that it had transitioned outreach calling from in-house to an external vendor, Eliza, in May 2020. **WS** had identified an issue in August through September 2021 with the code used to extract members for outreach and sent to Eliza. Members who had been identified for outreach at the time of their initial enrollment that occurred prior to the transition were not being re-identified when it came time for their annual outreach and were not sent to Eliza. A code fix was put in place in August 2021. **WS** noted 52,000 members who were missed for this annual outreach and sent catch-up files to address this issue. While HSAG identified this as an opportunity, the issue had no impact on the final outcome of the HRA.08 rates, as HSAG determined **WS** was compliant with the requirements of the measure. Improving this requirement will facilitate ***quality of care***.
- Revise the provisional credentialing process document to define the process for when **WS** would apply the provisional credentialing date as the application date. Improving this requirement will facilitate ***access to care***.

- Revise the workflow chart to include titles of individuals responsible for each of the validation activities noted in the workflow chart. Ensuring that employees note validation activities and are accountable for the information provided on the workflow chart will facilitate ***quality of care***.

NAV

The following sections provide information concerning **WS**'s strengths identified during the NAV study and opportunities for improvement.

Strengths

- HSAG reviewers located the provider information for the vast majority of **WS** providers sampled in the NAV. This included locating 97.1 percent of PCPs, between 95.2 percent and 100 percent of all specialty providers, and 91.8 percent of BH providers. Based on these findings, members' ***access to care*** is robust with respect to being able to find the majority of **WS**'s network in the online directory.
- HSAG reviewers confirmed that provider contact information, specialty provider types, and other key data indicators in the online provider directories matched with the data files submitted by **WS** for 90 percent of cases or more. This finding carried across PCPs and BH providers. These findings indicate that members' ***access to care*** is robust with respect to their ability to find accurate information for PCPs and BH providers.
- **WS** providers reported relatively short median wait times for appointments for existing patients among PCPs at 7.0 calendar days; for new and existing patients among ENTs (17.0 and 16.0 calendar days, respectively), gastroenterologists (48.0 and 29.5 calendar days, respectively), OB/GYNs (14.0 and 14.0 calendar days, respectively), ophthalmologists (42.5 and 42.5 calendar days, respectively), orthopedists (6.0 and 6.0 calendar days, respectively), and urologists (48.0 and 46.0 calendar days, respectively); and for BH providers at 22.5 and 7.0 calendar days, respectively. The results indicate that **WS** members have relatively better ***timeliness of care*** for these provider types as compared to the other MCOs in the state.

Opportunities for Improvement

- **WS** PCPs reported accepting new patients in 78.0 percent of cases in the telephone survey, whereas the online provider directory indicated 98.8 percent of PCPs were accepting new patients. Among specialty providers, respondents to the telephone survey almost always indicated accepting new patients, which was incongruous with the online provider directory where new patient acceptance rates range from 11.8 percent among **WS** allergists to 42.9 percent for urologists. Among BH providers contracted with **WS**, the new patient acceptance rate reported in the telephone survey was 81.8 percent, which was lower than the 99.4 percent identified in the online directory. Discrepancies between the reported new patient acceptance rate and actual acceptance rate may produce confusion and frustration among members. Even when a provider's self-reported acceptance rate is higher than what is reported in the online directory, members may review the directories and choose not to contact providers listed as not accepting new patients. This could contribute to a false sense of limited ***access to care*** among members.

- **WS** PCPs reported the longest median wait time for an appointment among new members at 52.0 calendar days. Among specialty providers, **WS** had the longest median appointment wait times among allergists for new patients, and among pulmonologists for both new and existing patients. Lengthy wait times for appointments contribute to poor ***timeliness of care*** and an increased likelihood of more severe illness and complications.
- Across the three data sources reviewed, the provider contact information and specialty types agreed in only 40.6 percent of PCP cases, 19.0 to 42.9 percent of specialty providers, and 17.6 percent of BH providers. This finding indicates that while **WS**'s internal databases and online provider directories may be largely in alignment, providers' offices indicate that the information is often incorrect. For members, the data inaccuracies in the online directories result in reduced ***access to care***, and potentially reduced ***timeliness of care***.

CAHPS

Three 2022 child measure rates, representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains, were statistically significantly higher than the 2021 NCQA child Medicaid national averages.

For one 2022 adult Medicaid population measure representing the ***quality of care*** domain (i.e., *Rating of Personal Doctor)*, the rate was statistically significantly lower than the 2021 NCQA adult Medicaid national average.

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.

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 2021 representing MY 2020.

Table 4-7—Summary of Scores for MY 2021 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	6	7	7	3	**23**
Acute and Chronic Care	3	0	5	3	2	**13**
BH	7	5	3	4	2	**21**
All Domains	**10**	**11**	**15**	**14**	**7**	**57**
Percentage	**17.54%**	**19.30%**	**26.32%**	**24.56%**	**12.28%**	**100%**

WS's rates ranked at or above the 50th percentile for 36 measures (63.16 percent), with 10 of these measures (17.54 percent) meeting or exceeding the 90th percentile. The rates for 21 measures (36.84 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 32 of 53 (60.38 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):

- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*, *12–17 Years*, *18–21 Years*, and *Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *Appropriate Treatment for Upper Respiratory Infection (URI)**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator** and *Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total*
- *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)—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—Total* and *Counseling for Nutrition—Total*
- *Childhood Immunization Status (CIS)—Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)*
- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years†*, and *Total†*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%,)* and *HbA1c Control (<8.0%)*
- *Use of Imaging Studies for Low Back Pain (LBP)†*
- *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)*
- *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†*
- *Pharmacotherapy for Opioid Use Disorder (POD)*

To improve ***quality of care***, **WS** should educate members to help them 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, 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 13 of the 19 (68.42 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):

- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator** and *Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Initiation and Engagement of Alcohol and Other Drug 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*
- *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 ***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 their babies. Providers also need to be aware of the importance of follow-up care for children prescribed ADHD medication as well care for diabetics with a bipolar or schizophrenia diagnosis with or without the use of antipsychotic medications.

WS demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for 14 of the 19 (73.68 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):

- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*, *12–17 Years*, *18–21 Years*, and *Total*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *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*
- *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:

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal 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 its efforts on encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits, which 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

In the IS review activity, **WS** subcontractors performed at least one data quality check before and/or after submitting encounters to **WS**/DHHS. However, the types of quality checks varied across subcontractors. **WS** performed at least one data quality check before and/or after submitting encounters to DHHS except for the NEMT and vision encounters. The quality checks generally included, but were not limited to, EDI compliance edits, field-level completeness and validity, timeliness, reconciliation with financial reports, and claim volume by submission month. **WS** did not note quality checks evaluating whether the payment fields in the encounters align with any financial reports. **WS** also submitted all required types of claims/encounters to DHHS. **WS** noted challenges with DHHS' denied response file edits for its encounter data; however, DHHS clarified that the denied response file edits

were intended only as a warning, not as rejections. **WS** should work with DHHS to clarify the confusion regarding the purpose of the denied response files.

WS 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. 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 837P/I encounters. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. **WS** should continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for all encounter types, especially pharmacy encounters. 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 of care*** issues.

WS has five items listed in Table 3-58 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. Of note, HSAG identified the last few issues as a result of its file review process. 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***.

Aggregate Conclusions for WS

The following tables include aggregated conclusions concerning strengths and weaknesses for **WS** in the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

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

Quality	Access	Timeliness	Strengths
✓	✓		**WS** continued HSAG's rapid-cycle PIP approach for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total* PIP topic in SFY 2022, and **WS** chose to focus on opioid abuse or dependence treatment. That measure achieved a HEDIS rating in the 75th–89th percentile indicating that the PIP activities positively impacted the HEDIS rate for that measure.
✓	✓	✓	The compliance review determined that **WS** demonstrated strength by maintaining a health IS that accurately and completely collected, analyzed, integrated, and reported data for New Hampshire Medicaid members. HSAG also reviewed **WS**'s health IS during the SFY 2022 PMV review and the HEDIS IS review. All three system reviews confirmed the MCO's ability to collect provider and member information and ensure that data are accurate and complete.

Quality	Access	Timeliness	Strengths
✓			One of the measures showing strong performance for **WS** during the PMV activity was GRIEVANCE.03: *Member Grievances Received.* The SFY 2022 compliance review included HSAG's review of 10 grievance files, and the results of that review confirmed that **WS** sent 10 acknowledgement letters as required confirming the receipt of those grievances with the member.
	✓	✓	**WS** received an *Acceptable* score during the PMV audit on the APPEALS.03: *Resolution of Expedited Appeals Within 72 Hours* performance measure. During the compliance activity, HSAG reviewed 10 appeal files, and the file review also confirmed that **WS** processed expedited appeals within the established timelines.
✓	✓		In the comparison between the MCO files and the online directory, HSAG reviewers located the provider information for the vast majority of **WS** providers sampled in the NAV. This included locating 97.1 percent of PCPs, between 95.2 percent and 100 percent of all specialty providers, and 91.8 percent of BH providers. This finding contributed to members' access to care for the HEDIS measures that achieved the 75th and 90th percentile ratings.

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

Quality	Access	Timeliness	Weaknesses
	✓		In the online provider directory, **WS** identified providers as accepting new patients for 98.8 percent of PCPs. After calling providers in the telephone survey, however, HSAG learned that **WS**'s PCP offices reported accepting new patients in 78.0 percent of cases. With 12.0 percent of the **WS** PCPs contacted during the study not accepting new patients, **WS** may have experienced an access to care issue that affected the HEDIS rates for preventive care measures, especially the measures scoring less than the 25th percentile or between the 25th and 49th percentile. **Recommendation:** **WS** should contact PCP offices to determine which offices are accepting new patients and correct the information in the provider files and the online provider directory.
	✓		Across the three data sources reviewed, the provider contact information (i.e., name, address, city, state, ZIP Code, telephone number, and specialty) agreed in only 40.6 percent of PCP cases, 19.0 to 42.9 percent of specialty providers, and 17.6 percent of BH providers. **Recommendation:** **WS** should conduct provider surveys to obtain current information and ensure that the MCO data files and the online directory contain correct contact information.

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]

Methodology

DHHS provided HSAG with the most recent version of the New Hampshire MCM Quality Strategy and the New Hampshire MCM Quality Performance Report update dated SFY 2022.[5-2,5-3] After receiving the documents, HSAG reviewed the goals of the New 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]

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 9, 2022.

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: Nov 9, 2022.

5-3 New Hampshire Department of Health and Human Services. *New Hampshire Medicaid Care Management Quality Performance Report: NH MCM Quality Improvement Priority Update–SFY 2022*. Oct 2021.

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 9, 2022.

Findings

The New Hampshire MCM Quality Strategy dated SFY 2020 included specific goals for four preventive care measures (i.e., Objective 1.1) and six treatment measures (i.e., Objective 1.2). Annually the Medicaid Quality Program Division of Medicaid Services publishes updates to the quality strategy with current HEDIS rates to track the progress of achieving the goals established for the measures. The titles of the measures reviewed in this section will match the titles listed in the HEDIS section of this report. The three-letter description of the measures, however, match those listed in the New Hampshire quality strategy and annual update reports.

The national benchmarks used as a comparison in this report were based on NCQA's Quality Compass national Medicaid HMO percentiles. 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 *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)*. The 10 HEDIS measures noted in the New Hampshire Medicaid Care Management Quality Strategy dated SFY 2020 are shown below:

- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)*
- *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)*
- *Chlamydia Screening in Women (CHL)— Total*
- *Prenatal and Postpartum Care (PPC)— 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)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) —Total*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Monitoring Phase*
- *Initiation and Engagement of Alcohol & Other Drug Abuse of Dependence Treatment (IET)—Initiation Total*
- *Use of Imaging Studies for Low Back Pain (LBP)*

The SFY 2021 New Hampshire MCM Quality Performance Report contained a table of the 10 measures, and the information deleted *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* and added *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA).*

During SFY 2022, clinical representatives from the Division of Public Health Services, Division of Medicaid Services, Quality, and the DHHS Chief Medical Officer met to review the current status of the 10 quality priorities and decided to retire four measures. They retired the diabetes measure and three additional measures that achieved or nearly achieved the goal of equal to or above the 75th percentile. Those four deleted measures included:

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

- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Initiation and Engagement of Alcohol & Other Drug Abuse of Dependence Treatment (IET)—Initiation Total*
- *Use of Imaging Studies for Low Back Pain (LBP)*

DHHS added five measures including a diabetes screening measure focusing on all populations, not only those with schizophrenia or bipolar disorder, and four additional measures:

- *Comprehensive Diabetes Care (CDC)— HbA1c Control (<8.0%)*
- *Controlling High Blood Pressure (CBP)*
- *Pharmacotherapy for Opioid Use Disorder (POD) —Total*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile–Total*

Table 5-1 displays the current list of HEDIS measures for the New Hampshire MCM and the rates and percentiles achieved by the New Hampshire MCM program in MY 2019, MY 2020, and MY 2021.

Table 5-1—Comparison of MY 2019 HEDIS Rates to MY 2020 and MY 2021 HEDIS Rates for the New Hampshire MCM Program

DHHS New Hampshire MCM Quality Strategy Objective and HEDIS Measures	NH MY 2019 Rate and Percentile	NH MY 2020 Rate and Percentile	NH MY 2021 Rate and Percentile
Objective 1.1: Preventive Care Measures			
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	78.2% 25th–49th Percentile	74.3% <25th Percentile	74.0%. <25th Percentile
Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)	33.1% 25th–49th Percentile	31.4% 25th–49th Percentile	29.8% <25th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total[1]	71.4% 25th–49th Percentile	63.9% <25th Percentile	70.7% 25th–49th Percentile
Chlamydia Screening in Women (CHL)—Total	50.1% <25th Percentile	46.5% <25th Percentile	48.3% 25th–49th Percentile
Prenatal and Postpartum Care (PPC)—Postpartum Care[1]	79.2% >90th Percentile	73.1% 25th–49th Percentile	79.0% 50th–74th Percentile
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care[1]	87.6% 75th–90th Percentile	77.1% <25th Percentile	82.1% 25th–49th Percentile

DHHS New Hampshire MCM Quality Strategy Objective and HEDIS Measures	NH MY 2019 Rate and Percentile	NH MY 2020 Rate and Percentile	NH MY 2021 Rate and Percentile
Objective 1.2: Treatment Measures			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total	75.4% >90th Percentile	62.4% 25th–49th Percentile	65.5% 50th–74th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase[1]	52.3% 25th–49th Percentile	53.6% 25th–49th Percentile	46.5% 25th–49th Percentile
Controlling High Blood Pressure (CBP) [2]	62.6% 50th–74th Percentile	52.7% NC[2]	57.0% 50th–74th Percentile
Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)	52.2% 50th–74th Percentile	42.8% <25th Percentile	45.7% 25th–49th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)—Total	32.2% NA[3]	28.0% 25th–49th Percentile	30.1% 25th–49th Percentile

[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.

[3] *Pharmacotherapy for Opioid Use Disorder (POD)* was a new measure in MY 2019. Benchmarks were available starting in MY 2020.

Evaluation Comparing the Three Years' Rates

Comparing the three years' rates for the 11 measures listed in Table 5-1 must be done with caution since the rates generated for MY 2019 were prior to the COVID-19 pandemic. Although the Centers for Disease Control and Prevention (CDC) declared the COVID-19 pandemic in March 2020, the health emergency continued during the entire year of 2021. The health emergency lifted many restrictions in 2021, however, it may have impacted beneficiaries' ability to schedule appointments with providers and their willingness travel to provider appointments. Although the use of telemedicine increased during the pandemic, it was difficult to conduct a visit for the preventive care measures via telehealth due to the physical contact required for a physical examination, an immunization, or a screening test.

During MY 2021, the percentile for *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)* did not achieve the 90th percentile goal nor did any other statewide average rate achieve the 75th percentile goal. The rate for *Chlamydia Screening in Women (CHL)—Total* dropped from MY 2019 to MY 2020 and improved from MY 2020 to MY 2021; however, the percentile ranking remained the same for MY 2019 to MY 2020 and improved from MY 2020 to MY 2021.

Although the measure rates varied from year to year with a significant drop from MY 2020 to MY 2021 for *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Monitoring Phase,* this measure achieved rates in the same percentile ranking for all three years. *Controlling High*

Blood Pressure (CBP) also remained in the 50th–74th percentile during the two years that percentiles could be computed.

The rate for one measure, *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap),* decreased each of the three years. The rates dropped a percentile from MY 2019 to MY 2020 and remained in the same percentile for MY 2021.

Five of the remaining measures dropped the rate and the percentile from MY 2019 to MY 2020; however, all five measures increased a percentile from MY 2020 to MY 2021. These measures included *Prenatal and Postpartum Care (PPC)—Postpartum Care, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) —Total, Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile–Total,* and *Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%).*

Pharmacotherapy for Opioid Use Disorder (POD) —Total was a new HEDIS measure in MY 2019. Since benchmarks compare the current measurement year to the prior measurement year, no comparisons to a prior year's benchmark could be made for the *POD* measure until MY 2020. The rate for the *POD* measure, however, dropped 4.2 percent from MY 2020 to MY 2021, then increased in MY 2021.

Although two rates were above the 90th percentile in MY 2019 (i.e., *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics [APP]—Total* and *Prenatal and Postpartum Care (PPC)— Postpartum Care*), neither rate sustained nor achieved that percentile during the next two years. Another rate, (i.e., *Prenatal and Postpartum Care [PPC]—Timeliness of Prenatal Care*) was in the 75th–90th percentile in MY 2019 but dropped to the lowest percentile in MY 2020, then increased one percentile in MY 2021.

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 provides recommendations concerning how the State's approach to targeting goals and objectives in its quality strategy will 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 the MCOs to develop, monitor, and evaluate member interventions to improve the HEDIS preventive care rates for children and adolescents.

Two measures for adolescent immunizations ranked in the lowest percentile in MY 2021: *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV).* Both of those rates target members who turned 13 years of age during the measurement year and who had the required vaccinations on or by their 13th

birthday. The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile–Total* also targets members 3–17 years of age.

DHHS should encourage the MCOs to continually remind providers about the need to educate parents concerning the importance of completing annual well-care visits and vaccinating their children against preventable diseases. Educating parents about adolescent immunizations *prior to* their child's 13th birthday also will improve those rates. The MCOs also may consider targeting obstetricians to assist in educating potential parents about the need for preventive care since a recent article noted that one of the best times to discuss infant vaccinations is during the prenatal period.[5-5]

The United States Department of Health and Human Services (USDHHS) reported that "HPV remains the most commonly sexually transmitted infection in the United States, with 79 million Americans infected, most in their late teens and early 20s."[5-6] Public awareness of the importance of the HPV vaccine is a current challenge for providers. Other barrier discovered by the USDHHS is the lack of provider awareness and training concerning HPV vaccinations, lack of vaccine confidence by some parents, and the parents' fear about talking to young adolescents about sexual encounters.[5-7] Strategies to overcome the barriers could include increasing public awareness of the need for HPV vaccination on or by an adolescent's 13th birthday, distributing information concerning the benefits of the vaccine in preventing various types of cancer, and working with state and community partners to develop materials to send to providers concerning the importance of ensuring that there are no *missed opportunities* to administer the HPV vaccine to adolescents.

The New Hampshire MCM Quality Strategy stipulates that "the NH MCM program requires MCOs to create member incentive programs to encourage healthy behaviors. The incentives in the program will be connected to healthy behaviors in alignment with the MCO's QAPI and the NH Medicaid Managed Care Quality Strategy."[5-8] HSAG researched the list of incentives found in the New Hampshire MCO member handbooks and member handbook supplements. Two MCOs offer financial incentives for well-child visits for members ages 2 to 21 years, and the incentives range from $20 to $50 per year. The third MCO offers a $50 financial incentive for pre-teen vaccinations received by the teen's 13th birthday. "For a financial incentive to be effective in health care, it must be well constructed, feel *logical* to participants and be proportional to the value of the behavior change desired. In addition, incentives should be kept as simple as possible."[5-9] The MCO incentives will meet the requirement of being *kept as*

5-5 Rubincam C, Greyson D, Haselden C, Saunders R, Bettinger JA. Is the pre-natal period a missed opportunity for communicating with parents about immunizations? Evidence from a longitudinal qualitative study in Victoria, British Columbia. *BMC Public Health*. 2022; 22:237. Available at: EBSCOhost database. Accessed on: Nov 9, 2022.

5-6 U.S. Department of Health & Human Services. Sexually Transmitted Infections (STIs). Available at: https://www.hhs.gov/programs/topic-sites/sexually-transmitted-infections/index.html. Accessed on: Nov 9, 2022.

5-7 U.S. Department of Health & Human Services. Sexually Transmitted Infections National Strategic Plan for the United States 2021–2025. Available at: https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf. Accessed on: Nov 9, 2022.

5-8 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: Nov 9, 2022.

5-9 Bradley K, Shachmut K, Viswanathan S, Griffin B, and Vielehr D. The Role of Incentives in Health—Closing the Gap. *Military Medicine*. 2018; 183, 3(suppl): 208–212. Available at: https://doi.org/10.1093/milmed/usy216. Accessed on: Nov 9, 2022.

simple as possible, if the application for the reward is not difficult to complete and submit to the MCO, and if the MCO responds with prompt payment of the incentive.

The semi-structured member interviews in the spring of 2022 revealed that some participants expressed frustration that they completed the required activities for member rewards but had not received the rewards. This finding prompted DHHS to require the MCOs to review and improve the MCOs' rewards programs. Adding this requirement to the managed care quality program goals and objectives in the New Hampshire Medicaid Care Management Quality Strategy could encourage the MCOs to continually evaluate their rewards and incentive programs to ensure they accomplish the *desired behavior change*. Establishing meaningful member incentives and ensuring that the rewards are paid to qualifying members to accomplish the desired behavior changes will improve ***timeliness of care***, ***access to care***, and the ***quality of care*** furnished to New Hampshire MCM program beneficiaries.

Recommendation 2: Continue to include postpartum care visits and timeliness of prenatal care as a measure in the MCM Quality Strategy.

Although the statewide average rate for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* was 82.1 percent in MY 2021, the rate only achieved the 25th–49th percentile. The MY 2021 rate remained below the MY 2019 rate of 87.6 percent. The statewide average rate for *Prenatal and Postpartum Care (PPC)— Postpartum Care* for MY 2021 was in the 50th–74th percentile but still below the percentile achieved in MY 2019, which was above the 90th percentile.

A recent article examined qualitative literature concerning the perspectives of low-income women concerning the barriers encountered when accessing prenatal and postpartum care. The authors reviewed 34 studies and found that barriers to prenatal and postpartum care often were structural: obtaining Medicaid coverage for the pregnancy, locating providers accepting Medicaid, provider continuity of care, transportation, and childcare.[5-10] Individual-level factors included being unaware or denial of the pregnancy, limited family support, conflicting priorities, and a total indifference to the pregnancy. Medicaid policy actions identified by the authors to overcome barriers included expanding presumptive eligibility, greater parity in state Medicaid payment rates, extending pregnancy Medicaid coverage to 12 months postpartum, and increasing covered services.[5-11] Ensuring that beneficiaries receive timely prenatal care and postpartum visits will improve ***access to care***, ***timeliness of care***, and ***quality of care***.

[5-10] Bellerose M, Rodriguez M, Vivier PM. A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health Services Research*. 2022; 57:775–785. Available at: EBSCOhost database. Accessed on: Nov 9, 2022.

[5-11] Ibid.

Recommendation 3: Consider convening provider focus groups to discuss the feasibility of including chlamydia screenings as an opt-out screening in well-care/preventive care visits for females ages 16 to 24 years of age.

The rate of chlamydia screening in women 16 to 24 years of age in New Hampshire was below the 25th percentile in MY 2019 and MY 2020. In MY 2021, the rate achieved the 25th–49th percentile. This measure represents an opportunity for improvement.

The CDC reports that "chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States."[5-12] In 2019, the number of reported chlamydia cases was over 1.8 million cases in the United States.[5-13] Research published in July 2021 indicated that people ages 15 to 24 years comprised 13 percent of the population in the United States; however, that age group accounted for 62 percent of the chlamydia cases.[5-14]

The most significant challenge related to efforts to increase testing for chlamydia is that a large proportion of reported cases are asymptomatic. Additional barriers to screening for chlamydia include limited resources, patient discomfort with disclosing sexual behavior, patient concern about confidentiality, the stigma associated with testing for a sexually transmitted disease, and perceived lack of risk in having a sexually transmitted disease. DHHS could consider convening provider focus groups to consider implementation of an opt-out screening program by notifying females 16 to 24 years of age that chlamydia testing will be administered unless the woman declines. Opt-out screening increases the number of participants who could possibly have chlamydia because it eliminates uncomfortable conversations about sexual health.[5-15] Chlamydia screening then could be considered the standard of care in New Hampshire for women 16 to 24 years of age. Increasing the rate of chlamydia screening would improve the ***quality of care*** for women ages 16 to 24 in New Hampshire and assist in improving the HEDIS rate.

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

All HEDIS measures displayed in Table 5-1 depend on a member being able to schedule an appointment with a provider. An established patient will know how to contact his/her provider, however, creating a new relationship with a provider requires information concerning which providers are included on an MCO's network. For that information, members frequently access the automated provider directory.

The NAV section of this report offers multiple suggestions to the MCOs to improve the quality of information found in their automated provider directories. Incorrect address and telephone information in the automated directories impacts ***access to care*** since the MCM program members often search for

5-12 Centers for Disease Control and Prevention. Chlamydia Statistics. 2022. Available at: https://www.cdc.gov/std/chlamydia/stats.htm. Accessed on: Nov 9, 2022.

5-13 Territo H, Burstein, G. Chlamydia Screening Post COVID-19. *Contemporary OB/GYN*. Jul 2021. Available at: EBSCOhost. Accessed on: Oct 19, 2022.

5-14 Ibid.

5-15 Territo H, Burstein G. Opt-Out Chlamydia Screening Should Be Part of Routine Adolescent Health Care Services. *Contemporary Pediatrics*. Nov 2021. Available at: EBSCOhost. Accessed on: Nov 9, 2022.

providers by a geographic location then attempt to contact the providers by telephone to make appointments.

The discrepancies found in the MCO data in the NAV concerning whether PCPs are accepting new patients are also a major concern. The MCOs are responsible for ensuring network capacity, and determining capacity is impossible to do without correct information concerning the availability of providers for new and existing members. Those discrepancies were not always noted when comparing information in the two data sources (i.e., the MCO provided data files and the online provider directory); however, they were clearly evident when compared to the responses generated by provider office staff who participated in the telephone survey. DHHS needs to consider adding a quality measure to the Medicaid Care Management Quality Strategy requiring the MCOs to contact PCPs at least annually to determine if they are accepting new patients. The MCOs could send emails, letters, or faxes to providers requesting this information. Those who do not respond within a certain time frame then need to be called to obtain the information. Ensuring that provider information is accurate will alleviate frustration by members searching for a new provider and improve ***timeliness of care*** and ***access to care***.

Conclusions

Table 5-2 is a summary of the rates achieved by the 11 measures included in the New Hampshire MCM Quality Strategy.

Table 5-2—Summary of Rates for MY 2021 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	1	3	2	**6**
Treatment	0	0	2	3	0	**5**
All Domains	**0**	**0**	**3**	**6**	**2**	**11**
Percentage	**0**	**0**	**27.27%**	**54.55%**	**18.18%**	**100%**

After reviewing the rates achieved for the 11 measures, it appears that none of the measures achieved the 75th percentile. Three measures met the 50th percentile, while the remaining eight measure scored below the 50th percentile. It is unlikely that those eight measures will be able to achieve the 75th percentile by the end of SFY 2023. DHHS could consider implementing a methodology for reaching the 75th percentile that reduces the gap annually by 10 percent. Identifying the desired improvement goals and specifying annual 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 2021 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 2021 EQR Technical Report contained opportunities for improvement for **ACNH** related to the contract compliance audit, NAV, HEDIS, 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 2022 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG reviewed one-third of the compliance standards for **ACNH** during SFY 2021, which included six standards and 193 elements. HSAG received a completed CAP from **ACNH** for each element found noncompliant in the standards listed below, and HSAG determined that all items were compliant with the revisions instituted by **ACNH** during the CAP process. More than one *Partially Met* finding may be attributed to the elements 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**	**Results After CAP**
Contract Compliance: Standard VI—Member Enrollment and Disenrollment	One element was *Partially Met* in this standard because **ACNH** did not submit evidence of compliance with the following requirements: The MCO provides members and their representatives with written notice of disenrollment rights, at least 60 calendar days before the start of each re-enrollment period.	17 Applicable Elements: *16 Met* *1 Partially Met*	17 Applicable Elements: *17 Met*
ACNH's Contract Compliance CAP Response #1			
ACNH submitted the revised policy and procedure #163-003: Voluntary and Involuntary Member Disenrollment. The updated policy and procedure maintained that **ACNH** will retain documentation of mailing the written notice of disenrollment rights annually, at least 60 calendar days before the start of each re-enrollment period. **ACNH** reported that the current annual mailing was sent to members on 6/1/21 to meet the 60 calendar day notice requirement prior to open enrollment. The updated information meets the requirements of this element. This element is *Met*.			

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**	**Results After CAP**
Contract Compliance: Standard VII—Member Services	One element was *Partially Met* in this standard because **ACNH** did not submit evidence of compliance with the following requirements: The MCO sends a letter to a member 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.	50 Applicable Elements: *49 Met* *1 Partially Met*	50 Applicable Elements: *50 Met*
ACNH's Contract Compliance CAP Response #2			
ACNH created an ID Card carrier that included the information required by this element and began sending the revised information to members in August 2021. This element is *Met*.			

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**	**Results After CAP**
Contract Compliance: Standard XII—UM	Two elements were *Partially Met* in this standard because two files included in the denial file review did not indicate compliance with the following requirements: 1. For standard authorization decisions, the MCO provides notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. 2. The MCO notifies the requesting provider, and gives the enrollee 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.	64 Applicable Elements: *62 Met* *2 Partially Met*	64 Applicable Elements: *64 Met*
ACNH's Contract Compliance CAP Response #3			
ACNH submitted the Decision Response Time policy addressing the required turnaround times for denials, and the updated policies described processes that met the requirements of this element. **ACNH** submitted the Refresher on Denials staff training agenda with the names and titles of staff members who attended the training. **ACNH** reminded staff members about the turnaround time for standard authorization decisions and the system reports to assist in monitoring those timelines. **ACNH**'s UM leadership also reviewed two denial letter reports (one generated daily; the second generated weekly) to ensure that denial letters were issued as required. These elements are *Met*.			

NAV

The SFY 2021 EQR Technical Report contained opportunities for improvement for **ACNH** in NAV. The activities implemented by **ACNH** during SFY 2022 to improve the NAV results are shown below.

Table 6-4—NAV—Opportunities for Improvement and MCO Response #1

ACNH's NAV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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 BH providers	33.1%	90.0%
	Provider Uniform Resource Locator (URL)	0.0%	90.0%

ACNH's NAV Response #1

ACNH has completed a review and analysis of the opportunities for improvement regarding provider data and based on the review has implemented the following action items. The revised processes ensure that accurate information is available for all new providers joining the network and increase the availability of information for existing providers within our provider network.

- Identified and corrected system the issue for DME suppliers in the provider directory. DME suppliers were not set up correctly in Facets (claims system) to cascade to the provider directory properly. Providers were listed as participating but were exempt from cascading and reflecting participation in the provider directory.
- Identified the missing element of a provider's ability to accommodate members with physical disabilities. This element was not entered into the Facets (claims system) for participating providers; therefore, was not able to cascade to the provider directory properly. Participating providers have been corrected and a corrected process has been implemented to ensure that this information is captured for all new participating providers moving forward.
- Identified the missing element to capture providers who speak non-English language(s) (including American Sign Language). **ACNH** Provider Network Team outreached all participating providers to gather the missing element and will update Facets (claims system) which will enable the element to cascade to the provider directory.
- Provider Network Operations has confirmed that when applicable, provider board certification for PCPs and BH providers is loaded to Facets. The **ACNH** credentialing policy does not require board certification for participation with the plan.
- Identified the missing element of provider URL. This element was not entered into the Facets (claims system) for participating providers, therefore it was not able to cascade to the provider directory properly. **ACNH** Provider Network Team outreached all participating facility/practices to gather the missing element and updated Facets (claims system), which enabled this element to cascade to each provider, facility, and practice in the provider directory.

ACNH's NAV Response #1
• In addition to the corrected actions above, **ACNH** has updated all provider intake forms and rosters to include the data elements of provider accommodations for physical disabilities, languages, certifications, and provider URL. • Applications and rosters received from participating providers that do not include the information in these required fields are returned for completion.

HEDIS

The SFY 2021 EQR Technical Report contained opportunities for improvement for **ACNH** in seven HEDIS measures. The activities implemented by **ACNH** during SFY 2022 to improve the HEDIS results are shown below.

Table 6-5—HEDIS—Opportunities for Improvement and MCO Response #1

ACNH's HEDIS Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average

ACNH's HEDIS Response #1
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM Contract Exhibit O requirement. A number of opportunities for improvement were identified, based on *Adults' Access to Preventive/Ambulatory Health Services (AAP)* Total measure rate and analysis. Limited member experience with managed care contributed to the low rate since the majority of members enrolled with **ACNH** were new to Medicaid managed care through preferential auto assignment. Throughout most of 2020, the COVID-19 pandemic caused significant disruption to ongoing healthcare management in the ambulatory setting for preventive and condition management services. The New Hampshire governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, which lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. The Medicaid National HMO percentile for measurement year 2020 experienced a drop in the average rate *Adults' Access to Preventive/Ambulatory Health Services (AAP)–Total* by 3.61 percentage points compared to pre-pandemic measurement year 2019. Members within age cohort 20–44-year-olds was the largest population within the measures, and those members experienced the second lowest rate. The lowest rate was for age cohort 65-year-olds and older which was influenced by claims to the members' primary insurer, Medicare. Interventions included, but were not limited to, the following activities: member outreach with education to all new members about the need to schedule an appointment with their selected PCP for ongoing well visits or health management of condition(s); Provider Network Management Account Executives expanding outreach to PCPs to educate providers on the use of the **ACNH** provider portal care gaps inquiry and resolutions; and promote the utilization of telehealth visits for appropriate healthcare management service for members. In addition, Network Management Account Executives worked with PCPs to determine the members who had not established with their PCP. A planned outreach program was established for members who did not have any encounters or those members who only had acute care in an emergency room or inpatient episodes.

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

ACNH's HEDIS Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*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
ACNH's HEDIS Response #2			
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM Contract Exhibit O requirement. A number of opportunities were identified for improvement based *on Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measure rates and analysis. Limited member experience with managed care contributed to the low rate since the majority of members enrolled with **ACNH** were new to Medicaid managed care through preferential auto assignment. This measure was highly dependent on medical records since 95% of the numerator-compliant members were identified through medical records. Also of note was insufficient documentation of BMI with providers documenting the BMI percentage but not the BMI percentile without indicating both height and weight measurements. During 2020 no PCPs in the **ACNH** provider network agreed to data exchange agreements with **ACNH** which did not allow for the collection of data via continuity of care document (CCD) feed or flat file in an ongoing fashion. One of the most significant root causes for below average rates was the COVID-19 pandemic. In most of 2020, the pandemic caused significant disruption to in-person ongoing healthcare management in the ambulatory setting for preventive and condition management services. The governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. Although nutrition and physical activity counseling could be successfully completed during a telehealth visit, the BMI requires an in-person assessment. The Medicaid National HMO percentile for measurement year 2020 saw a drop in the average rate for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI* rate by 2.49 percentage points compared to pre-pandemic measurement year 2019. Interventions included, but were not limited to, the following activities: member incentive for well visit and education with outreach to all new members about the need to schedule an appointment with their selected PCP for ongoing well visits or health management of condition(s). Provider outreach occurred on a scheduled basis with reminders of preventive care and to include weight assessment and counseling for nutrition and physical activity as elements of the well visit. This also included guidance on documenting the BMI per HEDIS requirements. Provider Network Management Account Executives also expanded provider outreach with PCPs to educate them on the use of the **ACNH's** provider portal care gaps inquiry and resolutions and promote the utilization of telehealth visits for members.			

Table 6-7—HEDIS—Opportunities for Improvement and MCO Response #3

ACNH's HEDIS Opportunities for Improvement #3			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*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
ACNH's HEDIS Response #3			
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM Contract Exhibit O requirement. **ACNH** initiated operations in New Hampshire on September 1, 2019, four months prior to the beginning of the measurement year 2020, and members did not have the required enrollment to meet some of the HEDIS inclusion requirements. This played a significant factor in the reported rates for measurement year 2020. During the second full year of operations, measurement year 2021, the rate had already demonstrated an increase of over 16 percentage points with the *Childhood Immunization Status (CIS) Combination 10* measure. Another significant issue was that throughout most of 2020, the COVID-19 pandemic caused disruption to in-person and ongoing healthcare management in the ambulatory setting for preventive and condition management services. The governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. This measure was highly dependent on medical records since 80% of the numerator compliant members were identified through medical records. Also, the state of New Hampshire does not make its state immunization registry data available to MCOs for HEDIS reporting. Interventions included, but were not limited to, the following activities: significant financial member incentive for babies who completed the ten infant immunizations; and the development of a birthday card for parent/guardian of children under 2 years of age with reminders concerning the incentive and other needed preventive screenings. Member education with outreach to all new members occurred concerning the need to schedule an appointment with their selected PCP and ongoing well visit or health management of condition(s). Provider Network Management Account Executives expanded provider outreach with PCPs to educate providers on the use of the **ACNH** provider portal care gaps inquiry and resolutions. In addition, **ACNH** Care Management staff reminded parent/guardian of infant immunizations and other needed services during pregnancy and postpartum as part of the Bright Start maternity program outreach. Lastly, **ACNH** will continue to obtain much needed immunization registry data from the New Hampshire DHHS Public Health Department.		

Table 6-8—HEDIS—Opportunities for Improvement and MCO Response #4

ACNH's HEDIS Opportunities for Improvement #4			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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
ACNH's HEDIS Response #4			
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM contract Exhibit O requirement. A number of opportunities were identified for improvement,			

ACNH's HEDIS Response #4
based on *Chlamydia Screening in Women (CHL)* measure rate and analysis. Limited member experience with managed care contributed to the low rate since the majority of members enrolled with **ACNH** were new to Medicaid managed care through preferential auto assignment. Throughout most of 2020, the COVID-19 pandemic caused significant disruption to ongoing in-person healthcare management in the ambulatory setting for preventive and condition management care services. The governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. The Medicaid National HMO percentile for measurement year 2020 saw a drop in the average rate for CHL Total by 3.55 percentage points compared to the pre-pandemic measurement year 2019. Specific to the measure was that the members within age cohort 16–20 years of age had the lower rate among the two age cohorts. Further data analysis revealed significant noncompliance for pregnant women. Interventions included, but were not limited to, the following activities: providing member incentive for women through age 21 to obtain preventive services, creating reminders to schedule an appointment with primary care for clinically appropriate screening, and conducting member education with member outreach to all new members about the need to schedule an appointment with their selected PCP for ongoing well visits or health management of condition(s). Provider Network Management Account Executives expanded outreach to PCPs to educate them on the use of the **ACNH** provider portal care gaps inquiry and resolutions. In addition, there is a women's health provider value-based payment program in development that will include CHL measure incentive.

Table 6-9—HEDIS—Opportunities for Improvement and MCO Response #5

ACNH's HEDIS Opportunities for Improvement #5			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*	Below the 25th Percentile	Equal to or Higher than the National Average

ACNH's HEDIS Response #5
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM contract Exhibit O requirement. A number of opportunities were identified for improvement, based on the *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure rate and analysis. Lack of member tenure with **ACNH** contributed to the low rate since having services rendered and captured within the allowable eligible population timeframe was a major factor. This was due to the fact that **ACNH** initiated operations in New Hampshire on September 1, 2019. The expectation for prenatal care was prior to the September 1, 2019, because the eligible population was based on women who had a live birth starting on October 8, 2019. The Medicaid National HMO percentile for measurement year 2020 experienced a drop in the average rate for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure by 3.56 percentage points compared to pre-pandemic measurement year 2019. Analysis revealed another major cause for underreporting of services specific to the measure rate was related to bundled billing of prenatal services within the delivery claim submitted by the obstetrical provider. A total of 44 percent of the measure results was identified through medical records. During 2020, no PCPs in the **ACNH** provider network agreed to data exchange agreements with **ACNH** which did not allow for the collection of data via CCD feed or flat file in an ongoing fashion. Another root cause of the lower-than-expected rate was that throughout most of 2020, the COVID-19 pandemic caused significant disruption to ongoing healthcare management in the ambulatory setting for preventive and condition management services. The governor declared a state of emergency to exist in the

ACNH's HEDIS Response #5
entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. Interventions included, but were not limited to, the following activities: removing barriers to the prenatal member incentive for women obtaining prenatal care in the first trimester by not requiring a claim and providing access to infant car seats for pregnant women as an additional incentive. In addition, **ACNH** is developing a woman's health maternity provider value-based payment program that incentivizes timely prenatal and postpartum care. **ACNH** care management Bright Start maternity program staff will continue to make outreach attempts to pregnant and postpartum members. Lastly, **ACNH** Provider Network Management Account Executives are promoting automated electronic data exchange for prenatal service data collection.

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

ACNH's HEDIS Opportunities for Improvement #6			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*	Below the 25th Percentile	Equal to or Higher than the National Average

ACNH's HEDIS Response #6
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS per the MCM contract Exhibit O requirement. A number of opportunities were identified for improvement, based on *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* measure rate and analysis. Limited member experience with managed care contributed to the rate since the majority of members enrolled with **ACNH** were new to Medicaid managed care through preferential auto assignment. Throughout most of 2020, the COVID-19 pandemic caused significant disruption to ongoing healthcare management in the ambulatory setting for condition management services. The governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for routine preventive and condition management services. Interventions for *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* include increased monitoring of medication adherence by our Pharmacy Benefits Management program, PerformRx, and medication adherence data is reviewed by **ACNH**'s Director of Pharmacy services for trends to develop needed outreach to the prescribing providers. Also, Network Management Account Executives expanded outreach to PCPs to educate providers concerning the use of the **ACNH** provider portal care gaps inquiry and resolution. The account executives also promoted the utilization of telehealth visits for members to assist with treatment adherence and calling in needed prescriptions to the member pharmacy. In addition, **ACNH** care management staff has a detailed protocol for members' transition of care from inpatient to ambulatory care including follow-up of medications.

Table 6-11—HEDIS—Opportunities for Improvement and MCO Response #7

ACNH's HEDIS Opportunities for Improvement #7			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response #7			
Measurement year 2020 was the first HEDIS cycle collected and reported to NCQA and New Hampshire DHHS since **ACNH** started operations in New Hampshire on September 1, 2019. A number of opportunities were identified for improvement, based on *Plan All-Cause Readmissions (PCR)* measure rates and analysis. **ACNH** determined that members with primary BH diagnoses and those with sepsis inpatient diagnosis were most likely to readmit. Throughout most of 2020, the COVID-19 pandemic caused significant disruption to ongoing healthcare management in the ambulatory setting for follow-up after acute episode care services. The governor declared a state of emergency to exist in the entire State of New Hampshire as of March 13, 2020, and it lasted throughout 2020. This effectively interrupted normal provider face-to-face services for follow-up and condition management services. Interventions to reduce readmissions within 30 days included, but were not limited to, the following activities: increasing care management staff awareness of inpatient episodes during the member's inpatient stay by reviewing the daily admission, discharge, and transfer file in order to coordinate discharge follow-up services with the inpatient discharge planner and ambulatory providers. In addition, **ACNH** has a BH value-based payment program for community mental health centers that includes incentives for follow-up after hospitalization within seven days. Also, **ACNH** promotes the use of telehealth services for follow-up after hospitalization and monitors the utilization of those services.			

EDV

The SFY 2021 EQR Technical Report contained opportunities for improvement for **ACNH** in EDV. The activities implemented by **ACNH** during SFY 2022 to improve the EDV results are shown below.

Table 6-12—EDV—Opportunities for Improvement and MCO Response #1

ACNH's EDV Opportunities for Improvement #1 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional (P) Encounters (837P): Initial Submission Within 14 Days of Claim Payment	98.8%	100%
ACNH's EDV Response #1			
ACNH continues to track towards meeting the expected 100% rate. Newborns – We cover newborns under the moms' Medicaid identification (ID) number for up to 60 days, until the newborn is assigned a State Medicaid ID of their own. Once the newborn is assigned a new State Medicaid ID, we resubmit the claim with corrected ID, however, the State recognizes this as a "new claim" and flags us for being out of timeliness for the 14-day window. The State allows us to identify these and submit for metric (Medicaid ID) adjustment since these are not truly untimely claims.			

ACNH's EDV Response #1
Subcon – We acknowledge a few gaps around our delegate services, specifically a miss for our vision vendor in May 2021. We meet with our subcontractors on a regular basis and review their metrics with them. We have increased our number of submissions per week. We had an escalation meeting with the vision vendor on this item and they have implemented additional checks and balances around their submission process to address this going forward.

Table 6-13—EDV—Opportunities for Improvement and MCO Response #2

ACNH's EDV Opportunities for Improvement #2 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional (I) Encounters (837I): Initial Submission Within 14 Days of Claim Payment	99.1%	100%
ACNH's EDV Response #2			
ACNH continues to track towards meeting the expected 100% rate. **Newborns**–We cover newborns under the moms' Medicaid ID for up to 60 days, until the newborn is assigned a State Medicaid ID of their own. Once the newborn is assigned a new State Medicaid ID, we resubmit the claim with corrected ID, however, the State recognizes this as a "new claim" and flags us for being out of timeliness for the 14-day window. The State allows us to identify these and submit for metric (Medicaid ID) adjustment since these are not truly untimely claims.			

Table 6-14—EDV—Opportunities for Improvement and MCO Response #3

ACNH's EDV Opportunities for Improvement #3 Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (P) and (Pharmacy); Record Surplus (P) and (I); Elements Surplus (P) and (I); Element Missing (I); Element Omission (I); Element Accuracy (P)	Rates ranged from 6.4%–98.4%	100%
ACNH's EDV Response #3			
Professional–ACNH did not submit all of the referring provider, billing provider, rendering provider data for this study resulting in a high element of surplus rate. **ACNH** will be making improvements for the EDV 2022 Study submission. **Institutional–ACNH** did not submit all of the attending provider data for this study resulting in a high element of surplus rate. **ACNH** worked with DHHS to identify that the DRG being submitted on encounters was the DRG sent in by the provider's instead of **ACNH** internal system computed/calculated DRG. **ACNH** has planned changes to their process to be implemented in August 2022 to address this issue and begin submitting the correct DRG values. Once changes are implemented, **ACNH** will be performing resubmission of previously submitted claims with incorrect DRG. **ACNH** has validated the encounter data submitted for the time period related to			

ACNH's EDV Response #3
EDV SFY 2021 and acknowledges that Surgical Procedure code may be a higher omission rate than other MCO's. **ACNH** believes this is due to calculation based on lines of the claim, as claim line volume can vary greatly for institutional encounters. When calculating omission based on the claim level, **ACNH** finds a rate closer to 96.9 percent. **ACNH** checked the data set submitted to HSAG for this EDV period and confirmed the surgical procedure code is being sent on all encounters when present on the claim. **ACNH** will be making improvements for the EDV 2022 Study submission. **Pharmacy**–Based on HSAG examples provided, **ACNH** found pharmacy encounters omitted to be reversals that should not have been included in **ACNH** data set. **ACNH** will be making improvements in the EDV 2022 Study to only include final paid status pharmacy encounters.

Table 6-15—EDV—Opportunities for Improvement and MCO Response #4

ACNH's EDV Opportunities for Improvement #4 IS Review			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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
ACNH's EDV Response #4			
ACNH previously reported that vision and transportation vendor claims are submitted on a monthly basis, however, claims for these vendors actually are submitted weekly in order to comply with the 14-day timeliness standard.			

New Hampshire Healthy Families

The SFY 2021 EQR Technical Report contained opportunities for improvement for **NHHF** related to the contract compliance audit, NAV, 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 2022 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG reviewed one-third of the compliance standards for **NHHF** during SFY 2021, which included six standards and 193 elements. HSAG received a completed CAP from **NHHF** for each element found noncompliant in the standard 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* finding may be attributed to the elements listed for each standard.

Table 6-16—Contract Compliance—Opportunities for Improvement and MCO Response #1

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Results After CAP**
Contract Compliance: Standard VII—Member Services	Two elements were *Partially Met* in this standard because **NHHF** did not submit evidence of compliance with the following requirements: 1. The MCO sends a letter to new members within 10 calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven calendar days after the effective date of enrollment informing the member of the right to a printed version of the provider directory upon request. 2. The MCO issues an ID Card to all new members within 10 calendar days following the MCO's receipt of a valid enrollment file from DHHS, but no later than seven calendar days after the effective date of enrollment. The contents of the ID card include how to file an appeal or grievance.	50 Applicable Elements: *48 Partially Met* *2 Partially Met*	50 Applicable Elements: *50 Met*
NHHF's Contract Compliance CAP Response #1			
NHHF submitted the revised Welcome Letter informing members that a printed version of the provider directory could be obtained, at no cost, by calling **NHHF**'s Member Services department. The letter also contained the revised ID card listing a toll-free telephone number to call to file a grievance or appeal. **NHHF** began sending the revised letter and tracking the mailings to ensure that they met the 10-day requirement in July of 2021. These elements are *Met*.			

NAV

The SFY 2021 EQR Technical Report contained opportunities for improvement for **NHHF** in NAV. The activities implemented by **NHHF** during SFY 2022 to improve the NAV results are shown below.

Table 6-17—NAV—Opportunities for Improvement and MCO Response #1

NHHF's NAV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	Providers Found in Directory for Primary Care Providers (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%
NHHF's NAV Response #1			
Not all providers contained in the active provider listing will be displayed in the online provider directory. This is as designed since Find A Provider (FAP) has built in logic that alters what does/does not display for the members. For example, an active hospitalist or urgent care practitioner will not display on FAP but will be listed in the active provider listing. Only provider locations where a member can call and schedule an appointment within their mile radius are included in FAP. The provider listing that was submitted, however, contained all locations for the providers. In addition, FAP has built-in suppression features such as if a provider group does not have any active practitioners, the group will not display in FAP; or a BH practitioner who works for a facility will not display in FAP under the facility. The maximum number of locations for PCPs (3) and specialists (5) is also included as built-in logic for FAP that would not be included in the provider listing file submitted. It is difficult to know if the provider being reviewed was displaying correctly in FAP. In addition, FAP has built-in logic for the telephone number display. It should display at the provider level, and if the provider does not have a number, it will display at the practitioner level. Comparing a snapshot-of-time listing of providers to the online directory may not produce matching results given the nature of the data being continually updated and the online directory having built-in logic and other factors that could alter what is displayed to a member. We are not able to determine the overall impact this had on the scoring. Cultural competency has a generic default display on FAP, and if there is no mention of cultural competency, the default indicates that the provider has not completed training. Therefore, by default, all providers have their cultural competency displayed. If the provider has supplied a website or physical accommodations, we display the information on FAP. However, the user does need to drill into the "More Contact Information" for the provider in order for the data to display.			

HEDIS

The SFY 2021 EQR Technical Report contained opportunities for improvement for **NHHF** in five HEDIS measures. The activities implemented by **NHHF** during SFY 2022 to improve the HEDIS results are shown below.

Table 6-18—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)—16–20 Years, 21–24 Years,* and *Total*	Below the 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #1			
NHHF's goal was to achieve the 75th National Benchmark of 61.75 percent. While this was a stretch goal, **NHHF** achieved improvement of the rate from MY 2020. In MY 2020 and MY 2022 **NHHF** did not implement ***new*** interventions due to the instability relating to the COVID-19 pandemic. Ongoing outreach to members to encourage adherence to this measure continued. Members were identified using our HEDIS application. All female members in the appropriate age categories were sent a reminder via standard US mail outlining the need to get this screening. **NHHF** sends the mailer in the month of the member's birthday annually. Approximately 21,000 female members were sent this mailer. **NHHF** will be participating in a state-wide forum to identify opportunities to improve this measure in the future			

Table 6-19—HEDIS—Opportunities for Improvement and MCO Response #2

NHHF's HEDIS Opportunities for Improvement #2			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal*	Below the 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #2			
NHHF continued to expand its Start Smart for Baby (SSFB) program and attempt to identify members who may potentially be pregnant, but for whom we have not received a claim specific to pregnancy. A report which included members who have an indicator of potential pregnancy has been utilized to outreach to members and encourage them to engage in prenatal care as soon as possible. Outreach was completed by a specialized team within the care management team.			

Table 6-20—HEDIS—Opportunities for Improvement and MCO Response #3

NHHF's HEDIS Opportunities for Improvement #3			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Comprehensive Diabetes Care (CDC)—HbA1c Testing*	Below the 25th Percentile	Equal to or Higher than the National Average
NHHF's HEDIS Response #3			
NHHF utilized an email campaign to provider reminders to members who had outstanding A1c testing in the measurement year. Members with the diagnosis of diabetes were also considered a higher risk and therefore were triggered for outreach by care management staff for potential assistance with any barriers to completing their required screenings.			

Table 6-21—HEDIS—Opportunities for Improvement and MCO Response #4

NHHF's HEDIS Opportunities for Improvement #4			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
NHHF's HEDIS Response #4			
NHHF included this measure in a Performance Improvement Project, in collaboration with the EQRO and specified by DHHS. The project was performed as a Rapid-cycle PSDA which was extended due to the pandemic. **NHHF** did show improvement in the measure from MY 2020 (76.62 percent) to MY 2021, reaching the 50th NCQA Quality Benchmarks. The project included a multi-disciplinary team, multiple interventions and adjustments based on EQRO recommendations. The primary intervention in 2021 included phone calls and follow up letters to members who still required the screening for diabetes to be compliant. **NHHF** telephoned members and provided them with education, encouraged them to reach out to their provider and followed up with a letter in support of the conversation. While any improvement is seen as a success during the pandemic, **NHHF** will continue to strive to reach the next level of achievement – the 75th National benchmark, in the coming years. The plan believes that there were multiple barriers that could not be accounted for due to the pandemic, which played a major part in the limited success of the interventions. The interventions could be revisited following a return-to-normal state after the pandemic.			

Table 6-22—HEDIS—Opportunities for Improvement and MCO Response #5

NHHF's HEDIS Opportunities for Improvement #5			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*	Below the 25th Percentile	Equal to or Higher than the National Average

NHHF's HEDIS Response #5
NHHF partnered with the CMHCs to share information about members who were attributed to them and still in need of monitoring and/or screening for diabetes based on their diagnosis. Many members with this complex diagnosis were seen at the local CMHCs, so partnering with them to increase compliancy was advantageous. These members were also considered a higher risk so outreach through the care management team continues.

EDV

The SFY 2021 EQR Technical Report contained opportunities for improvement for NHHF in EDV. The activities implemented by NHHF during SFY 2022 to improve the EDV results are shown below.

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

NHHF's EDV Opportunities for Improvement #1 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional (P) Encounters (837P): Validity of Member Identification Number—Percent Valid	99.8%	100%
NHHF's EDV Response #1			
The prior discrepancy in member identification numbers was due to a timing issue with retroactive eligibility terminations. NHHF enhanced the encounter submission process by adding a step to ensure the eligibility process has loaded current files prior to encounter file creation and submission. In turn, NHHF reviews eligibility encounter rejects on a regular basis for resubmission.			

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

NHHF's EDV Opportunities for Improvement #2 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Pharmacy: Validity of Member Identification Number–Percent Valid	99.9%	100%
NHHF's EDV Response #2			
The prior discrepancy in member identification numbers was due to a timing issue with retroactive eligibility terminations. Pharmacy is a point of service (POS), and eligibility is validated at that time. NHHF reviews encounter eligibility rejections on a regular basis for resubmission.			

Table 6-25—EDV—Opportunities for Improvement and MCO Response #3

NHHF's EDV Opportunities for Improvement #3 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837(P): Initial Submission Within 14 Days of Claim Payment	99.0%	100%
NHHF's EDV Response #3			
NHHF's original intervention was to implement enhanced reporting to measure timeliness on a weekly basis for medical, behavior, and vision encounters. Following review of the reports, necessary action is taken to mitigate identified concerns. The result of this has been a 12.9 percent increase in timeliness. In 2022 encounter submission file creation and monitoring was migrated to a new system, which will further support timely submission of encounters.			

Table 6-26—EDV—Opportunities for Improvement and MCO Response #4

NHHF's EDV Opportunities for Improvement #4 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional (I) Encounters (837I): Initial Submission Within 14 Days of Claim Payment	99.6%	100%
NHHF's EDV Response #4			
NHHF's original intervention was to implement enhanced reporting to measure timeliness on a weekly basis for medical and behavior encounters. Following review of the reports, necessary action is taken to mitigate identified concerns. The result of this has been a 1.9 percent increase in timeliness. In 2022 encounter submission file creation and monitoring was migrated to a new system which will further support timely submission of encounters.			

Table 6-27—EDV—Opportunities for Improvement and MCO Response #5

NHHF's EDV Opportunities for Improvement #5 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	85.5%	100%
NHHF's EDV Response #5			
NHHF's original intervention was to implement enhanced reporting to measure timeliness on a weekly basis for pharmacy encounters. Following review of the reports, necessary action is taken to mitigate identified concerns. **NHHF** also worked with DHHS on identified concerns related to paid date logic and timeliness calculation logic. The result of these efforts has been a 37.4 percent increase in timeliness, which is expected to further improve in future reviews.			

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

NHHF's EDV Opportunities for Improvement #6 Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (I) and (Pharmacy); Elements Surplus (P); Element Missing (I); Element Omissions (I); Element Accuracy (P), (I), and (Pharmacy)	Rates ranged from 4.6%—93.8%	100%

NHHF's EDV Response #6
Summary–The majority of completeness and accuracy discrepancies were the result of differences in data pull criteria for HSAG file creation versus encounter file format. Internal guidance has been updated to remediate this for future HSAG data pull requests. Below is a by-issue summary of **NHHF**'s actions. **Record Omission (I)–NHHF** intends to update encounter submission logic to no longer bundle similar services on submission, which was the primary cause of Institutional record omissions. This change is currently in testing with DHHS and will be implemented once approved. **Record Omission (Pharmacy)–**The pharmacy record omissions were related to timing between claim reversal and B2 submission. CVS reviewed examples provided for this finding and confirmed that B2 transactions were submitted for the approved records after the claim was reversed. **Elements Surplus (P)–**Updates have been made to the **NHHF** data pull to collect data from the same tables used for encounter submissions. Encounter submissions reflect the manner in which the claim was processed; however, the data pull sourced from a different table causing the discrepancies. **Element Missing (I)–NHHF** has updated its data pull requirements to ensure Referring Provider/NPI is included in the data pull if it was available and sent on the encounter. **Element Omission (I)–NHHF** reviewed the examples sent for Detail Paid Amount omissions and found that the data was included in the data pull and the encounter submission. The data appeared to only be missing on DHHS data. **Element Accuracy (P)–NHHF** updated their data pull process for behavioral capitation services where allowed amount is sent in the paid amount field on encounter submission. **Element Accuracy (I)–NHHF** intends to update submission logic to no longer bundle similar services on submission, which was the primary cause of Institutional Procedure Code, Revenue Code, and Detail Paid Amount inaccuracies. This change is currently in testing with DHHS and will be implemented once approved. **Element Accuracy (Pharmacy)–**CVS updated their data pull query to correctly pull Header Paid Amounts as they were sent on the pharmacy encounters.

Table 6-29—EDV—Opportunities for Improvement and MCO Response #7

NHHF's EDV Opportunities for Improvement #7 Medical Record Review (MRR)	
EQR Activity	**Measure Standard**
EDV	Review the reasons for the non-submission of medical records
NHHF's EDV Response #7	
NHHF reviewed the reasons for non-submission and determined some specific responses included: Non-responsive providers, office permanently closed, unable to locate records and no records at this site. The plan will review these responses early at the time of the next audit to proactively compare responses to the claims reports.	

Table 6-30—EDV—Opportunities for Improvement and MCO Response #8

NHHF's EDV Opportunities for Improvement #8 Medical Record Review	
EQR Activity	**Measure Standard**
EDV	Educate providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472
NHHF's EDV Response #8	
NHHF developed a provider facing Quick Reference Guide which includes the immunization administration procedure codes. The guide is available on the provider website and distributed at regular provider meetings to encourage proper coding.	

Table 6-31—EDV—Opportunities for Improvement and MCO Response #9

NHHF's EDV Opportunities for Improvement #9 Medical Record Review	
EQR Activity	**Measure Standard**
EDV	Perform periodic MRRs of submitted claims to verify appropriate coding and data completeness
NHHF's EDV Response #9	
NHHF works with two vendors who conduct medical record reviews to ensure accurate claim submission. The vendors are Performant and Cotiviti. Additionally, medical records are reviewed via special investigation unit (SIU) investigations.	

Well Sense Health Plan

The SFY 2020 EQR Technical Report contained opportunities for improvement for **WS** related to the contract compliance audit, PMV, NAV, 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 2021, which included six standards and 193 elements. HSAG received a completed CAP from **WS** for each element found noncompliant in the standard 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 6-32—Contract Compliance—Opportunities for Improvement and MCO Response #1

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Results After CAP**
Contract Compliance: Standard III—Care Management/ Care Coordination	Four elements were *Partially Met* and two elements were *Not Met* in this standard. Four elements were *Partially Met* in this standard because **WS** did not submit evidence of compliance with the following requirements: 1. Care managers must remain conflict-free: Not being related by blood or marriage to a member, financially responsible for a member, or with any legal power to make financial or health-related decisions for the member. 2. The MCO demonstrates and ensures that admission, discharge, and transfer (ADT) data from applicable hospitals be made available to PCPs, behavioral health providers, Integrated Delivery Networks, Local Care Management Networks, and other care management entities within 12 hours of admission, discharge, or transfer. 3. The MCO conducts a Health Risk Assessment (HRA) Screening of all existing and newly enrolled members within 90 calendar days of	34 Applicable Elements: *28 Met* *4 Partially Met* *2 Not Met*	34 Applicable Elements: *34 Met*

HSAG Contract Compliance Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Results After CAP**
	the effective date of MCO enrollment to identify members who may have unmet health care needs and/or special health care needs. 4. The MCO shares 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. Two elements were *Not Met* in this standard because **WS** did not meet the following requirements: 1. All completed HRAs are shared with the member's assigned PCP for inclusion in the member's medical record and within seven calendar days of completing the screening. 2. The MCO submits 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's Contract Compliance CAP Response #1

Partially Met Elements

1. **WS** submitted two revised policies: (1) Conflict of Interest Directors and Above and (2) Conflict of Interest Write Access that met the requirements of this element. **WS** also submitted evidence of Care Management Conflict of Interest Survey tracking that documented receipt of employees' attestations regarding conflicts of interest. This element is *Met*.
2. **WS** submitted the Standard III Element 12 Admission, Discharge, and Transfer (ADT) Data Sources document to address the requirements of this element. **WS** also developed processes and procedures to ensure that providers received notification of ADTs as required in this element. This element is *Met*.
3. **WS** submitted the updated HRA Screening Policy that met the requirement to screen members within 90-days of enrollment. HSAG also followed-up on the reporting of the HRA screening requirement, HRA.08, in the SFY 2022 PMV audit. This element is *Met*.
4. **WS** submitted the updated draft Comprehensive Assessment and Plan of Care policy. The policy indicated that **WS** shared the results of the comprehensive assessment, as documented in the plan of care, with the member's local community-based care team within 14 calendar days of completion to inform the team of the treatment plan and to prevent duplication of activities. This element is *Met*.

WS's Contract Compliance CAP Response #1
Not Met Elements 1. WS submitted the updated HRA Screening Policy that included the requirement to share completed HRAs with the member's PCP within seven days of completion. This element is *Met*. 2. WS submitted the updated draft Member Risk Stratification to Identify Members Eligible for Care Management that included the requirement to send any additions or deletions to that methodology to DHHS for review 90 calendar days prior to the change being implemented. This element is *Met*.

Table 6-33—Contract Compliance—Opportunities for Improvement and MCO Response #2

HSAG Contract Compliance Opportunities for Improvement #2			
EQR Activity	**Measure Standard**	**MCO Results**	**Results After CAP**
Contract Compliance: Standard VI—Member Enrollment and Disenrollment	One element was *Not Met* in this standard because WS did not submit evidence of compliance with the following requirements: The MCO notifies DHHS within five business days when it identifies information in 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 death of the member.	17 Applicable Elements: *16 Met* *1 Not Met*	17 Applicable Elements: *17 Met*
WS's Contract Compliance CAP Response #2			
WS submitted the Address Training for New Hampshire Members training aid for Enrollment and Customer Service leadership and staff. The document explained the process to update addresses in Facets, and WS conducted training with staff members to ensure compliance with the requirement. This element is *Met*.			

PMV

The SFY 2021 EQR Technical Report contained opportunities for improvement for WS in PMV. The activities implemented by WS during SFY 2022 to improve the PMV results are shown below.

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

WS's PMV Opportunities for Improvement #1			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
PMV	ACCESSREQ.05—*Requests for Assistance Accessing MCO Designated Primary Care Providers by County*	Not Compliant	Compliant
WS's PMV Response #1			
The PMV audit identified that we were previously reporting on additional values that did not limit the member assistance reasons to only PCPs. Our SMEs reviewed the ACCESSREQ.05 data and conducted an RCA, which showed that the initial report was inappropriately configured in our system, and that user acceptance testing			

WS's PMV Response #1
(UAT) may not have been conducted at the time. As outlined above, UAT has been addressed. We have updated our source code to remove all non-PCP related inquiries and expanded the data set based on our SMEs' interpretations of the specification and the data that should be included. The categories we are now reporting on for ACCESSREQ.05 are outlined below: ○ PCP Changes ○ Request for PCP Directory ○ Request for list of PCPs ○ PCP confirmation (no change, just confirming that the PCP on file is accurate) **WS** reviewed the code for ACCESSREQ.05 to identify and correct gaps. **WS** also met with DHHS representatives to discuss the intent of the reports and ensure that the data provided on the reports only included applicable information. The business owners of this measure will monitor the requirements document and ensure that the code remains up to date. Additional quality assessment (QA) steps were implemented which includes reviewing samples to ensure that **WS** only includes the applicable categories.

NAV

The SFY 2021 EQR Technical Report contained opportunities for improvement for **WS** in NAV. The activities implemented by **WS** during SFY 2022 to improve the NAV results are shown below.

Table 6-35—NAV—Opportunities for Improvement and MCO Response #1

WS's NAV Opportunities for Improvement #1			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	Providers Found in Directory for BH Providers	41.2%	90.0%
	Providers Found in Directory for Durable Medical Equipment (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%

WS's NAV Response #1
WS has conducted a root cause analysis of the provider directory validation (PDV) study data mismatches and believe they are attributed to an incorrect/incomplete pull of vendor data following a misinterpretation of the

WS's NAV Response #1
instructions outlined in the validation instructions. Processes have been put to support future provider directory validation activities across all Plan products to ensure WS and applicable vendor provider data are accurately pulled from our various systems and presented in an accurate format. For future activities, WS will review the instructions and outreach to DHHS with clarifying questions before the data are pulled. Once the data have been pulled, WS will conduct a quality check to ensure it is displayed as needed.

HEDIS

The SFY 2021 EQR Technical Report contained opportunities for improvement for WS in 12 HEDIS measures. The activities implemented by WS during SFY 2022 to improve the HEDIS results are shown below.

Table 6-36—HEDIS—Opportunities for Improvement and MCO Response #1

WS's HEDIS Opportunities for Improvement #1			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Breast Cancer Screening (BCS)*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #1			
WS has identified a continued decrease in breast cancer screenings among the membership. After discussion with providers and members, there appears to be continued impact from COVID-19 staffing issues. This has led to delays in accessing services such as mammograms and other preventive screenings. WS continues to outreach to all members to encourage breast cancer screening through telephone calls, texting, and mailings. Additional interventions, such as incentives, will be considered if the decrease continues in 2022.			

Table 6-37—HEDIS—Opportunities for Improvement and MCO Response #2

WS's HEDIS Opportunities for Improvement #2			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #2			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs. Based on the most recent rate reflecting the performance in calendar year 2021, WS increased the rate by almost fifteen percentage points to the 25th percentile. Continued education of appropriate documentation and availability of medical records is being furnished to the provider network to further improve the rate.			

Table 6-38—HEDIS—Opportunities for Improvement and MCO Response #3

WS's HEDIS Opportunities for Improvement #3			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Childhood Immunization Status (CIS)—Combination 2 (DTaP, IPV, MMR, HIB, HepB, VZV)*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #3			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs. Based on the most recent rate reflecting the performance in calendar year 2021, we increased the rate by almost ten percentage points to the 50th percentile. **WS** is continuing to reach out to parents/guardians of members reminding them of the importance of immunizations through telephone calls, text messages, and mailings. There is also an incentive for members to attend their well visits where immunizations would be provided.			

Table 6-39—HEDIS—Opportunities for Improvement and MCO Response #4

WS's HEDIS Opportunities for Improvement #4			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #4			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs and a continued hesitancy in going to in person appointments due to COVID-19. Based on the most recent rate reflecting the performance in calendar year 2021, **WS** increased the rates to the 25th percentile. **WS** is continuing to reach out to parents/guardians of members and members over 18 years of age reminding them of the importance of immunizations through telephone calls, text messages, and mailings. There is also an incentive for members to attend their well visits where immunizations would be provided. **WS** is in the process of developing additional outreach efforts focused on adolescents by the end of 2022.			

Table 6-40—HEDIS—Opportunities for Improvement and MCO Response #5

WS's HEDIS Opportunities for Improvement #5			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Cervical Cancer Screening (CCS)*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #5			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs. Based on the most recent rate reflecting the performance in calendar year 2021, we increased the rate by nine percentage points to the 50th percentile. **WS** is continuing to reach out to members encouraging cervical cancer screenings through telephone calls, text messages, and mailings.			

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

WS's HEDIS Opportunities for Improvement #6			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
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
WS's HEDIS Response #6			
WS has noted a consistently low performance for Chlamydia Screening in Women, ages 16–20, ages 21–24, and ages 16–24 in totality. Performance has been <25th Percentile for multiple years with a steady decline year over year. It should be noted that the ages 21–24 does perform at a higher rate than ages 16–20. While the assumption is that the stigma and age differentiation is the contributing factor to this finding, it is something that should be further explored to understand the unique needs of our members in an effort to provide member-centric care. **WS** has member outreach programs that promote both age-appropriate screenings, as well as women's health. **WS** will continue to evaluate these outreach programs to consider appropriateness of including chlamydia screening. **WS** will evaluate how best to promote screening in both the minor population, targeting appropriate education and activation with parents/guardians, as well as how to best promote screening with the adult population. **WS** will evaluate opportunities to improve this measure through provider partnerships, member outreach programs, as well as community awareness initiatives.			

Table 6-42—HEDIS—Opportunities for Improvement and MCO Response #7

WS's HEDIS Opportunities for Improvement #7			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #7			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs. Based on the most recent rate reflecting the performance in calendar year 2021, we increased the rate by eleven percentage points to the 25th percentile. **WS** is continuing to reach out to members encouraging prenatal visits and engaging in care management through telephone calls, text messages, and mailings.			

Table 6-43—HEDIS—Opportunities for Improvement and MCO Response #8

WS's HEDIS Opportunities for Improvement #8			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #8			
WS confirmed that the decrease in the rate for this measure in 2020 was mostly due to a decrease in access to medical records due to provider staffing shortages and competing priorities to address COVID-19 needs. Based on the most recent rate reflecting the performance in calendar year 2021, we increased the HbA1c Testing rate to the 50th percentile and the HbA1c Poor Control and Control rates improved to the 25th percentile. An incentive was provided to members and providers to complete HbA1c tests in 2021. **WS** is continuing to reach out to members encouraging diabetes self-management and control through telephone calls, text messages, and mailings.			

Table 6-44—HEDIS—Opportunities for Improvement and MCO Response #9

WS's HEDIS Opportunities for Improvement #9			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #9			
WS worked closely with targeted providers to improve the diabetes screening rate among members in this measure cohort. After discussion with providers and members, there appears to be continued impact from			

WS's HEDIS Response #9
COVID-19 staffing issues. This has led to delays in accessing services such as diabetes screening and other preventive screenings. WS continues to outreach to all members and providers to encourage diabetes screening through telephone calls and mailings. Additional interventions, such as incentives, will be considered if the rate does not improve in 2022.

Table 6-45—HEDIS—Opportunities for Improvement and MCO Response #10

WS's HEDIS Opportunities for Improvement #10			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response #10			
WS noted a decrease in 2020 for this measure. After discussion with providers and members, there appears to be continued impact from COVID-19 staffing issues. This has led to delays in accessing services such as diabetes screening and other preventive screenings. Although the rate did increase to the 25th percentile, WS continues to outreach to all members and providers to encourage diabetes screening through telephone calls and mailings. Additional interventions, such as incentives, will be considered if the rate does not improve in 2022.			

Table 6-46—HEDIS—Opportunities for Improvement and MCO Response #11

WS's HEDIS Opportunities for Improvement #11			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #11			
WS worked closely with targeted providers to improve the metabolic monitoring rate among members in this measure cohort. There has been an increase in 2021 to the 50th percentile, however, WS continues to outreach to all members and providers to encourage metabolic monitoring through telephone calls and mailings.			

Table 6-47—HEDIS—Opportunities for Improvement and MCO Response #12

WS's HEDIS Opportunities for Improvement #12			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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
WS's HEDIS Response #12			
WS has identified a continued decrease in the ADD rate for the continuation and maintenance phase among the membership. After discussion with providers and members, there appears to be continued impact from COVID-19 staffing issues. This has led to delays in accessing services such as follow up services and other preventive screenings. **WS** continues to outreach to all members to encourage following up with the provider through texting campaigns and mailings. Additional interventions, such as incentives, will be considered if the decrease continues in 2022.			

EDV

The SFY 2021 EQR Technical Report contained opportunities for improvement for **WS** in EDV. The activities implemented by **WS** during SFY 2022 to improve the EDV results are shown below.

Table 6-48—EDV—Opportunities for Improvement and MCO Response #1

WS's EDV Opportunities for Improvement #1 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional (P) Encounters (837P): Validity of Member Identification Number	99.7%	100%
WS's EDV Response #1			
WS has researched the samples provided, and the comments were the same for the P and I claim types. All but two of the sample errors can be attributed to the encounter being submitted to DHHS with an internal **WS** identification number for a newborn rather than the permanent IDs. For the two members on the sample list not related to newborns, the identification number provided on the encounter submission matches the ID **WS** received from DHHS. There is a separate process where **WS** supplies a crosswalk and the DHHS data warehouse is updated with the updated member ID. No edits to the files were required. **WS** will also continue with a monthly monitoring process.			

Table 6-49—EDV—Opportunities for Improvement and MCO Response #2

WS's EDV Opportunities for Improvement #2 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Institutional (I) Encounters (837I): Validity of Member Identification Number	99.6%	100%
WS's EDV Response #2			
WS has researched the samples provided. All but two of the sample errors can be attributed to the encounter being submitted to DHHS with an internal **WS** identification number for a newborn rather than the permanent ID. For the two members on the sample list not related to newborns, the identification number provided on the encounter submission matches the ID **WS** received from DHHS. There is a separate process where **WS** supplies a crosswalk and the DHHS data warehouse is updated with the updated member ID. **WS** will also continue with a monthly monitoring process.			

Table 6-50—EDV—Opportunities for Improvement and MCO Response #3

WS's EDV Opportunities for Improvement #3 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	99.2%	100%
WS's EDV Response #3			
WS has identified some delays in receiving and loading its vendor files that caused the timeliness rates to be slightly below standard for the 837P encounters. **WS** is working on an internal process to monitor and load the vendor files to ensure timely encounter submissions. **WS** has implemented improved monitoring protocols and reporting with our current pharmacy benefit manager (PBM) to allow for better oversight and escalation on deliverables.			

Table 6-51—EDV—Opportunities for Improvement and MCO Response #4

WS's EDV Opportunities for Improvement #4 Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	95.3%	100%
WS's EDV Response #4			
Some of the pharmacy encounter data not being submitted within 14 calendar days was a shortfall on the previous PBM. **WS** is working on an internal process to monitor and load the vendor files to ensure timely encounter submissions. **WS** has implemented improved monitoring protocols and reporting with our current PBM to allow for better oversight and escalation on deliverables.			

Table 6-52—EDV—Opportunities for Improvement and MCO Response #5

WS's EDV Opportunities for Improvement #5 Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Completeness and Accuracy of Data Submitted to DHHS: Record Omissions (Pharmacy); Record Surplus (Pharmacy); Elements Missing (P) and (I); Element Omission (I); Element Accuracy (I)	Rates ranged from 4.7%—99.4%	100%
WS's EDV Response #5			
BH–The Beacon system and the weekly claims report do include dedicated fields for the Referring NPI. The Referring NPI values are absorbed and submitted when available. However, the Referring NPI is not a required field since not all encounters are results of a referral. **Vision**–Because the plan is routine vision, Vision Service Plan (VSP) does NOT require a referring provider on the claim. **DME**–Northwood is not currently sending **WS** the referring provider NPI. **WS** is planning to address this issue by the third quarter of 2023. **WS** is aware of secondary diagnosis code not being sent and has submitted a request to fix it by the second quarter of 2023.			

Table 6-53—EDV—Opportunities for Improvement and MCO Response #6

WS's EDV Opportunities for Improvement #6 Medical Record Review	
EQR Activity	**Measure Standard**
EDV	Review the reasons for the non-submission of medical records
WS's EDV Response #6	
WS did review the non-submission reasons shared with the health plan and most were that the member could not be found in the medical record system. Internal discussion identified the opportunity to further expand the request for the medical record based on a broader timeframe to reduce the risk of missing the medical record. Additionally, the quality team is exploring the opportunity to streamline access to medical records for higher volume provider groups to reduce the dependency on staffing at the provider offices. Review of the non-submission reasons gave **WS** the opportunity to identify additional approaches to access medical records including expanding the search request and streamlining access to records so as to not to be affected by staffing constraints at the facility. **WS** will work to implement broader requests for medical records in regard to the required timeframes in order to not miss a record. **WS** will also continue to work with providers to increase better access to records to reduce the impact on their staff when medical records are needed, especially at high volume provider groups.	

Table 6-54—EDV—Opportunities for Improvement and MCO Response #7

WS's EDV Opportunities for Improvement #7 Medical Record Review	
EQR Activity	**Measure Standard**
EDV	Educate providers regarding the proper use of immunization administration procedure codes 90460, 90461, 90471, and 90472
WS's EDV Response #7	
WS reviewed the Immunization Services reimbursement policy and found to be consistent with the DHHS Vaccine Guidelines. It was determined additional provider communication was not needed.	

Table 6-55—EDV—Opportunities for Improvement and MCO Response #8

WS's EDV Opportunities for Improvement #8 Medical Record Review	
EQR Activity	**Measure Standard**
EDV	Investigate the relatively high encounter data omission rate for the data element *Procedure Code*
WS's EDV Response #8	
WS will conduct a root cause investigation on the omission rate for the data element ***Procedure Code*** and take appropriate action. **WS** expects to conduct and complete this review during the second quarter of 2023. Data used for the review will include information prior to the Edifecs implementation and after the Edifecs implementation.	

Appendix A. Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

- **AAP**—Adults' Access to Preventive/Ambulatory Health Services
- **ABX**—Antibiotic Utilization
- **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; alternate payment model
- **APP**—Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics
- **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
- **CASS**—Coding Accuracy Support System
- **CBP**—Controlling High Blood Pressure
- **CCC**—Children with Chronic Conditions
- **CCD**—continuity of care document
- **CCS**—Cervical Cancer Screening
- **CDC**—Comprehensive Diabetes Care; Centers for Disease Control and Prevention
- **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
- **CMHC**—Community Mental Health Clinic
- **CMS**—Centers for Medicare & Medicaid Services
- **COPD**—chronic obstructive pulmonary disease
- **COVID-19**—coronavirus disease 2019
- **CPG**—clinical practice guideline
- **CPT**—Current Procedural Terminology
- **CWP**—Appropriate Testing for Children with Pharyngitis
- **CY**—calendar year
- **DAV**—data aggregator validation
- **DCYF**—Division for Children, Youth, and Families
- **DHHS**—New Hampshire Department of Health and Human Services
- **DME**—durable medical equipment
- **DNR**—Do Not Report
- **DRG**—diagnosis related group
- **DTaP**—diphtheria, tetanus, and acellular pertussis vaccine
- **EBI**—Enterprise Business Intelligence
- **ECHO**—Extension for Community Healthcare Outcomes
- **ED**—emergency department
- **EDA**—encounter data accuracy
- **EDC**—encounter data completeness
- **EDI**—electronic data interchange
- **EDT**—encounter data timeliness
- **EDV**—encounter data validation
- **ENT**—otolaryngologist (ear, nose, and throat specialist)
- **EPSDT**—Early and Periodic Screening, Diagnostic, and Treatment
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FAP**—Find-A-Provider
- **FAR**—final audit report
- **FCA**—False Claims Act

- **FFCRA—**Families First Coronavirus Response Act
- **FFS—**fee-for-service
- **FMEA—**failure modes and effects analysis
- **FQHC**—Federally Qualified Health Center
- **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
- **FWA**—fraud, waste, and abuse
- **HbA1c—**hemoglobin A1c; a measure of longer-term glucose management
- **HCPCS—**Healthcare Common Procedure Coding System
- **HEDIS—**Healthcare Effectiveness Data and Information Set
- **HepA**—hepatitis A vaccine
- **HepB**—hepatitis B vaccine
- **HIB—**Haemophilus influenzae type B vaccine
- **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
- **ID—**identification
- **IDSS—**Interactive Data Submission System
- **IET—**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- **IMA—**Immunizations for Adolescents
- **IPV**—polio vaccine
- **IS—**information systems
- **ISCAT—**Information System Capability Assessment Tool
- **IUD—**intrauterine device
- **LBP—**Use of Imaging Studies for Low Back Pain
- **LEP—**limited English proficiency
- **LO—**National Committee for Quality Assurance-licensed organization
- **LSC—**Lead Screening in Children

- **MAT**—medication-assisted treatment
- **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
- **MY**—measurement year
- **NA**—not applicable; for HEDIS, small denominator
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NCS**—Non-recommended Cervical Cancer Screening in Adolescent Females
- **NDC**—national drug code
- **NEMT**—non-emergency medical transportation
- **NHHF**—New Hampshire Healthy Families
- **NPI**—National Provider Identifier
- **NR**—not reported
- **OB/GYN**—obstetrician/gynecologist
- **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
- **POD**—Pharmacotherapy for Opioid Use Disorder
- **POS**—place of service; point of service

- **PPC**—Prenatal and Postpartum Care
- **PSV**—primary source verification
- **QA**—quality assessment
- **QAPI**—quality assessment and performance improvement
- **QI**—quality improvement
- **R**—report
- **RV**—rotavirus
- **SAA**—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- **SAC**—submission accuracy and completeness
- **SAMHSA**—Substance Abuse and Mental Health Services Administration
- **SFTP**—secure file transfer protocol
- **SFY**—state fiscal year
- **SIU**–special investigation unit
- **SMART**—specific, measurable, attainable, relevant, and time-bound
- **SMD**—Diabetes Monitoring for People With Diabetes and Schizophrenia
- **SOP**—standard operating procedure
- **SPHA**—Symphony Performance Health Analytics
- **SSD**—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SSFB**—Start Smart for Baby
- **SUD**—substance use disorder
- **Tdap**—tetanus, diphtheria, and acellular pertussis vaccine
- **TOB**—type of bill
- **TOC**—transition of care
- **UAT**—user acceptance testing
- **UM**—utilization management
- **URI**—Appropriate Treatment for Upper Respiratory Infection
- **URL**—uniform resource locator
- **USDHHS**—United States Department of Health and Human Services
- **USPS**—United States Postal Service
- **VSP**—Vision Service Plan
- **VZV**—varicella (chicken pox) vaccine
- **W30**—Well-Child Visits 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
- **WIC—**Women, Infants & Children
- **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 9, 2022.

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 9, 2022.

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 review.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 9, 2022.

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: Sept 20, 2022.

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 9, 2022.

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 9, 2022.

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/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 9, 2022.

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. All standards achieved 100 percent compliance after the completion of the CAP.

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 2022 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates included in the review period (i.e., CY 2021)
- The Member Handbook and additional documents sent to members
- The Provider Manual 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
- FWA documents
- Documentation supporting requirements for the health IS
- Grievance and appeal file reviews
- 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 ***quality of care***, ***timeliness of care***, or ***access to 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 ***quality of care***, ***timeliness of care***, or ***access to 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

	42 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	BH	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	Grievances and Appeals 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%

	42 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 IS 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 IS Reviews From SFY 2017–2019

NHHF	Health IS	2017	2018	2019
42 CFR §438.242	Health IS	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

	42 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	BH	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			

	42 CFR	Standard Name	2017	2018	2019
		438.358(b)(iii)	Three Year Period		
IX.	NA	Cultural Considerations	100%	100%	100%
X.	§438.228	Grievances and Appeals 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 IS 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 IS Reviews From SFY 2017–2019

WS	Health IS	2017	2018	2019
42 CFR §438.242	Health IS	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 SFY 2020–SFY 2022. 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.

ACNH

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 From SFY 2020–SFY 2022

	42 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%		100%
III.	§438.208	Coordination and Continuity of Care Care Management/Care Coordination	90.0%	100%	
IV.	NA	Wellness and Prevention	100%		100%
V.	NA	BH	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%		100%
IX.	§438.228	Grievances and Appeals Systems	93.6%		100%
X.	§438.206	Availability of Services Access to Care	86.3%		99.1%
XI.	§438.214 §438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	91.4%		

	42 CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
XII.	§438.210	Coverage and Authorization of Services	74.3%	96.9%	
		UM			
XIII.	§438.236 §438.224 §438.330	Practice Guidelines	80.6%	100%	
		Confidentiality			
		Quality Assessment and Performance Improvement Program			
		Quality Management			
XIV.	NA	Substance Use Disorder	84.0%		
XV.	NA	FWA	91.2%		91.7%
XVI.	NA	Financial	92.9%		
XVII.	NA	TPL*		100%	
XVIII	§438.242	Health IS**			100%
OVERALL RESULTS			**93.9%**	**98.4%**	**99.2%**

*HSAG added this standard to the review in 2021
**HSAG added this standard to the review in 2022.

A comparison of the overall results from the compliance review in 2022 to the previous year (i.e., 2021) indicates that **ACNH** improved its score by 0.8 percentage points.

HSAG provides an in-depth review of the health IS 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 the reviews for SFY 2020 and SFY 2021 are listed in Table B-6. The score for the 2022 review of health IS included in Table B-5.

Table B-6—Health IS Review–ACNH

42 CFR	Health IS	2020	2021	2022*
§438.242	Health IS	96.9%	99.9%	
	Encounter Data Validation			

* **ACNH**'s 2022 score for health IS included in Table B-5.

HSAG also includes information concerning **ACNH**'s health IS in the HEDIS, PMV, and EDV sections of this report.

NHHF

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 From SFY 2020–SFY 2022

	CFR	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting	96.9%		
II.	438.114	Emergency and Post-Stabilization Care			100%
III.	438.208	Coordination and Continuity of Care Care Management/Care Coordination		100%	
IV.	NA	Wellness and Prevention			100%
V.	NA	BH	98.3%		
VI.	438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment		100%	
VII.	438.100	Enrollee Rights Member Services		98.0%	
VIII.	NA	Cultural Considerations			100%
IX.	438.228	Grievances and Appeals Systems			100%
X.	438.206	Availability of Services Access to Care			99.1%
XI.	438.214 438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management	94.8%		
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	89.0%		
XV.	NA	FWA			97.2%
XVI.	NA	Financial	100%		
XVII.	NA	TPL		100%	
XVIII.	NA	Health IS			100%
OVERALL RESULTS			**94.3%**	**99.5%**	**99.6%**

A comparison of the overall results from the compliance review score from 2022 to the previous year (i.e., 2021) indicates that **NHHF** improved its score by 0.1 percentage points.

HSAG provides an in-depth review of the health IS 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 the reviews for SFY 2020 and SFY 2021 are listed in Table B-8. The score for the 2022 review of Health IS included in Table B-7.

Table B-8—Health IS Review–NHHF

CFR	Health IS	2020	2021	2022*
438.242	Health IS	96.7%	99.2%	
	Encounter Data Validation			

* **NHHF**'s 2022 score for health IS included in Table B-7.

HSAG also includes information concerning **NHHF**'s health IS in the HEDIS, PMV, and EDV sections of this report.

WS

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 From SFY 2020–SFY 2022

	WS	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
I.	438.230	Subcontractual Relationships and Delegation	91.2%		
		Delegation and Subcontracting			
II.	438.114	Emergency and Post-Stabilization Care			100%
III.	438.208	Coordination and Continuity of Care		88.2%	
		Care Management/Care Coordination			
IV.	NA	Wellness and Prevention			100%
V.	NA	BH	96.6%		
VI.	438.56	Disenrollment: Requirements and Limitations		94.1%	
		Member Enrollment and Disenrollment			
VII.	438.100	Enrollee Rights		100%	
		Member Services			
VIII.	NA	Cultural Considerations			100%
IX.	438.228	Grievances and Appeals Systems			99.3%

	WS	Standard Name	2020	2021	2022
		438.358(b)(iii)	Three Year Period		
X.	438.206	Availability of Services			97.3%
		Access to Care			
XI.	438.214 438.207	Provider Selection	94.9%		
		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	93.0%		
XV.	NA	FWA			97.2%
XVI.	NA	Financial	100%		
XVII.	NA	TPL		100%	
XVIII.	NA	Health IS			100%
OVERALL RESULTS			**94.5%**	**96.4%**	**98.8%**

A comparison of the overall results from the compliance review score from 2022 to the previous year (i.e., 2021) indicates that **WS** improved its score by 2.4 percentage points.

HSAG provides an in-depth review of the health IS 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 the reviews for SFY 2020 and SFY 2021 are listed in Table B-10. The score for the 2022 review of health IS included in Table B-9.

Table B-10—Health IS Review–WS

CFR	Health IS	2020	2021	2022*
438.242	Health IS	92.0%	99.7%	
	Encounter Data Validation			

* **WS**'s 2022 score for health IS included in Table B-9.

HSAG also includes information concerning **WS**'s health IS in the HEDIS, PMV, and EDV sections of this report.

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., Aim statement, population, indicator[s], and data collection methodology) is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and indicators used have the capability to achieve statistically significant and sustained improvement.

Evaluation of the Implementation of the PIP

Objectives

The purpose of conducting PIPs, as required in 42 CFR §438.330(b)(1),[B-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, 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

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B-9 U. S. Government Printing Office. (2019). *Activities related to external quality review.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 9, 2022.

B-10 Ibid.

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 9, 2022.

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.
- **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

[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: https://www.ihi.org/resources/Pages/Publications/ImprovementGuidePracticalApproachEnhancingOrganizationalPerformance.aspx. Accessed on: Nov 9, 2022.

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 through 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, *at least one of the tested interventions* could reasonably result in the demonstrated statistically significant improvement and/or achievement of the SMART Aim goal, and the MCO conducted accurate data analysis, and accurately interpreted the PIP results.
- ***Moderate Confidence*** = The PIP was methodologically sound and at least one of the tested interventions could reasonably result in the demonstrated improvement; however, one of the following occurred:
  - There was statistically significant improvement and/or SMART Aim goal was achieved; however, the MCO did not conduct accurate data analysis and/or did not accurately interpret the PIP results.
  - The improvement achieved was not statistically significant (non-statistically significant improvement in the SMART Aim measure), the SMART Aim goal was not achieved, with or without achieving clinical or programmatic significant improvement.
  - The improvement achieved was not statistically significant (non-statistically significant improvement in the SMART Aim measure), the SMART Aim goal was not achieved, with or without achieving clinical or programmatic significant improvement, and the MCO did not conduct accurate data analysis and/or did not accurately interpret the PIP results.

- ***Low confidence*** = The PIP was methodologically sound with or without accurate data analysis and interpretation of results and one of the following occurred:
  - There was no improvement in the SMART Aim measure.
  - Any one of the improvement options was achieved but none of the interventions tested could reasonably result in the demonstrated improvement.
  - There was only clinically significant improvement and/or programmatically significant improvement for the PIP.
- ***No confidence*****:** The MCO did not adhere to an acceptable methodology for all phases of the PIP.

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 are 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 13 state-selected performance measures for the SFY 2022 validation activities in New Hampshire. HSAG completed the reports for this activity in May 2022.

Table B-11—Performance Measures Audited by HSAG for SFY 2022

Performance Measures
ACCESSREQ.05: *Requests for Assistance Accessing MCO Designated Primary Care Providers by County*
CAREMGT.39: *Members Enrolled in Care Management*
HRA.08: *Successful Completion of MCO Health Risk Assessment*

[B-13] U. S. Government Printing Office. (2020). *Activities related to external quality review.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Nov 9, 2022.

Performance Measures
CLAIM.23: *Timely Processing of All Clean Provider Claims: Thirty Days of Receipt*
APPEALS.03: *Resolution of Expedited Appeals Within 72 Hours*
GRIEVANCE.03: *Member Grievances Received*
PROVCOMM.01: *Provider Communications: Speed to Answer Within 30 Seconds*
NHHDISCAHRGE13: *NH Hospital Discharges—Discharge Plan Provided to Aftercare Provider Within 7 Calendar Days of Member Discharge*
POLYPHARM.04: *Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days*
TIMELYCRED.02: *Timely Provider Credentialing—Specialty Providers*
SERVICEAUTH.13: *Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate*
SUD.48*: Readmissions Among Members With SUD by Subpopulation*
WITHHOLD.21.05: *Percent of Pregnant Women who are referred to Care Management Prior to Delivery*

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) virtual review 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.

[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: Nov 9, 2022.

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 state specifications.
Do Not Report (DNR)	MCO rate was materially biased and should not be reported.
No Applicable (NA)	The MCO was not required to report the measure.
Not Reported (NR)	Measure was not reported because the MCO did not offer the required benefit.

Description of Data Obtained

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

- Completed responses to the ISCAT by each MCO.
- Source code, computer programming, and query language (if applicable) used by the MCOs to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Final performance measure rates.

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 recommendations for the MCOs related to ***quality of care***, ***timeliness of care***, or ***access to care***. Once HSAG completed the validation process, the reviewers evaluated the designation category (i.e., R, DNR, NA, NR) 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 ***quality of care***, ***timeliness of care***, or ***access to care*** from the results of the PMV activity.

NAV

Objectives

The goal of the SFY 2022 NAV 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. As part of the NAV, HSAG compared the key elements published in each online provider directory with the data in the MCO's provider file. HSAG then validated the accuracy of the online provider directories by completing a revealed caller telephone survey and confirmed whether each MCO's website met the federal requirements in Title 42 of the Code of Federal Regulations (42 CFR) §438.10(h) and the MCM Services Contract, Amendment #8 requirements in §4.4.1.5.[B-15]

The objective of the online provider directory review was to determine if information presented in each of the MCOs' online provider directories matched the data in the MCOs' submitted provider data files. The objective of the revealed caller telephone survey was to determine whether respondents from provider offices could confirm the information found in the online directory as well as to determine appointment wait times for Medicaid members. Through these two activities, the NAV activity triangulated the results across three data sources to identify issues that would impact members in their attempts to locate and contact providers and make timely appointments for care.

Technical Methods of Data Collection and Analysis

HSAG used three main data sources to address the objective of the NAV: (1) the MCOs' provider data files reflecting PCPs, specialty providers, and BH providers, including those subcontracted by the MCO, (2) the MCOs' online provider directories, and (3) provider office staff members responding to the revealed caller survey.

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, specialty providers, and BH providers actively enrolled with the MCO to serve New Hampshire MCM program members as of January 1, 2022. HSAG included out-of-state offices for PCPs, specialty providers, and BH providers

[B-15] State of New Hampshire Department of Health and Human Services. (2021). Medicaid Care Management Services Contract, Amendment #8. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Nov 9, 2022.

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). The data request included a specific data file format, data field contents, as well as a request for specific indicators to be in the online provider directory review and revealed caller telephone survey.

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, specialty providers, and BH providers unique by the provider's name, NPI, telephone number and address within each MCO and provider category. HSAG sampled 408 unique providers per MCO, which were divided among the provider domains such that there were 136 unique PCPs; 136 specialty providers, evenly divided to select 17 providers from each specialty category; and 136 BH providers. HSAG identified all MCO-contracted locations and randomly selected one provider for each location to be included in the review. Provider locations selected for the online provider directory review were unique to each MCO, and a provider location may have been included in the directory review for more than one MCO.

Once the data request was sent to the MCOs, HSAG hosted a webinar with DHHS and the MCOs to review the provider data request and clarify any questions. Upon receipt of the data files, HSAG assessed the data file format, data field content, and consistency between the submitted data and the indicators requested. Additionally, HSAG standardized the providers' address data to align with the United States Postal Service Coding Accuracy Support System (CASS) in an effort to reduce the likelihood of sampling the same provider locations within and between MCOs.

Description of Data Obtained

HSAG received each MCO's data submissions containing the MCO's current provider network data on February 1, 2022. The MCO-submitted data files were reviewed by HSAG analysts to identify the extent of missing data, implausible values, or logical inconsistencies in the data based on knowledge of New Hampshire Medicaid-enrolled providers and MCOs (e.g., an MCO lacking key provider types, too many providers of specific types). HSAG submitted questions for clarification to the MCOs and requested the resubmission of data in situations where corrections were needed to proceed with sampling and the subsequent data online provider directory review and revealed caller surveys.

During March 2022, 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.

After completion of the online provider directory review, HSAG analysts identified the sampled cases for which the MCO-submitted provider data matched the online provider directories on seven key indicators—provider name, provider address, provider city, provider state, provider ZIP Code, provider

telephone number, and provider type/specialty. Cases that matched on these data elements were passed on to be included in the revealed caller telephone survey.

HSAG's trained interviewers contacted the telephone number listed in the online provider directory and collected survey responses using a standardized script approved by DHHS. HSAG instructed interviewers not to schedule actual appointments. HSAG's interviewers made two attempts to contact each survey case during standard business hours (i.e., 9:00 a.m. to 5:00 p.m. Eastern Time).[B-16] If put on hold at any point during the call, the interviewer waited on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the interviewer made a second call attempt on a different day and at a different time of day. If an interviewer reached a voicemail or answering service during the second call attempt, the interviewer left a message requesting an inbound call within two business days.

HSAG reviewers collected information on the accuracy of the following data elements: the provider's telephone number, the provider's address, the provider's affiliation with the requested MCO, the provider's specialty category or service domain, whether the provider accepts commercial insurance with Anthem, whether the provider is accepting new patients, and the dates of the next available appointments for new and existing patients.

How Conclusions Were Drawn

HSAG compared the data obtained from the MCOs' online provider directories to the MCO-submitted data files, and discrepancies were flagged. Analysts calculated the percentage of cases for each data element with an exact match across the data sources. Similarly, analysts calculated the number of cases in the revealed caller telephone survey where the provider office respondent confirmed the data identified in the online provider directory. Where match rates for a data element were identified to be below 90 percent, HSAG identified opportunities for improvement in the quality of the data availability and accuracy across data sources. Including correct and complete provider data in the provider directory directly affects a member's choice of PCP, specialty provider, and BH provider. The results of the analysis therefore speak directly to the member's ***access to care*** as defined by their ability to accurately identify and contact providers, and indirectly to the ***timeliness of care*** in that the longer it takes members to contact a provider, the longer the delay in receiving treatment. The results also speak to the ***timeliness of care*** in that the median wait time for an appointment is a direct measure of timeliness.

[B-16] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer called and reached a recording that stated the office is closed for lunch, the call attempt did not count toward the two attempts to reach the office. HSAG instructed the interviewer to attempt to contact the office up to two times outside of the known lunch hour.

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 administer CAHPS surveys for their adult and child Medicaid populations. Symphony Performance Health Analytics (SPHA), an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2022 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-17] Adult members and parents or caretakers of child members completed the surveys in 2022, following NCQA's data collection protocol.

The CAHPS 5.1H Health Plan 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 members' experience with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite scores.[B-18] 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

[B-17] 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-18] For this report, the 2022 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.

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 2021 NCQA CAHPS adult and general child Medicaid national averages.[B-19]

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.

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 2021).

The MCOs' CAHPS vendors administered the surveys from February to May 2022. 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-20] 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 2022 CAHPS survey results to the

[B-19] National data were obtained from NCQA's 2021 Quality Compass.

[B-20] 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.

2021 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 2022 CAHPS scores for **ACNH**, **NHHF**, and **WS** revealed that one child measure rate for **ACNH** and three child measure rates for **WS** scored statistically significantly above the national averages. Conversely, two child measure rates for **ACNH** and one adult measure rate for **WS** scored statistically significantly lower than the national averages. The remaining rates for all three MCOs were neither statistically significantly higher nor 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***, and/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.

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 2021 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 2021 and the definition of the domains included on 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 2021 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 2021 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 2021 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)	✓		

Performance Measures	Quality	Timeliness	Access
Chlamydia Screening in Women (CHL)	✓		
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Lead Screening in Children (LSC)	✓		
Acute and Chronic Care			
Appropriate Testing for Children with Pharyngitis (CWP)	✓		
Appropriate Treatment for 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—Total (AMB)	NA	NA	NA
Antibiotic Utilization—Total (ABX)	NA	NA	NA
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓
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 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 (FUM)	✓	✓	✓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	✓	✓	
Pharmacotherapy for Opioid Use Disorder (POD)	✓	✓	

EDV

During SFY 2022, DHHS contracted HSAG to conduct an EDV study. In alignment with CMS' EQR Protocol 5, HSAG conducted the following three core evaluation activities for all three MCOs:

- IS review—assessment of MCOs' IS and processes to examine the extent to which the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. Of note, DHHS does not currently require MCOs to submit encounters for value-added services (e.g., dental and food services) to its MMIS; therefore, encounters for value-added services were out of scope for the IS review.
- Ongoing encounter data quality reports—assess monthly and quarterly the completeness, accuracy, and timeliness of MCOs' encounter data files submitted to DHHS
- 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

While the ongoing encounter data quality reports evaluated encounters submitted to DHHS between July 1, 2021, and June 30, 2022, HSAG included encounter data with dates of service between July 1, 2020, and June 30, 2021, in the comparative analysis. The following sections describe the methodology for each activity.

IS 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.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DHHS. Documents for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and DHHS' current encounter data submission requirements, among others. The information obtained from this review is important for developing a targeted questionnaire to address important topics of interest to DHHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the MCOs' most recent Information Systems Capabilities Assessment Tool (ISCAT) collected through Protocol 2, *Validation of Performance Measures*. This process allowed the IS review activity to be coordinated across projects, preventing duplication and minimizing the impact on the MCOs. HSAG then 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 provider data. Lastly, this review included specific topics of interest to DHHS.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DHHS and MCO information technology personnel to clarify any questions from the 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 each MCO completed the DHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the MCO'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.

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. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS' EQR Protocol 5.

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 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 2022 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

Measure Element	Specification
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

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
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
NDC			✓	In national NDC code sets

- **Study Indicator EDT.2**—Percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment date

Measure Element	Specification
Numerator	Number of initial encounters (i.e., the unique number of *ClaimNo*) submitted to DHHS within 14 calendar days of the latest claim payment date
Denominator	Total number of initial encounters (i.e., the unique number of *ClaimNo*) passing X12 EDI compliance edits and submitted during the measurement period
File Type	Initial 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[2] for each submission month[3]
Denominator	Number of final paid professional visits for each submission month
File Type	Final paid professional encounters after EDI translation
Reporting Frequency	Quarterly

Measure Element	Specification
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 POS categories were defined based on the distribution of values within the professional encounters and all categories are the same as those in the SFY 2021 report.
3 Submission months are reported for a rolling six months.

- **Study Indicator EDC.5**—Number/percentage of institutional visits by type of bill (TOB) for each submission month

Measure Element	Specification
Numerator	Percentage of visits[1] in each TOB category[2] for each submission month[3]
Denominator	Number of final paid institutional visits for each submission month
File Type	Final paid institutional encounters after EDI translation
Reporting Frequency	Quarterly
Reporting Level(s)	Record-Level—by MCO and statewide

1 A visit is defined by the unique combination of member ID, date of service, and provider ID.
2 TOB categories were defined based on the distribution of values within the institutional encounters and all categories are the same as those in the SFY 2021 reports.
3 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 paid claims paid in a quarter and submitted to DHHS within two months from the end of the quarter (i.e., the first quarterly results for the EDA.3 measure included encounters paid between April 1, 2021, and June 30, 2021, and submitted to DHHS by August 31, 2021) b. Total MCO paid amount in a quarter and submitted to DHHS within two months from the end of the quarter (i.e., the first quarterly results for the EDA.3 measure included encounters paid between April 1, 2021, and June 30, 2021, and submitted to DHHS by August 31, 2021)
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, 2021, and June 30, 2022. 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 4, 2022.

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 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.

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 activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS' EQR Protocol 5.

Technical Methods of Data Collection and Analysis

HSAG developed a data requirements document requesting claims and encounter data from both DHHS and the MCOs. To help the MCOs prepare data for the EDV study, HSAG added a section regarding the common data extraction errors to the data requirements document. Follow-up technical assistance

[B-21] New Hampshire Department of Health and Human Services. Care Management Services. Medicaid Care Management Services Contract, Amendment #8. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Nov 9, 2022.

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		✓	
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			✓

Key Data Elements	Professional	Institutional	Pharmacy
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).

Additionally, results were stratified by subcontractor to provide a better understanding of the aggregate results by distinguishing data anomalies that may only pertain to a specific subcontractor. In addition, NEMT encounters were excluded from the comparative analysis.

Description of Data Obtained

HSAG used data from both DHHS and the MCOs with dates of service between July 1, 2020, and June 30, 2021, 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, 2021, and submitted to DHHS on or before December 31, 2021. This anchor date allowed sufficient time for the SFY 2022 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 the MCOs and DHHS to resubmit data, as appropriate.

How Conclusions Were Drawn

Since DHHS had not yet established standards in the MCO contract for results from the comparative analysis, HSAG selected results needing the MCOs' attention based on its experience. Table B-16 displays the criteria used. In addition, HSAG noted a few recommendations based on the file review responses from the MCOs.

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.

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 notetaking. 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. For this study, 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 notetaking 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 report 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 ***quality of care***, ***timeliness of care***, and ***access to care***.

Reveal Caller Telephone 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-22] 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 conducted a telephone survey among a sample of physical health specialty locations contracted with one or more of the MCOs. Callers 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.

[B-22] The Specialty Provider Survey included providers contracted with the Medicaid MCOs and specializing in one of five physical health specialties: Cardiology, Dermatology, Endocrinology, Hematology/Oncology, and Neurology.

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 July 31, 2021. 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 selected survey cases by MCO and provider category from a de-duplicated list of unique provider locations.[B-23]

Description of Data Obtained

HSAG's trained interviewers contacted the telephone number listed in the online provider directory and collected survey responses using a standardized script approved by DHHS. HSAG instructed interviewers not to schedule actual appointments. HSAG's interviewers made two attempts to contact each survey case during standard business hours (i.e., 9:00 a.m. to 5:00 p.m. Eastern Time).[B-24] If put on hold at any point during the call, the interviewer waited on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the interviewer made a second call attempt on a different day and at a different time of day. If an interviewer reached a voicemail or answering service during the second call attempt, the interviewer left a message requesting an inbound call within two business days.

A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number supplied by the MCO connected to a fax line or a message that the number was no longer in service)
- Telephone number connected to an individual or business unrelated to a medical practice or facility
- Office personnel refused to participate in the survey
- Office personnel failed to respond within two business days to the voicemail request to complete the survey
- The interviewer was unable to speak with office personnel during either call attempt (e.g., the call was answered by an automated answering service or call center that prevents the interviewer from speaking with office staff or leaving a voicemail)

How Conclusions Were Drawn

After completion of the calls, the data were tabulated electronically, and HSAG employees analyzed the information obtained during the telephone calls. HSAG reviewed the answers to the survey questions and drew conclusions based on the provider locations' responses. Recommendations from the report included items to improve ***timeliness of care*** and ***access to care***.

[B-23] HSAG sampled 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 varied.

[B-24] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer called and reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. HSAG instructed the interviewer to attempt to contact the office up to two times outside of the known lunch hour.