State of New Hampshire
Department of Health and Human Services

2023 New Hampshire External Quality Review Technical Report

February 2024

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acknowledgements

The preparation of this report was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

Health Services Advisory Group, Inc., confirms that no one conducting 2023 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) 2022, there were 242,529 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[1-1]

During state fiscal year (SFY) 2023, 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 2023, 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, a quality study, and a reveal caller provider survey.

The SFY 2023 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 2022 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 October 26, 2023 (data loaded through end of September 2023).

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

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

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

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

Table 1-1—Opportunities for Improvement for ACNH

EQR Activity	Measure Standard	ACNH's Results	Standard
Contract Compliance Audit	Standard I—Delegation and Subcontracting	88.6%	100%
	Standard XI—Network Management	99.5%	100%
PIPs	Use short testing periods to ensure quick and timely data collection and analyses for each intervention; test as many interventions as possible.		
	Revisit quality improvement (QI) tools and processes throughout the PIP process to determine new interventions to test.		
	Complete the supplemental Intervention Progress Form when testing interventions.		
NAV	Review the provider categories not meeting the time/distance standards.		
	Monitor processes for creating the provider network data files; review the files for accuracy prior to submitting to HSAG.		
CAHPS	Child Medicaid: *Rating of Health Plan*	Statistically significantly lower than the national average	Equal to or higher than the national average
	Child Medicaid: *Rating of Personal Doctor*	Statistically significantly lower than the national average	Equal to or higher than the national average
HEDIS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile—Total*	Below the 25th percentile	Equal to or higher than the national average
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total	Below the 25th percentile	Equal to or higher than the national average
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total	Below the 25th percentile	Equal to or higher than the national average

EQR Activity	Measure Standard	ACNH's Results	Standard
HEDIS	*Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap [tetanus, diphtheria, and acellular pertussis vaccine])*	Below the 25th percentile	Equal to or higher than the national average
	Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV [human papillomavirus])	Below the 25th percentile	Equal to or higher than the national Average
	Cervical Cancer Screening (CCS)	Below the 25th percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—21–24 Years	Below the 25th percentile	Equal to or higher than the national average
	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	Below the 25th percentile	Equal to or higher than the national average
	Hemoglobin A1c Control for Patients With Diabetes (HBD)—Poor Hemoglobin A1c (HbA1c) Control (>9.0%)	Below the 25th percentile	Equal to or higher than the national average
	Hemoglobin A1c Control for Patients With Diabetes (HBD)— HbA1c Control (<8.0%)	Below the 25th percentile	Equal to or higher than the national average
	Asthma Medication Ratio (AMR)—Total	Below the 25th percentile	Equal to or higher than the national average
EDV	**Ongoing Encounter Data Quality Reports**		
	837 Professional (P): Initial Submission Within 14 Days of Claim Payment	99.9%	100%

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

Table 1-2—Opportunities for Improvement for NHHF

EQR Activity	Measure Standard	NHHF's Results	Standard
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
	Standard XI—Network Management	94.8%	100%
PIPs	Use short testing periods to ensure quick and timely data collection and analyses for each intervention; test as many interventions as possible.		
	Revisit QI tools and processes throughout the PIP process to determine new interventions to test.		
	Complete the supplemental Intervention Progress Form when testing interventions.		
NAV	Review the provider categories not meeting the time/distance standards.		
	Monitor processes for creating the provider network data files; review the files for accuracy prior to submitting to HSAG.		
CAHPS	Child Medicaid: *Rating of All Health Care*	Statistically significantly lower than the national average	Equal to or higher than the national average
HEDIS	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*	Below the 25th percentile	Equal to or higher than the national average
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Below the 25th percentile	Equal to or higher than the national average
EDV	**Information System Review**		
	Submit complete and accurate encounter data to DHHS.	**NHHF** should perform more quality checks, such as field-level completeness and validity, reconciliation with financial reports, Electronic Data Interchange (EDI)	NA

EQR Activity	Measure Standard	NHHF's Results	Standard
EDV		compliance edits, and claim volume by submission month on the non-emergency medical transportation (NEMT) encounters.	
	Ongoing Encounter Data Quality Reports		
	837P: Initial Submission Within 14 Days of Claim Payment	97.0%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.7%	100%
	Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG		
	Element Accuracy (Institutional [I])–Procedure Code	92.8%	≥95.0%
	Element Accuracy (I)–Detail Paid Amount	92.1%	≥95.0%

= Indicates rates that improved from the SFY 2022 EDV Aggregate Report by more than 10.0 percentage points.

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

Table 1-3—Opportunities for Improvement for WS

EQR Activity	Measure Standard	WS's Results	Standard
Contract Compliance Audit	Standard XI—Network Management	96.9%	100%
PIPs	Use short testing periods to ensure quick and timely data collection and analyses for each intervention; test as many interventions as possible.		
	Revisit QI tools and processes throughout the PIP process to determine new interventions to test.		
	Complete the supplemental Intervention Progress Form when testing interventions.		
NAV	Review the provider categories not meeting the time/distance standards.		
	Monitor processes for creating the provider network data files; review the files for accuracy prior to submitting to HSAG.		
CAHPS	Child Medicaid: *Rating of All Health Care*	Statistically significantly lower than the national average	Equal to or higher than the national average
	Child Medicaid: *Rating of Personal Doctor*	Statistically significantly lower than the national average	Equal to or higher than the national average
	Child Medicaid: *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 2 (Meningococcal, Tdap, HPV)*	Below the 25th percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—16–20 Years	Below the 25th percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—21–24 Years	Below the 25th percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—Total	Below the 25th percentile	Equal to or higher than the national average

EQR Activity	Measure Standard	WS's 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
	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
EDV	**Information Systems Review**		
	Submit complete and accurate encounter data to DHHS.	**WS** should perform more quality checks, such as reconciliation with financial reports and EDI compliance edits, on the NEMT encounters.	NA
	Ongoing Encounter Data Quality Reports		
	837P: Validity of Member Identification Number—Percent Valid	99.9%	100%
	837I: Validity of Member Identification Number—Percent Valid	99.9%	100%
	837P: Initial Submission Within 14 Days of Claim Payment	94.5%*	100%
	837I: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
	Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.7%	100%
	Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG		
	Record Omission: Institutional (I)	4.5%	≤4.0%
	Element Missing: P (behavioral health [BH], Durable Medical Equipment [DME], and Vision)–Referring Provider Number/National Provider Identifier [NPI]	68.5%	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 Surgical Procedure Codes	NA	All values submitted by

EQR Activity	Measure Standard	WS's Results	Standard
EDV			providers to the subcontractors for these fields should be submitted to DHHS

* Per request from DHHS, HSAG excluded the backlog files received from **WS**'s NEMT subcontractor from the measure calculation.

2. Overview of the MCM Program

The New Hampshire statewide MCM program is the primary method of service delivery covering 97.1 percent[2-1] of the New Hampshire Medicaid population as of December 1, 2022. At the end of CY 2022, there were 242,529 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[2-2] That number represents an increase of 13,777 beneficiaries from the end of CY 2021 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 October 26, 2023 (data loaded through end of September 2023).

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 except the following services that are covered by the Medicaid FFS program:

- Child Dental Benefits and Adult Dental Benefits prior to April 1, 2023;
- 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 2023:

- **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 2023 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 2023.

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 during SFY 2023 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 2023. The tasks include MCO contractual compliance, PIPs, PMV, NAV, CAHPS, HEDIS, EDV, semi-structured qualitative interviews, a quality study, and a reveal caller provider survey.

3-1 U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Jul 10, 2023.

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: Jul 10, 2023.

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*, February 2023,[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 2021 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 2023, HSAG reviewed five 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 2023 Compliance Review

Standard	42 CFR	CFR Standard Name	New Hampshire Standard Name
I.	§438.230	Subcontractual Relationships and Delegation	Delegation and Subcontracting
V.	Not Applicable (NA)*	NA	BH
XI.	§438.214 §438.207	Provider Selection Assurance of Adequate Capacity and Services	Network Management
XIV.	NA*	NA	SUD
XVI.	NA*	NA	Financial Management

* 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. (2022). Amendment #8 to the Medicaid Care Management Services Contract. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Sept 21, 2023.

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: Sept 12, 2023.

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: Sept 12, 2023.

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*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sept 12, 2023.

The five 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 2022. 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, 2022)
- The Provider Manual, provider newsletters, and other MCO communication to providers/subcontractors
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- Financial management policies and procedures
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG scheduled the three two-day compliance reviews in May 2023. DHHS and HSAG agreed to perform this year's review virtually using Microsoft Teams. The use of Teams, 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 2023 compliance review activity and the level of confidence associated with the overall scores.

Table 3-2—Rates Achieved by the MCOs for the SFY 2023 Compliance Review

Standard	Standard Name	ACNH	NHHF	WS
I.	Delegation and Subcontracting	88.6%	79.5%	100%
V.	Behavioral Health (BH)	100%	100%	100%
XI.	Network Management	99.5%	94.8%	96.9%
XIV.	Substance Use Disorder (SUD)	100%	100%	100%
XVI.	Financial Management	100%	100%	100%
Overall Results		**98.6%**	**94.5%**	**97.7%**
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 94.5 percent or higher. The scores for the individual standards ranged from 79.5 percent to 100 percent for the three MCOs. The two scores for the Delegation and Subcontracting standard for **ACNH** and **NHHF** represent areas for focused improvement.

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*, February 2023.[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 submitted 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 2024 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 May 11 and 12, 2023. Table 3-3 details the scores achieved by **ACNH** for the five standards included in the SFY 2023 review.

Table 3-3—SFY 2023 Compliance Review Scores for ACNH

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
I.	Delegation and Subcontracting	48	44***	38	2	4	88.6%
V.	BH	33	33	33	0	0	100%
XI.	Network Management	394	370****	367	2	1	99.5%
XIV.	SUD	55	55	55	0	0	100%
XVI.	Financial Management	8	8	8	0	0	100%
Overall Results		**515**	**510**	**501**	**4**	**5**	**98.6%**

* ***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.
***This standard included elements from the contract file reviews (i.e., 36 elements).
****This standard included elements from the initial credentialing and recredentialing file reviews (i.e., 304 elements).
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

The **ACNH** compliance tool included five standards representing 510 applicable elements. **ACNH** *Met* the requirements for 501 elements, *Partially Met* the requirements for four elements, and scored *Not Met* for the requirements in five elements. **ACNH** achieved an overall score of 98.6 percent. Of the five standard areas reviewed, **ACNH** achieved 100 percent compliance on three standards, demonstrating adherence to all requirements within:

- BH
- SUD
- Financial Management

ACNH received a score of 99.5 percent in the Network Management standard, representing strength in achieving compliance with those requirements.

The remaining standard, Delegation and Subcontracting, achieved a score of 88.6 percent, representing the area of focused improvement for **ACNH**.

The five 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 subcontracts, initial credentialing, and recredentialing files. HSAG included the results from those file reviews in the scores for the following standards:

- Delegation and Subcontracting includes the results of the subcontract file reviews.
- Network Management includes the results of the initial credentialing and recredentialing file reviews.

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

- Confirm a subcontractor's ability to perform the activities to be delegated prior to delegation.
- Ensure that subcontractor agreements address all requirements listed in the contract between DHHS to include:
  - Information about the grievance and appeal system and member rights.
  - Requiring the subcontractor to hold harmless DHHS and its employees, and all members served under the terms of the Agreement between **ACNH** and DHHS in the event of nonpayment by the MCO.
  - Developing policies and procedures for requirements to refer credible allegations of fraud to the DHHS Program Integrity Unit and the Medicaid Fraud Control Unit (MFCU) and for payment suspension when there is a credible allegation of fraud.
  - Requiring subcontractors to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses that may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees, or contractors.
  - Ensuring that there is a written agreement between the MCO and each subcontractor stipulating that the MCO, DHHS, New Hampshire MFCU, New Hampshire Department of Justice (DOJ), U.S. DOJ, the Office of Inspector General (OIG), and the Comptroller General or their respective designees have the right to audit, evaluate, and inspect, and that it will make available for the purpose of audit, evaluation, or inspection any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under this Agreement between **ACNH** and DHHS.
  - Informing subcontractors that they can be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later.
  - Notifying the MCO within one business day of being cited by any State or federal regulatory authority.
  - Requiring the subcontractor to have a compliance plan that meets the requirements of 42 CFR §438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements.
  - Revoking delegation of activities or obligations or imposing other sanctions if the subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS.

  - Incorporating issues pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965 (nondiscrimination in hiring and employment of governmental contractors), unless exempted by rules, regulations, or orders of the Secretary of Labor.
  - Requiring any subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the agreement between **ACNH** and DHHS, to implement policies and procedures, as approved by DHHS, for reporting of all overpayments identified, including embezzlement or receipt of capitation payments to which it was not entitled or recovered, specifying the overpayments due to potential fraud, to the State.
- Develop and furnish provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty BH services and BH providers know when and how to refer members who need physical health services.
- Ensure that the Provider Manual includes information concerning the dedicated contact number to MCO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m., Monday through Friday; and 9:00 a.m. to 12:00 p.m. on Saturday for the purposes of answering questions related to contracting, billing, and service provision.
- Stipulate in plan documents that parties to a State fair hearing include the MCO as well as the provider.

NHHF

HSAG conducted the compliance review for **NHHF** on May 9 and 10, 2023. Table 3-4 details the scores achieved by **NHHF** for the five standards included in the SFY 2023 review.

Table 3-4—SFY 2023 Compliance Review Scores for NHHF

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
I.	Delegation and Subcontracting	48	44***	35	0	9	79.5%
V.	BH	33	33	33	0	0	100%
XI.	Network Management	468	426****	404	0	22	94.8%
XIV.	SUD	55	55	55	0	0	100%
XVI.	Financial Management	8	8	8	0	0	100%
Overall Results		**612**	**566**	**535**	**0**	**31**	**94.5%**

* ***Partially Met*** and ***Not Met*** elements were addressed in the CAP completed by **NHHF**.
** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.
***This standard included elements from the contract file reviews (i.e., 36 elements).
****This standard included elements from the initial credentialing and recredentialing file reviews (i.e., 360 elements).
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

The **NHHF** compliance tool included five standards representing 566 applicable elements. **NHHF** *Met* the requirements for 535 elements and scored *Not Met* for the requirements in 31 elements. **NHHF**

achieved an overall score of 94.5 percent. Of the five standard areas reviewed, **NHHF** achieved 100 percent compliance on three standards, demonstrating adherence to all requirements within:

- BH
- SUD
- Financial Management

NHHF received a score of 94.8 percent on the Network Management standard, representing an area of relative strength.

NHHF received a score of 79.5 percent on the Delegation and Subcontracting standard, representing an area of focus for improvement.

The five 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 subcontracts, initial credentialing, and recredentialing files. HSAG included the results from those file reviews in the scores for the following standards:

- Delegation and Subcontracting includes the results of the subcontract file reviews.
- Network Management includes the results of the initial credentialing and recredentialing file reviews.

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

- Ensure that written agreements with subcontractors include:
  - All required activities and obligations of the subcontractor and related reporting responsibilities and safeguarding of confidential information according to State rules, and State and federal laws.
  - The process to transition services when the agreement expires or terminates.
  - Information about the grievance and appeal system and the rights of the member.
  - Requirements to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and applicable provisions of this Agreement.
  - Requirements for the subcontractor to hold harmless DHHS and its employees, and all members served under the terms of this Agreement in the event of nonpayment by the MCO.
  - Program integrity requirements to include policies and procedures for referrals to DHHS Program Integrity Unit and the MFCU on credible allegations of fraud and for payment suspension where there is a credible allegation of fraud.
  - Requirements for the subcontractor to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against DHHS or its employees through intentional

misconduct, negligence, or omission of the subcontractor, its agents, officers, employees, or contractors.

- A written agreement between the MCO and each subcontractor stipulating that the MCO, DHHS, New Hampshire MFCU, New Hampshire DOJ, U.S. DOJ, the OIG, and the Comptroller General or their respective designees have the right to audit, evaluate, and inspect, and that it will make available for the purpose of audit, evaluation or inspection, any premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the services and/or activities performed or determination of amounts payable under this Agreement.
- Statements that the subcontractor agrees that it can be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later.
- Information requiring the notification of the MCO within one business day of being cited by any State or federal regulatory authority.
- Requirements for subcontractors to investigate and disclose to the MCO, at contract execution or renewal and upon request by the MCO, of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs and who is:
  - A person who has an ownership or control interest in the subcontractor or Participating Provider.
  - An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or participating provider.
  - An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the subcontractor or participating provider.
- Requirements for subcontractors to screen its directors, officers, employees, contractors, and subcontractors against each of the Exclusion Lists monthly and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within 48 hours unless the individual is part of a federally approved waiver program.
- Information indicating that subcontractors must have a compliance plan that meets the requirements of 42 CFR §438.608 and policies and procedures that meet the DRA of 2005 requirements.

- Ensure that written agreements include provisions for:
  - Prohibiting subcontractors from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.
  - Revoking delegation of activities or obligations or imposing other sanctions if the subcontractor's performance is determined to be unsatisfactory by the MCO or DHHS.
  - Complying with the Americans with Disabilities Act.
  - Including issues pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965 (nondiscrimination in hiring and employment of governmental contractors) unless exempted by rules, regulations, or orders of the Secretary of Labor.

  - Requiring any subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under this Agreement, to implement policies and procedures, as approved by DHHS, for reporting of all overpayments identified, including embezzlement or receipt of capitation payments to which it was not entitled or recovered, specifying the overpayments due to potential fraud, to the State.
  - Requiring any subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.
- Ensure that written agreements include:
  - Activities and obligations, and related reporting responsibilities.
  - Provisions concerning revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determines that the subcontractor has not performed satisfactorily.
- Ensure that all credentialing files contain a hospital letter or electronic verification of hospital privileges and all initial credentialing files contain primary source verification (PSV) of malpractice insurance.

WS

HSAG conducted the compliance review for **WS** on May 16 and 17, 2023. Table 3-5 details the scores achieved by **WS** for the five standards included in the SFY 2023 review.

Table 3-5—SFY 2023 Compliance Review Scores for WS

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
I.	Delegation and Subcontracting	48	44***	44	0	0	100%
V.	BH	33	33	33	0	0	100%
XI.	Network Management	509	437****	423	1	13	96.9%
XIV.	SUD	55	55	55	0	0	100%
0XVI.	Financial Management	8	8	8	0	0	100%
Overall Results		**653**	**577**	**563**	**1**	**13**	**97.7%**

* ***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.
***This standard included elements from the contract file reviews (i.e., 36 elements).
****This standard included elements from the initial credentialing and recredentialing file reviews (i.e., 372 elements).
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after removing nonapplicable elements.

The **WS** compliance tool included five standards representing 577 applicable elements. **WS** *Met* the requirements for 563 elements, *Partially Met* the requirements for one element, and scored *Not Met* for the requirements in 13 elements. **WS** achieved an overall score of 97.7 percent. Of the five standard

areas reviewed, **WS** achieved 100 percent compliance on four standards, demonstrating adherence to all requirements within:

- Delegation and Subcontracting
- BH
- SUD
- Financial Management

WS received a score of 96.9 percent on the remaining standard, representing areas of relative strength in Network Management.

The five 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 subcontracts, initial credentialing, and recredentialing files. HSAG included the results from those file reviews in the scores for the following standards:

- Delegation and Subcontracting includes the results of the subcontract file reviews.
- Network Management includes the results of the initial credentialing and recredentialing file reviews.

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

- Ensure that whenever the MCO delegates credentialing to another entity, the MCO monitors the credentialing files to ensure that the entity includes the requirements found in the New Hampshire Code of Administrative Rules, Section 420-J:4.
- Develop processes and train staff members concerning the requirement that all initial credentialing and recredentialing files contain a letter from the hospital or evidence of electronic verification of hospital privileges.
- Receive a copy of the signed attestation statement and attestation concerning the correctness and completeness of the application for all initial credentialing files.

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

PIPs

In SFY 2020, DHHS 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 2023, the MCOs concluded the first two required rapid-cycle PIPs of this multi-year rapid-cycle approach. The MCOs collaborated with DHHS to select all 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.* The PIP topics address ***quality***, ***timeliness of care***, and ***access to care***.

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 conclusion of the PIPs, HSAG established an overall level of confidence for this year's PIP activities as defined below:

- High confidence in reported PIP results: 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 in reported PIP results: 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.

The confidence levels for **ACNH**'s PIP activities in SFY 2023 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	Completed. Not all validation criteria were achieved.	Moderate: There was statistically significant improvement achieved; however, the MCO did not conduct accurate data analysis and/or did not accurately interpret the PIP results.
Initiation and Engagement of Alcohol and Other Drug (AOD) 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	Completed. Not all validation criteria were achieved.	Moderate: The improvement achieved was not statistically significant, and the SMART Aim goal was not achieved.

The confidence levels for **NHHF**'s PIP activities in SFY 2023 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	Completed. Not all validation criteria were achieved.	Moderate: The improvement achieved was not statistically significant and the SMART Aim goal was not achieved; however, there was evidence of significant programmatic improvement.
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	Completed. Not all validation criteria were achieved.	Low: Statistically significant improvement was achieved; however, none of the tested interventions could be reasonably linked to the improvement.

The confidence levels for **WS**'s PIP activities in SFY 2023 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

PIP Topic	Module	Status	Confidence Level
	4. PIP Conclusions	Completed. Not all validation criteria were achieved.	Moderate: The improvement achieved was not statistically significant.
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	Completed. Not all validation criteria were achieved.	Low: All reported rolling 12-month measurements demonstrated a decline in performance compared to the baseline results. The Module 4 submission form was incomplete. The MCO did not provide the final completed SMART Aim measure run chart; however, the PDSA worksheets were thoroughly and accurately completed.

Table 3-6 through Table 3-8 present a summary of the SFY 2023 final intervention testing results and validation findings from Module 4 (PIP Conclusions).

AmeriHealth Caritas New Hampshire

In SFY 2023, HSAG evaluated the final PIP intervention testing results. With Module 4, **ACNH** submitted final PDSA worksheets that included complete intervention testing results for each PIP. Table 3-9 summarizes **ACNH**'s interventions any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 3-9—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Provider-focused: Outreach The intervention had three effectiveness measures defined as:	The MCO did not provide intervention evaluation data for each of the effectiveness measures. The MCO reported the SMART Aim measure data in the final PDSA worksheet.	The MCO reported that it needed additional time for testing to yield results from data because of claim lags, analysis, outreach, and scheduling for screening. The MCO implemented additional reporting

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
• The percentage of prescribing providers for targeted members who received outreach. • The percentage of prescribing providers that were successfully outreached and ordered metabolic screening. • The percentage of targeted members who received an order for metabolic screening and completed the screen.	**ACNH** reported that it did not know the full impact of the intervention due to the time needed for claims lag. Initial results showed a positive impact; however, this initial success showed minimal effect on total SMART Aim measure results.	and tracking of provider outreach to decrease any potential provider abrasion.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total		
Member-focused: Timely communication Facilitation of timely communication between **ACNH** Transition of Care (TOC) coordinator and the hospital discharge planner for timely discharge planning with an established outpatient appointment in place.	The MCO did not provide the intervention effectiveness measure(s) or the evaluation data. The MCO reported the SMART Aim measure and its data in the final PDSA worksheet.	**ACNH** reported no significant success in increasing the rate of compliance to reach the goal rate during this cycle of intervention testing and planned to adapt the intervention.

In SFY 2023, **ACNH** completed Module 4, the final module of the rapid-cycle PIP process. HSAG reviewed and conducted the final validation using the submitted Module 4 submission forms.

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

The MCO's final Module 4 submission did not meet all validation criteria. The PIP was methodologically sound, and the MCO achieved statistically significant improvement; however, HSAG identified opportunities for improvement with reporting accurate outcomes and the completion of intervention testing and PDSA cycle documentation. Based on the validation findings, HSAG assigned the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP a level of *Moderate Confidence*.

HSAG analyzed **ACNH**'s PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **ACNH**'s success in achieving the SMART Aim goal or one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-10 presents the final SMART Aim measure results for **ACNH**'s PIPs. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-10—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members 18–64 years of age residing in Hillsborough County, New Hampshire, with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.	67.4%	88.0%	86.9%	*Yes*	*Moderate Confidence*

ACNH reported 22 data points for the SMART Aim measure over the course of the PIP. Although the MCO did not achieve the SMART Aim goal for the PIP, it did achieve statistically significant and non-statistically significant improvement. The highest rate achieved was 86.9 percent, which is 19.5 percentage points above the baseline performance.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total

The MCO's final Module 4 submission did not meet all validation criteria. The PIP was methodologically sound, and the MCO achieved non-statistically significant improvement for all but one rolling 12-month measurement period; however, HSAG identified opportunities for improvement with the completion of intervention testing and PDSA cycle documentation. Based on the validation findings, HSAG assigned the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* PIP a level of *Moderate Confidence*.

HSAG analyzed **ACNH**'s PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **ACNH**'s success in achieving the SMART Aim goal or one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-11 presents the final SMART Aim measure results. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-11—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total					
The percentage of adult members 18 years of age and older having two or more additional AOD services or medication treatment within 34 days after discharge during the measurement period among adult members 18 years of age and older discharged from an acute inpatient stay with any diagnosis of SUD during the measurement period.	26.5%	42.6%	31.4%	*No*	*Moderate Confidence*

ACNH reported 22 data points for the SMART Aim measure over the course of the PIP. The PIP did not result in the MCO achieving the SMART Aim goal or statistically significant improvement. The highest rate achieved was 31.4 percent which is 4.9 percentage points above the baseline performance. All but one rolling 12-month measurement period demonstrated non-statistically significant improvement.

New Hampshire Healthy Families

In SFY 2023, HSAG evaluated the final PIP intervention testing results. With Module 4, **NHHF** submitted final PDSA worksheets that included complete intervention testing results for each PIP. Table 3-12 summarizes **NHHF**'s interventions any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 3-12—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of 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.	The MCO tested the intervention for seven PDSA cycles. While the intervention showed success in increasing confirmed lab orders, the intervention did not impact the overall SMART Aim goal of the PIP. The MCO thought that by increasing the number of lab orders on file, the number of total annual diabetic screenings would improve; however, this did not occur.	*Abandoned*

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Member proactive outreach manager (POM) telephonic calls to remind members about the lab screenings required to monitor their medication.	The MCO tested the intervention for three PDSA cycles. Although the number of members who received the POM call and are now compliant for the measure, the intervention did not impact the overall SMART Aim measure for the PIP.	*Abandoned*
Telephonic outreach to noncompliant members, providing education and reminding them of the needed lab test(s).	The MCO tested this intervention for four cycles. **NHHF** documented that it struggled to find resources to make the outreach calls due to staffing constraints. The outreach achieved only a 17 percent success rate, and member demographics were consistently challenging to maintain.	*Abandoned*
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total		
Provider education on use and completion of Notification of Alcohol and Other Drug (AOD) Diagnosis and/or Referral (NDR) Form within 48 hours of the date of service where the original AOD diagnosis was first identified.	**NHHF** reported that it abandoned the intervention due to the lack of NDR forms received after testing for two cycles, and the rapid-cycle timeline did not allow for further time to overcome system barriers. The MCO reported that the intervention was limited to the manual notification, but even the concept of automated notification reporting was too time consuming to allow for its evolution. The initiative caused additional administrative burden which was exacerbated by a pandemic based on feedback from providers.	*Abandoned*
NHHF outreached primary care providers (PCPs) after member's acute care Admission/Discharge/Transfer (ADT) for AOD dependence diagnosis to support treatment engagement.	The MCO tested the intervention for three cycles for a total of nine months of data, and there was no impact on the overall SMART Aim goal of the PIP.	*Abandoned*

In SFY 2023, **NHHF** completed Module 4, the final module of the rapid-cycle PIP process. HSAG reviewed and conducted the final validation using the submitted Module 4 submission forms.

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

The MCO's final Module 4 submission for the above PIP did not meet all validation criteria. The MCO did not meet the SMART Aim goal or achieve statistically significant improvement over the baseline for at least one rolling 12-month measurement period. The SMART Aim measure data showed variations between non-statistically significant improvements and declines in performance. Six of the measurement periods had non-statistically significant improvement over the baseline, and 28 data points indicated non-statistically significant declines with some measurement periods falling below the baseline

performance. NHHF presented intervention effectiveness data for the prescribing provider outreach intervention which supported the conclusion that the intervention resulted in significant programmatic improvement in the percentage of prescribing providers who ordered the diabetes screening for eligible members. Based on this outcome, HSAG assigned a *Moderate Confidence* rating to the PIP.

HSAG analyzed NHHF's PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated NHHF's success in achieving the SMART Aim goal or one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-13 presents the final SMART Aim measure results for NHHF's PIPs. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-13—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members 18–64 years of age living in Hillsborough County and diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (a glucose test or an HbA1c test) during the measurement period.	80.8%	90.0%	82.5%	*No*	*Moderate Confidence*

NHHF reported 34 data points for the SMART Aim measure over the course of the PIP. The SMART Aim measure data showed mixed results with non-statistically significant improvements and declines in performance. The highest rate achieved was 82.5 percent which is 1.7 percentage point above the baseline performance.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total

The MCO's final Module 4 submission for the above PIP did not meet all validation criteria. The PIP was methodologically sound, the SMART Aim goal was achieved, and all but the last two data points demonstrated non-statistically significant improvement. The last two reported data points demonstrated statistically significant improvement, but this improvement could not reasonably be linked to the interventions. The MCO abandoned all interventions due to the testing results. Due to the inability to

reasonably link the improvement to any interventions, HSAG assigned a *Low Confidence* rating to the PIP.

HSAG analyzed **NHHF**'s PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **NHHF**'s success in achieving the SMART Aim goal or one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-14 presents the final SMART Aim measure results. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-14—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total					
The percentage of members 13 years of age and older and living in Rockingham County who initiated treatment for AOD abuse or dependency and completed two or more additional treatment visits within 34 days of initiation during the measurement period.	13.45%	20.0%	21.4%	*Yes*	*Low Confidence*

NHHF reported 34 data points for the SMART Aim measure over the course of the PIP. The MCO achieved the SMART Aim goal, and 32 rolling 12-month measurement periods demonstrated non-statistically significant improvement. The highest rate achieved was 21.4 percent which is 7.95 percentage points above the baseline performance.

Well Sense Health Plan

In SFY 2023, HSAG evaluated the final PIP intervention testing results. With Module 4, WS submitted final PDSA worksheets that included complete intervention testing results for each PIP. Table 3-15 summarizes WS's interventions, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 3-15—Final Intervention Testing Results

Intervention Description	Intervention Evaluation Results	Final Intervention Status
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Provider-focused Alternative Payment Model (APM) Member Outreach and HbA1c Testing: This incentive intervention involves outreach from the health system to the member to schedule appointments and HbA1c testing.	This intervention was tested for two cycles. After the initial round of testing, the MCO's quality contact at Southern New Hampshire Health Systems was unable to complete the intervention activity. WS reported that the PDSA testing period was extended until October 1, 2022, versus June 30, 2022. The testing results demonstrated that this intervention had a positive impact. Results were slightly lower than the predicted outcome. While outreach efforts drastically improved from Cycle 1, the percentage of members in the numerator did not meet the initial goal.	*Adapted* WS will make the following changes: Correctly identifying the member's provider group before the outreach. Ensuring the correct provider group is updated in the MCO's operating systems. Attempting the outreach and engaging the member at the MCO level. This will assist the MCO in meeting the member's needs (needed care including but not limited to behavioral healthcare/medical care/housing/or other support services).
Continued Engagement of Opioid Abuse or Dependence Treatment		
Medication-Assisted Treatment (MAT) Provider Outreach and Education: This intervention tested engagement with opioid use disorder (OUD) treatment by working with high-volume MAT providers to better understand barriers to MAT adherence and determine ways to guide improvement.	WS tested this intervention for four cycles. WS reported that results of this intervention certainly gave an optimistic view of how willing MAT providers in New Hampshire are to collaborate with the MCO with performance improvement activities. However, WS also highlighted that it encountered limitations with data comparisons. For example, the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* Healthcare Effectiveness Data and Information Set (HEDIS®) measure may be	*Adopted*

Intervention Description	Intervention Evaluation Results	Final Intervention Status
	a better indicator of consistent SUD treatment for members in future initiatives. Given the data limitations with this intervention, **WS** planned to continue with this intervention through March 2023. The MCO was also going to identify at least one more high-volume MAT provider in New Hampshire to better generalize the results to other MAT providers.	
NH Project ECHO [Extension for Community Healthcare Outcomes] OUD Provider Education: This intervention focused on educating targeted providers on treatment best practices and available treatment options and resources available. (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).	This intervention was tested for one cycle. Project ECHO for OUD produced positive results with almost a quarter of participants attending most of the sessions. The MCO reported that this response demonstrated that providers were not only attending these sessions and gaining knowledge about OUD and medications for opioid use disorder (MOUD) treatment best practices, but they were also taking time out of their day to participate in this educational opportunity with other experts in the field. The MCO reported that survey responses highlighted the positive perception of Project ECHO and its impact among participating providers, with the majority highly rating their understanding of OUD treatment and confidence in the ability to educate patients about appropriate treatment options. The combination of these results indicated the positive impact that Project ECHO had among participants.	*Adopted*
Provider Resource Guide Educational Email: This intervention was an email blast to selected BH sites with the lowest rates of opioid treatment engagement.	This intervention was tested for two cycles. **WS** reported that the provider resource guide email blast was sent to five BH sites with the lowest rates of opioid treatment engagement. Of the 73 providers who received the email, 12 opened the email. The MCO reported that for the survey feedback, it only received five responses; however, all five providers who responded to the survey indicated that the Provider Resource Guide contained useful substance use care information. Opioid treatment engagement among the targeted provider sites was collected pre-	*Abandoned*

Intervention Description	Intervention Evaluation Results	Final Intervention Status
	and post-email blast distribution. Results showed no increase or substantial change in the rate of members who indexed at a targeted provider and engaged in opioid treatment after the intervention.	
Provider Telehealth Promotion and Educational Email Blast: This intervention was an email blast targeted to the five sites with the highest volumes and lowest telehealth utilization.	**WS** tested this intervention for three cycles. **WS** sent the email blast to 41 SUD providers, and seven opened the email. The links receiving the most clicks included Best Practices in Videoconferencing-Based Telemental Health, Delivering Substance Use Disorder Care via Telehealth (Microsoft [MS] PowerPoint presentation), and Telehealth 101: What you need to know to get started (Microsoft [MS] PowerPoint presentation). One provider showed interest in the telehealth documentation MS PowerPoint presentation. The MCO reported that while providers showed limited engagement with this content, results indicated providers' interest in enhancing their understanding of telehealth standards and procedures. The MCO reported that the survey feedback from the two providers who responded 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. The MCO reported that measuring the impact of certain education interventions is challenging and difficult to assess whether the information provided in the email had a direct impact on provider knowledge and behavior related to telehealth utilization.	*Abandoned*

In SFY 2023, **WS** completed Module 4, the final module of the rapid-cycle PIP process. HSAG reviewed and conducted the final validation using the submitted Module 4 submission forms.

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

The MCO's final Module 4 submission did not meet all validation criteria. **WS** did not meet the SMART Aim goal or achieve statistically significant improvement over the baseline for at least one rolling 12-month measurement period. The SMART Aim measure data showed mixed results over the course of the PIP, with non-statistically significant increases and declines in performance. Ten measurement periods demonstrated performance above the baseline rate, and 20 measurement periods demonstrated performance below the baseline rate. **WS** did not provide the final SMART Aim run chart in the Module 4 submission. The MCO included an additional data table with rolling 12-month measurement periods that had some overlap between the two tables. HSAG was unclear as to what the second set of data that **WS** provided represented. The MCO tested the final intervention through October 14, 2022; however, the intervention testing was to end on June 30, 2022 (SMART Aim end date for the PIP). Based on these results, HSAG assigned a level of *Moderate Confidence* to the reported PIP results.

HSAG analyzed **WS**'s PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **WS**'s success in achieving the SMART Aim goal or at least one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-16 presents the final SMART Aim measure results for **WS**'s PIP. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-16—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication, assigned to selected physician hospital organizations (PHOs), and had a diabetes screening (a glucose or HbA1c test) during the measurement period.	78.57%	92.85%	80.85%	*No*	*Moderate Confidence*

WS reported 30 data points for the SMART Aim measure over the course of the PIP that showed mix results. WS did not achieve the SMART Aim goal or statistically significant improvement. The highest rate WS achieved was 80.85 percent, which was 2.28 percentage points above the baseline and non-statistically significant improvement.

Continued Engagement of Opioid Abuse or Dependence Treatment

The MCO's final Module 4 submission did not meet all validation criteria. WS did not achieve the SMART Aim goal, and all rolling 12-month measurement periods demonstrated declines in performance compared to the baseline results. Additionally, the Module 4 submission form was incomplete. The MCO did not provide the final completed SMART Aim measure run chart with the submission. Based on these findings, HSAG assigned a level of *Low Confidence* to the reported PIP results.

HSAG analyzed WS's PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated WS's success in achieving the SMART Aim goal or at least one of the options for improvement (i.e., statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement).

Table 3-17 presents the final SMART Aim measure results for WS's PIP. HSAG used the reported SMART Aim measure data to determine whether the MCO achieved the SMART Aim goal and statistically significant improvement over baseline results.

Table 3-17—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)	Confidence Rating
Continued Engagement of Opioid Abuse or Dependence Treatment					
The percentage of members 18 years of age and older who initiated treatment for opioid dependency and who had two or more additional visits within 34 days of the initiation visit during the measurement period.	35.6%	41.0%	35.1%	*No*	*Low Confidence*

Like the diabetes PIP, WS reported 30 data points for the SMART Aim measure over the course of the PIP. The MCO did not achieve the SMART Aim goal or statistically significant improvement, and all data points were below the baseline performance. The highest rate WS achieved was 35.1 percent, which was 0.5 percentage points below (i.e., the same as) the baseline.

Conclusions and Recommendations for Improvement

ACNH

ACNH completed two methodologically sound PIPs and achieved at least one of the improvement options for both PIPs.

- **ACNH** should ensure that the narrative summary of results accurately reflects the reported data.
- The intervention effectiveness measures and testing methodologies in the PDSA worksheets should align with the measures and data collection methodologies that were validated and approved by HSAG in Module 3.
- The intervention effectiveness data should be as real-time as possible so **ACNH** can collect and analyze data quickly to make decisions on the status of the intervention and make needed revisions and course corrections quickly.
- **ACNH** should test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **ACNH** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- HSAG encourages **ACNH** to contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.
- To improve QI efforts, **ACNH** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

NHHF

NHHF completed two methodologically sound PIPs and achieved at least one of the improvement options for both PIPs; however, because HSAG could not reasonably link the interventions for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* PIP to the demonstrated improvement, this PIP received a lower confidence level compared to the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP.

- **NHHF** should ensure that any improvement achieved can reasonably linked to the interventions.
- In future PIPs, **NHHF** needs to consider testing as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **NHHF** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- HSAG encourages **NHHF** to contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.

- To improve QI efforts, **NHHF** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

WS

WS completed two methodologically sound PIPs and achieved at least one of the improvement options for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP. Despite the lack of significant improvement, the MCO tested active and innovative interventions and reported having valuable lessons learned through the improvement process.

For the *Continued Engagement of Opioid Abuse of Dependence Treatment* PIP, **WS** did not achieve at least one of the improvement options or meet the SMART Aim goal, but like the diabetes PIP, the MCO tested active and innovative interventions and reported having valuable lessons learned through the improvement process.

- **WS** should ensure that any improvement achieved can reasonably linked to the interventions.
- **WS** should ensure that it includes SMART Aim measure data in the final module and reports these data accurately.
- To improve QI efforts, **WS** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

SFY 2023 New PIPs

In addition to the conclusions of the first two PIP topics, the MCOs initiated the last two PIPs for this multi-year, rapid-cycle PIP approach in SFY 2023. The MCOs collaborated with DHHS to select the new PIP topics from the DHHS priority measures identified in the New Hampshire MCM Quality Strategy. The two topics for all three MCOs are: *Health Risk Assessment (HRA) Completion* and *Human Papillomavirus (HPV) Vaccine.* The new PIP topics address ***quality***, ***timeliness of care***, and ***access to care***.

Based on modules 1 through 3 completed for these two topics, 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 confidence levels for modules 1–3 for **ACNH**'s new PIP activities in SFY 2023 are displayed in Table 3-18.

Table 3-18—ACNH's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
HRA Completion	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	To be determined (TBD): Will be submitted for validation April 15, 2024.	TBD
HPV Vaccine	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	TBD: Will be submitted for validation April 15, 2024.	TBD

The confidence levels for modules 1–3 for **NHHF**'s new PIP activities in SFY 2023 are displayed in Table 3-19.

Table 3-19—NHHF's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
HRA Completion	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	TBD: Will be submitted for validation April 15, 2024.	TBD

PIP Topic	Module	Status	Confidence Level
HPV Vaccine	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	TBD: Will be submitted for validation April 15, 2024.	TBD

The confidence levels for modules 1–3 for **WS**'s new PIP activities in SFY 2023 are displayed in Table 3-20.

Table 3-20—WS's PIP Topic, Module Status, and Confidence Level

PIP Topic	Module	Status	Confidence Level
HRA Completion	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	TBD: Will be submitted for validation April 15, 2024.	TBD
HPV Vaccine	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	TBD: Will be submitted for validation April 15, 2024.	TBD

ACNH

The following section outlines the validation findings for Module 1 for each topic.

Module 1: PIP Initiation

Improving HPV Vaccinations

ACNH followed the HEDIS *IMA-HPV* measure specifications. The MCO used claims data and conducted an analysis on the measure to determine the population characteristics of those members not completing the HPV vaccine series prior to their 13th birthday. HPV vaccination evidence (claims) includes any of the following:

- Three doses with different dates of service on or between the 9th and 13th birthdays.
- Two doses with at least 146 days between the first and second dose on or between the 9th and 13th birthdays.
- Anaphylaxis due to the vaccine on or before the 13th birthday.

Improving Health Risk Assessments

For this PIP, the MCO followed the New Hampshire Medicaid Quality Information System (MQIS) specifications for successful completion of the HRA. **ACNH** stores the HRA instrument in its medical management systems, JIVA. **ACNH** staff access this system to determine the HRA completion rate for the eligible population.

ACNH achieved all Module 1 validation criteria for both PIPs.

Module 2: Intervention Determination

The following section outlines the validation findings for Module 2 for each topic.

Improving HPV Vaccinations

ACNH completed a Five Why's root cause analysis, a failure modes and effects analysis (FMEA), and a key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **ACNH** identified the following prioritized barriers:

- Member/guardian refuses the vaccination.
- Appointments are not scheduled.
- Missed appointments.
- Member does not receive vaccination.

To address these barriers, **ACNH** developed the following planned interventions.

- Targeted member outreach for education, awareness, and rationale for the HPV vaccine conducted through a mailing of an early birthday card with an HPV vaccine reminder (Spanish version available).
- Member incentive for completion of vaccine series.
- Targeted provider outreach to deliver education on using care gap reports and vaccine timing requirements for the *Immunizations for Adolescents—HPV* measure.
- Removal of anniversary date claim edit for well visits.

Improving Health Risk Assessments

As it did for the *Improving HPV Vaccinations* PIP, **ACNH** completed a Five Why's root cause analysis, a FMEA, and a key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **ACNH** identified the following prioritized barriers:

- Member is unaware of the need to complete the HRA.
- MCO staff is unaware that the member needs to complete the HRA.

To address these barriers, **ACNH** developed the following planned interventions.

- Informational messaging and posting for access to the HRA for completion.
- Mailing to targeted members (Spanish version available).
- Adding the HRA to talk tracks for all outbound calls for Bright Start postpartum to include completion of the baby's HRA (interpretive services available).
- Member service department training and education will include an update to talk track for inbound calls from members requesting car seats.
- Member incentive earned upon completion of the HRA.
- **ACNH** achieved all Module 2 validation criteria for both PIPs.

Module 3: Intervention Testing

The following section outlines the validation findings for Module 3 for each topic.

Improving HPV Vaccinations

The first intervention **ACNH** submitted in Module 3 for validation was an early birthday card to those members turning 13 years of age during the measurement year who have not completed the HPV vaccine series. The goal of this intervention is to increase the number of eligible members who complete the HPV vaccine series. The intervention effectiveness measure is described below:

Table 3-21—Intervention Effectiveness Measure	
Intervention Measure Title	The percentage of targeted members who received a birthday card reminder and completed the HPV vaccination series.
Numerator Description	All targeted members who were sent an early HPV birthday card reminder and who completed their HPV immunizations before their 13th birthday.
Denominator Description	All targeted members who will turn 13 years of age during the measurement year and who were sent an early HPV birthday card reminder.

Improving Health Risk Assessments

The first intervention **ACNH** submitted in Module 3 for validation was testing telephonic engagement with members calling to request a child car seat. Designated **ACNH** staff members assist members with completing the HRA during this telephonic engagement. The goal of this intervention is to increase the number of HRAs completed. The intervention effectiveness measure is described below:

Table 3-22—Intervention Effectiveness Measure	
Intervention Measure Title	The percentage of **ACNH** members who successfully completed the HRA and requested a child car seat.
Numerator Description	The total number of targeted members from the denominator who completed the HRA.
Denominator Description	The total number of targeted members (those who have requested a child car seat but have not completed an HRA) who connected telephonically with designated member outreach staff.

ACNH achieved all Module 3 validation criteria for both PIPs.

Intervention Testing Check-In

HSAG conducted one of four scheduled intervention check-ins during SFY 2023. The first check-in occurred in April 2023. **ACNH** submitted its PDSA worksheets, one for each PIP topic, and reported the MCO's progress in the intervention testing process. For the *Improving HPV Vaccinations* PIP, the MCO decided to abandon the birthday reminder card intervention. The testing results were not favorable for continuing the intervention. After testing the intervention for eight weeks, **ACNH** found that only 17 of 163 members who received the birthday card reminder completed the vaccine series (10.43 percent). At the time of this report, the MCO was developing the methodology for its next intervention. Information for this intervention will be included in the next annual PIP report.

For the *Improving Health Risk Assessments* PIP, **ACNH** is adapting the telephonic engagement to have care management (CM) staff call Bright Start members postpartum and encourage them to complete the HRA. The goal of this revision is to reach a larger population. HSAG will include the final results of the intervention testing in the next annual EQR report.

NHHF

The following section outlines the validation findings for Module 1 for each topic.

Module 1: PIP Initiation

Improving HPV Vaccinations

NHHF followed the HEDIS *Immunizations for Adolescents—HPV* measure specifications. The MCO used claims data and conducted an analysis on the measure to determine the population characteristics of those members not completing the HPV vaccine series prior to their 13th birthday. HPV vaccination evidence (claims) includes any of the following:

- At least two HPV vaccines on or between the member's 9th and 13th birthdays with dates of service at least 146 days apart.
- At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.

Improving Health Risk Assessments

For this PIP, the MCO followed the New Hampshire MQIS specifications for successful completion of the HRA. **NHHF** pulls the data for this project from its HRA.08 compliance report. The MCO produced a quarterly report that identified eligible members and completed HRA details for the HRA.08 compliance report. When a member completes an HRA, **NHHF** enters the data into TruCare, the medical management system **NHHF** staff uses to provide accurate documentation of care provided to members. **NHHF** loads data from TruCare into the Enterprise Data Warehouse (EDW) database. **NHHF** pulls the eligible member information for the compliance report from the EDW.

- **NHHF** achieved all Module 1 validation criteria for both PIPs.

Module 2: Intervention Determination

The following section outlines the validation findings for Module 2 for each topic.

Improving HPV Vaccinations

NHHF completed a process map, cause-and-effect diagram, and key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **NHHF** identified the following prioritized barriers:

- Parent is unaware of the vaccine and the benefit of early vaccination.
- Provider is not recommending the vaccine.
- Office staff in clinics lack knowledge of the need for the HPV vaccine.
- Messaging about the HPV vaccine in schools and clinics is unclear and out-of-date.

- Parents whose first language is not English do not understand the need for getting their child vaccinated.

To address these barriers, **NHHF** developed the following planned interventions.

- Parent-focused education via email on the importance of protection against HPV and related cancers.
- Provider education program that includes watching the film, "Someone You Love: the HPV Epidemic" and breakout sessions on how to have conversations with parents.
- Provide education to clinic office staff on the HPV vaccine.
- Encourage provider offices and upper elementary schools to display educational materials and up-to-date information about the HPV vaccine.

Improving Health Risk Assessments

NHHF completed a process map, cause-and-effect diagram, and key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **NHHF** identified the following prioritized barriers:

- Member is unaware of the need to complete the HRA.
- The HRA email is unclear about the purpose of the assessment and how to complete it.
- Lack of options for the member to complete the HRA.
- Reminder phone call message about the HRA does not have an option to request assistance with completing the HRA.

To address these barriers, **NHHF** developed the following planned interventions.

- Include a member's story in the newsletter about how completing the HRA and CM improved the member's healthcare experience.
- Conduct a member focus group to review the HRA notification and completion process.
- Develop a **NHHF** smart phone application that provides access to the HRA.
- Update the reminder phone call message to include the option of leaving a message for assistance in completing the HRA.

NHHF achieved all Module 2 validation criteria for both PIPs.

Module 3: Intervention Testing

The following section outlines the validation findings for Module 3 for each topic.

Improving HPV Vaccinations

The first intervention NHHF submitted in Module 3 for validation involved educating providers on the HPV vaccine series using a video and breakout sessions. The goal of this intervention is to have providers respond that they would do at least one thing differently in their practice related to the HPV vaccine after attending the educational event. The intervention effectiveness measure is described below:

Table 3-23—Intervention Effectiveness Measure	
Video: "Someone You Love Screening" and Breakout Sessions	
Intervention Measure Title	The percentage of providers in the NHHF network who attend the event and indicate on the evaluation form at least one thing they will do differently in their practice after attending this event.
Numerator Description	Total number of providers from NHHF's network who attended the event and answered the survey question, "As a result of this training, I plan to implement at least one change to improve my practice or patient care to increase HPV vaccinations" with a response of Strongly Agree or Agree.
Denominator Description	Total number of providers from NHHF's network who attended the event. The evaluation form will contain a question asking providers to identify themselves as part of NHHF's provider network. If the provider does not answer the question, QI staff will attempt to match participants with names on the NHHF provider network database.

The second intervention NHHF submitted in Module 3 for validation involved emailing parents and/or guardians of members ages 9 to 12 years who have not yet received two doses of the vaccine. The goal of this intervention is to have parents/guardians of eligible members open and read the emailed information. The intervention effectiveness measure is described below:

Table 3-24—Intervention Effectiveness Measure	
HPV Vaccine Email Campaign	
Intervention Measure Title	The percentage of parents/guardians in the denominator who open the email.
Numerator Description	Total number of parents/guardians from the denominator who open the HPV informational email.
Denominator Description	Total number of parents/guardians of members ages 9 to 12 years who are noncompliant for the HPV vaccine that received the HPV informational email.

Improving Health Risk Assessments

The first intervention NHHF submitted in Module 3 for validation was testing a postcard with a quick response (QR) code link to the HRA form. The postcard also includes information about a $20.00 reward the member will receive for completing the HRA. The intervention effectiveness measure is described below:

Table 3-25—Intervention Effectiveness Measure	
QR Link HRA Postcard Mailing	
Intervention Measure Title	The percentage of members sent a postcard with a QR link to the online HRA form who complete the HRA form online within two weeks of the postcards being mailed.
Numerator Description	Total number of members sent a postcard with a QR link to the online HRA form who complete the HRA form online within two weeks after the postcards being mailed.
Denominator Description	Total number of members sent a postcard with a QR link to the online HRA form.

The second intervention **NHHF** submitted in Module 3 for validation involved testing a redesigned phone reminder message that offered the member a way to request assistance with completing the HRA. The goal of this intervention is to have members request assistance for completing the HRA. The intervention effectiveness measure is described below:

Table 3-26—Intervention Effectiveness Measure	
Redesigned Reminder Phone Call Message	
Intervention Measure Title	The percentage of members who receive an HRA reminder call after hours and leave a voice message for assistance with completing the HRA.
Numerator Description	Total number of members from the denominator who press "1" for assistance and leave a voice message.
Denominator Description	Total number of members who receive an HRA reminder phone call after hours.

NHHF achieved all Module 3 validation criteria for both PIPs.

Intervention Testing Check-In

HSAG conducted one of four scheduled intervention check-ins. The first check-in occurred in April 2023. **NHHF** submitted its PDSA worksheets, two for each PIP topic, and reported the MCO's progress in the intervention testing process. For the *Improving HPV Vaccinations* PIP, the MCO submitted a worksheet for the provider educational video and breakout session intervention. After one testing cycle, **NHHF** reported that the results were "positive" in terms of the number of providers in the network who participated. The MCO reported that the providers were all able to identify at least one thing they would change after attending this event. The MCO would like to have seen more **NHHF** provider practices in attendance and indicated that most participants were not providers, but staff from clinics. **NHHF** selected that it will be adapting this intervention and retesting. HSAG will include final testing results for this intervention in the next annual EQR report.

The second PDSA worksheet **NHHF** submitted was for the HPV vaccine email campaign intervention. After one cycle of testing, the MCO reported it had a 52 percent open rate for the email, which is high compared to industry standards. **NHHF** reported that using an email blast was an efficient way to provide information to parents of members and elected to adopt this intervention as a standard practice.

The MCO reported that going forward it will send the email at the beginning of each calendar year to members who have not yet begun the two-dose regimen for the HPV vaccine or who had their first dose over six months ago. For members who have had the first dose in the last six months of the prior year, the MCO will wait until mid-year to contact those who did not receive the second dose.

For the *Improving Health Risk Assessments* PIP, **NHHF** submitted a PDSA worksheet for the QR Link HRA postcard mailing intervention. At the time of this check-in, the MCO reported that it is still in the process of preparing the mailing. The State approved the mailing, and **NHHF** is compiling the mailing list and setting up a schedule with the printing vendor.

The second PDSA worksheet **NHHF** submitted for the *Improving Health Risk Assessments* PIP was for the redesigned reminder phone call message. After one cycle of testing, the MCO determined it will revise the intervention and test for a second cycle. For the first cycle testing results, no members who received the reminder call after hours left a message for member services requesting assistance in completing the HRA. For the second cycle of testing, **NHHF** will send the reminder message on a Saturday instead of mid-week. HSAG will include final testing results for this intervention in the next annual PIP report.

WS

The following section outlines the validation findings for Module 1 for each topic.

Module 1: PIP Initiation

Improving HPV Vaccinations

WS followed the HEDIS *Immunizations for Adolescents—HPV* measure specifications. The MCO used claims data and conducted an analysis on the measure to determine the population characteristics of those members not completing the HPV vaccine series prior to their 13th birthday. HPV vaccination evidence (claims) includes any of the following:

- At least two HPV vaccines on or between the member's 9th and 13th birthdays with dates of service at least 146 days apart.
- At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.

Improving Health Risk Assessments

For this PIP, the MCO followed the New Hampshire MQIS specifications for successful completion of the HRA. **WS** pulls data for this project from the member comma separated values (CSV) files that it created and sends these data daily to its vendor ELIZA. The vendor will conduct the outreach and complete the HRA. The vendor will send **WS** a "Completed Call" file weekly, which **WS** will use to create a "Completed HRA" MS Excel File. **WS**'s member services team will manually upload data from this file to JIVA and pull the HRA completion rate from JIVA.

- **WS** achieved all Module 1 validation criteria for both PIPs.

Module 2: Intervention Determination

The following section outlines the validation findings for Module 2 for each topic.

Improving HPV Vaccinations

WS completed a cause-and-effect diagram, Five Why's analysis, and key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **WS** identified the following barriers:

- Parents and providers are not prioritizing early HPV vaccinations.
- Adolescents and parents are not presented with persuasive information on why early HPV vaccinations are important.
- Providers are overburdened and lack time to obtain easily understood education concerning how to present recommendations about the HPV vaccine to parents and eligible adolescents.
- Competing demands for providers and provider office staff.

To address these barriers **WS** developed the following planned interventions.

- Send a letter to providers about the PIP and share two videos (one on education and one clinician-to-clinician) about how to present the information.
- Recommend that the providers bundle HPV vaccinations with Tdap, meningococcal, flu and well-child visits.
- Provide gap-in-care report to providers.

Improving Health Risk Assessments

As it did for the *Improving HPV Vaccinations* PIP, **WS** completed a cause-and-effect diagram, Five Why's analysis, and key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **WS** identified the following barriers:

- Members do not know why they need to complete the HRA.
- Members mistakenly throw the mailed paper version of the HRA away.
- If members do complete the mailed paper version of HRA, they find it inconvenient to mail the HRA back to the MCO.
- Members do not understand that with completing the HRA, they may have additional benefits available.

To address these barriers, **WS** developed the following planned interventions.

- Promote the newly implemented $30.00 incentive for completing the HRA.

- Deploy the texting program to eligible members. The text script will promote the incentive, explain the HRA benefits, and allow members to complete the HRA electronically using a smart phone.
- Update the MCO's database with correct member contact information.

WS achieved all Module 2 validation criteria for both PIPs.

Module 3: Intervention Testing

The following section outlines the validation findings for Module 3 for each topic.

Improving HPV Vaccinations

The first intervention **WS** submitted in Module 3 for validation involved targeted provider education using educational videos, gap-in-care lists, and vaccine bundling. The goal of this intervention is that the providers who receive the educational outreach will use the information and knowledge to improve their HPV vaccination rate. The intervention effectiveness measure is described below:

Table 3-27—Intervention Effectiveness Measure	
Effective Education and Enhanced Convenience for Providers	
Intervention Measure Title	The percentage of targeted provider groups who received the educational materials and provided a positive response on a follow-up survey.
Numerator Description	The total number of targeted provider groups from the denominator who positively respond in a follow-up survey.
Denominator Description	The total number of targeted provider groups who were sent the educational materials.

The second intervention **WS** submitted in Module 3 for validation involved testing an educational outreach campaign with parents who have adolescents eligible for the HPV vaccine series. Parents will receive a text message about the importance of early HPV vaccination, an educational video, and a recommendation to combine the HPV vaccination with other vaccines that are due at an annual well-child visit. The text script will be delivered in the member's primary language. The goal of this intervention is to have more eligible adolescent members receive the HPV vaccine series following the texted information to the targeted parents. The intervention effectiveness measures are described below:

Table 3-28—Intervention Effectiveness Measure #1	
Increased Motivation and Enhanced Convenience for Parents: Text Message Campaign	
Intervention Measure Title	The percentage of eligible adolescents whose parents were targeted by the HPV texting campaign and received the text message successfully.
Numerator Description	The total number of eligible adolescents whose parents received the text message successfully. (Success is defined as members who were targeted and received texts without being excluded due to invalid, missing, or wrong phone numbers, opt-outs, etc.)

Table 3-28—Intervention Effectiveness Measure #1	
Denominator Description	The total number of eligible adolescents whose parents were targeted by the HPV texting campaign and were sent a text message.
Intervention Effectiveness Measure #2	
Intervention Measure Title	The percentage of parents/guardians who received the text message whose eligible adolescents completed the vaccine series.
Numerator Description	The total number of eligible adolescents (whose parents received the text message) who completed the vaccine series.
Denominator Description	The total number of targeted parents of eligible adolescents who received a text message.

Improving Health Risk Assessments

The first intervention WS submitted in Module 3 for validation involved testing outreach using a text message with the ability to complete the HRA using a smart phone. WS will deliver the text script in the member's primary language. The goal of this intervention is to increase the number of members who complete the HRA because of the convenience of using their phone. The intervention effectiveness measure is described below:

Table 3-29—Intervention Effectiveness Measure	
HRA Texting Program	
Intervention Measure Title	The percentage of members who received a text message promoting HRA completion.
Numerator Description	The number of members who completed the HRA assessment through the text message link each month.
Denominator Description	The number of unique members who received the HRA text message each month.

The second intervention WS submitted in Module 3 for validation involved testing a text message that promotes a member incentive for completing the HRA. WS will deliver the text script in the member's primary language. The goal of this intervention is to have more members complete the HRA because of the incentive offered through the text message. The intervention effectiveness measure is described below:

Table 3-30—Intervention Effectiveness Measure	
HRA Incentive Promotion: Text Message Campaign	
Intervention Measure Title	The percentage of members who receive an HRA monetary incentive after receiving the text promotion.

Table 3-30—Intervention Effectiveness Measure	
Numerator Description	The total number of members who received the HRA text message and claimed the HRA incentive.
Denominator Description	The total number of unique members who received the HRA text message each month.

WS achieved all Module 3 validation criteria for both PIPs.

Intervention Testing Check-In

HSAG conducted one of four scheduled intervention check-ins. The first check-in occurred in April 2023. **WS** submitted its PDSA worksheets, two for each PIP topic, and reported the MCO's progress in the intervention testing process. For the *Improving HPV Vaccinations* PIP, the MCO submitted a worksheet for the Effective Education and Enhanced Convenience for Providers intervention. After one testing cycle, **WS** reported that only two of nine providers responded and indicated that peer-to-peer education has the potential to improve the process through which the providers offer effective recommendations to parents. The MCO indicated it will be adapting and retesting the intervention. HSAG will include the results for this intervention in the next annual EQR report.

The second PDSA worksheet **WS** submitted was for the Increased Motivation and Enhanced Convenience for Parents: Text Message Campaign intervention. After two cycles of testing, the MCO reported positive results for Cycle 1, with 72 percent of parents successfully receiving the text message making them aware of the importance of the vaccine (Intervention Effectiveness Measure #1). The data for Cycle 2 and the data for Intervention Effectiveness Measure #2 were not available at the time of this check-in.

For the *Improving Health Risk Assessments* PIP, **WS** submitted a PDSA worksheet for the HRA Texting Program and the HRA Incentive Promotion: Text Message Campaign interventions. At the time of this check-in, the MCO reported that this PIP is a massive interdepartmental undertaking with the potential to significantly improve the HRA completion rates. Before undertaking new HRA interventions and initiatives, **WS** reported that it must make necessary foundational improvements to processes to support new HRA completion methods. Therefore, **WS** had no intervention updates for this check-in.

Conclusions and Recommendations for Improvement

ACNH

ACNH completed two methodologically sound PIPs that met all State and federal requirements. The MCO completed the first three modules of the rapid-cycle PIP process and is currently testing interventions for each topic.

- HSAG recommends that **ACNH** continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.

- HSAG recommends that **ACNH** revisit its QI tools and processes throughout the PIP process to determine new interventions to test until the end of the year, allowing enough time to complete final analyses and final PDSA worksheets by December 31, 2023. The MCO should test as many interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.
- HSAG recommends that **ACNH** complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.
- HSAG recommends that **ACNH** test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **ACNH** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- HSAG recommends that **ACNH** contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.

NHHF

NHHF completed two methodologically sound PIPs that met all State and federal requirements. The MCO completed the first three modules of the rapid-cycle PIP process and is currently testing interventions for each topic.

- HSAG recommends that **NHHF** continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.
- HSAG recommends that **NHHF** revisit its QI tools and processes throughout the PIP process to determine new interventions to test until the end of the year, allowing enough time to complete final analyses and final PDSA worksheets by December 31, 2023. The MCO should test as many interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.
- HSAG recommends that **NHHF** complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.
- HSAG recommends that **NHHF** test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **NHHF** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- HSAG recommends that **NHHF** contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.

WS

WS completed two methodologically sound PIPs that met all State and federal requirements. The MCO completed the first three modules of the rapid-cycle PIP process and is currently testing interventions for each topic.

- HSAG recommends that **WS** continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.
- HSAG recommends that **WS** revisit its QI tools and processes throughout the PIP process to determine new interventions to test until the end of the year, allowing enough time to complete final analyses and final PDSA worksheets by December 31, 2023. The MCO should test as many interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.
- HSAG recommends that **WS** complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.
- HSAG recommends that **WS** test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **WS** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- HSAG recommends that **WS** contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.

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

PMV

HSAG conducted the validation activities in New Hampshire as outlined in the Centers for Medicaid & Medicare Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023.[3-8] The following section of the report describes the results of HSAG's SFY 2023 EQR activities and 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 2023, each MCO submitted rates for 17 State-specific measures

[3-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 17, 2023.

validated during PMV. HSAG offered recommendations to each MCO to facilitate continued 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 3-31 displays the findings from the PMV activities conducted for each MCO in SFY 2023.

Table 3-31—SFY 2023 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, 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.

Considering the issues identified related to National Imaging Associates (NIA) decision categories that **ACNH** incorrectly mapped to *SERVICEAUTH.14* as denials, HSAG recommends that **ACNH** enhance its internal understanding of NIA's utilization management (UM) operations and include confirmation of its understanding within its annual delegation oversight review of NIA to ensure that **ACNH** is appropriately querying from NIA source data for all UM measures in New Hampshire.

ACNH could consider immediately implementing a process to calculate provider appeal turnaround times from the date the appeal is received from the provider instead of relying on the date the appeal is opened within its system. Additionally, **ACNH** should improve upon its internal monitoring process of provider appeals to ensure that the date each appeal is received can be reliably and accurately identified. The *PROVAPPEAL.01* measure must be calculated using the date of receipt of the provider appeal as the start date for reporting turnaround time.

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 PSV without issue. HSAG had no concerns with the measure production for any measure under review this year.

NHHF could continue to explore options to avoid duplicate data entry of appeals in CenPAS and MS SharePoint due to the increased risk of manual documentation errors.

In addition, **NHHF** relied on manual steps to produce the *WITHHOLD.21.01* measure. Manual steps to track completion of comprehensive medication review and counseling and to produce the final measure may result in an increased risk of error. While HSAG identified no issues related to producing the *WITHHOLD.21.01* measure, had the *WITHHOLD.21.01* measure not been retired, HSAG would have recommended that **NHHF** explore opportunities to simplify the manual steps required to produce the Exhibit O report.

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 could maintain the monitoring of its updated *PROVAPPEAL.01* query that was implemented as a result of the SFY 2023 PMV. The updated *PROVAPPEAL.01* query includes identification of negative turnaround times (TATs) for provider appeal resolutions so **WS** can detect data entry errors that occur in documenting the dates for the measures.

WS's source code used the member's hospital admission date associated with the delivery, but the actual date reported was the admission date itself, even if the delivery occurred at a later date during the hospital stay. **WS** should implement additional quality assurance steps to identify any situations where the delivery occurs on a date after the initial hospital admission to adjust the *WITHHOLD.21.05* reporting accordingly.

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-15.

NAV

For SFY 2023, HSAG conducted the following activities to assess the adequacy of the MCOs' network adequacy. The two key tasks performed by HSAG during the SFY 2023 NAV included:

- GeoAccess analysis of the MCOs' provider networks compared to members' residences.
- Network capacity analyses of five provider types to assess whether the MCOs' provider networks met standards for contracting with a minimum percentage of providers per public health region.

The GeoAccess analysis compared the provider data submitted by each MCO to Medicaid member data provided by DHHS to assess whether the MCOs met DHHS' geographic access standards by providing a minimum number of network providers within specific time/distance parameters from members' residences. These standards apply to a broad range of providers, including PCPs, mental health providers, hospitals, and several types of physician specialists. For each MCO and county, HSAG calculated the percentage of members with a provider location within the time and distance requirements.

The network capacity analysis assessed whether the MCOs met network capacity standards for five types of providers: Master's Level Alcohol and Drug Counselors (MLADCs), opioid treatment providers (OTPs), buprenorphine prescribers, residential SUD treatment programs, and peer recovery programs. For the first four of these five categories of SUD providers or services, MCOs are required to contract with a minimum percentage of the total providers licensed and practicing in the State, and no less than two per public health region, unless there are less than two providers in the region.[3-9] For the fifth category, MCOs must contract with all willing peer recovery programs in the State. HSAG assessed whether each MCO met these standards by comparing the provider data submitted by each MCO to lists of providers obtained from DHHS that identified licensed and practicing providers in the State.

[3-9] State of New Hampshire Department of Health and Human Services. (2022). Amendment #8 to the Medicaid Care Management Services Contract, Section 4.7.3.4. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Sept 21, 2023.

Network Capacity Analysis

Network Capacity Findings

HSAG conducted the network capacity analysis by comparing the number of providers associated with each MCO's provider network relative to the total licensed and practicing providers in the State and in each public health region for the five specific provider categories established by DHHS. HSAG encountered challenges with using the DHHS-provided lists for this activity, as they were not developed for this purpose. Due to the challenges surrounding quantifying the statewide denominators for SUD providers and assigning providers to public health regions, HSAG recommended that the network capacity analysis be considered for information only at this point, not as an indication that MCOs met (or failed to meet) a particular standard.

MLADCs

Table 3-32 displays the statewide network capacity analysis results for MLADCs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). Red shading indicates that the MCO did not meet part of the standard. A checkmark in the Requirement Met column indicates that the MCO met both standards; an "X" indicates that the MCO failed to meet one or both standards for that provider category.

Table 3-32—Statewide Network Capacity Analysis Results for MLADCs by MCO

MCO	Standard	Percentage of Providers in the State	Percentage of Regions With Required Number of Providers per Region	Requirement Met
ACNH	70% of all providers / 2 providers per region*	34.2%	100.0%	X
NHHF	70% of all providers / 2 providers per region*	16.5%	92.3%	X
WS	70% of all providers / 2 providers per region*	11.9%	76.9%	X

Note: Red cells indicate that the MCO did not meet applicable capacity requirements for this provider category.
*At least two providers were identified in each region.

These results indicate that none of the MCOs was able to meet the statewide standard of contracting with 70 percent of all licensed and practicing MLADCs. Only one of the three MCOs, **ACNH**, was able to contract with the minimum number of providers in each public health region. None of the MCOs met both parts of the standard.

OTPs

Table 3-33 displays the statewide network capacity analysis results for OTPs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). As noted in Appendix G of the NAV report, discussions after finalizing the NAV Annual report revealed that the MCOs had been instructed to use a specific list of providers to identify the universe of OTPs licensed and practicing in the State. That list did not include three providers counted in the analysis in Table 3-33. Due to this known issue with the denominator, DHHS determined that the MCOs should not be assessed on whether they met the capacity standard for OTPs.

Table 3-33—Statewide Network Capacity Analysis Results for OTPs by MCO

MCO	Standard	Percentage of Providers in the State	Percentage of Regions With Required Number of Providers per Region	Requirement Met
ACNH	75% of all providers / 2 providers per region*	92.3%	100.0%	✓
NHHF	75% of all providers / 2 providers per region*	92.3%	100.0%	✓
WS	75% of all providers / 2 providers per region*	61.5%	76.9%	X

*Two providers are required in any public health region unless there are less than two providers in the region. Only one provider was identified in each the following regions: Capital, Greater Monadnock, Greater Nashua, South Central, Strafford County, Upper Valley, and Winnipesaukee. No providers were identified in each of the following regions: Carroll County, Central New Hampshire, Greater Sullivan, and North Country.

These results indicate that contracting with sufficient OTPs to meet the State's standards presented less of a challenge than contracting with MLADCs. Two MCOs were able to meet both parts of the standard for OTPs, with access rates substantially greater than the results for the third MCO, WS, which met neither requirement.

Buprenorphine Prescribers

Table 3-34 displays the statewide network capacity analysis results for buprenorphine prescribers (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers).

Table 3-34—Statewide Network Capacity Analysis Results for Buprenorphine Prescribers by MCO

MCO	Standard*	Percentage of Providers in the State	Percentage of Regions With Required Number of Providers per Region
ACNH	75% of all providers/ 2 providers per region*	63.5%	100.0%
NHHF	75% of all providers/ 2 providers per region*	64.8%	100.0%
WS	75% of all providers/ 2 providers per region*	50.5%	100.0%

Note: HSAG obtained a list of buprenorphine prescribers from the Substance Abuse and Mental Health Services Administration (SAMHSA) through a link provided by DHHS on November 7, 2022. While accurate at that time, DHHS acknowledges there have been subsequent changes to federal reporting requirements that are not reflected in the list. Results should be interpreted with caution.
*At least two providers were identified in each region.

These results indicate that all three MCOs were able to meet the regional standard, contracting with available buprenorphine prescribers in all public health regions. However, all three faced significant challenges meeting the statewide standard of contracting with 75 percent of licensed and practicing buprenorphine prescribers.

Residential SUD Treatment Programs

Table 3-35 displays the statewide network capacity analysis results for residential SUD treatment programs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). Red shading indicates that the MCO did not meet part of the standard. A checkmark in the Requirement Met column indicates that the MCO met both standards; an "X" indicates that the MCO failed to meet both standards for that provider category.

Table 3-35—Statewide Network Capacity Analysis Results for Residential SUD Treatment Programs by MCO

MCO	Standard	Percentage of Providers in the State	Percentage of Regions With Required Number of Providers per Region	Requirement Met
ACNH	50% of all providers/ 2 providers per region*	64.0%	38.5%	X
NHHF	50% of all providers/ 2 providers per region*	60.0%	38.5%	X
WS	50% of all providers/ 2 providers per region*	56.0%	69.2%	X

Note: Red cells indicate that the MCO did not meet applicable capacity requirements for this provider category.
*Two providers are required in any public health region unless there are less than two providers in the region. Only one provider was identified in each the following regions: Carroll County, Central New Hampshire, Greater Sullivan, and Seacoast.

These results indicate that all three MCOs were able to meet the statewide standard of contracting with 50 percent of all residential SUD treatment program providers, but none met the regional access requirement.

Peer Recovery Programs

Table 3-36 displays the statewide network capacity analysis results for peer recovery programs (i.e., the percentage of willing programs in New Hampshire identified in each MCO's provider data).

Table 3-36—Statewide Network Capacity Analysis Results for Willing Peer Recovery Programs by MCO

MCO	Percentage of Providers in the State
ACNH	64.3%
NHHF	60.7%
WS	3.6%

Note: WS indicated that peer recovery support services were provided and billed from a variety of SUD and mental health providers but were not separately identified in its provider data.

These results indicate that all MCOs faced challenges meeting the statewide standard of access to 100 percent of willing peer recovery programs in the State, although ACNH's and NHHF's provider data identified 64.3 percent and 60.7 percent of the State's willing peer recovery programs, respectively. WS's data permitted identification of only 3.6 percent of the State's peer recovery programs; however, WS explained that peer recovery services were not tracked in its provider data. Unlike the other four network capacity standards, there is no regional requirement for this provider category.

Geographic Network Distribution Analysis

HSAG conducted a geographic distribution analysis of the MCO-contracted providers relative to the MCOs' members.

Adherence to Time/Distance Standards

Table 3-37 displays the percentage of each MCO's members who had the access to care required by contract standards for all applicable provider categories by MCO. Red shading indicates that the MCO did not meet minimum geographic access standards for a specific provider category.

Table 3-37—Percentage of Members With Required Access to Care by Provider Category and MCO

	ACNH	NHHF	WS
Provider Category	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
PCP, Adult	100.0%	100.0%	100.0%

Provider Category	ACNH Percentage of Members With Required Access	NHHF Percentage of Members With Required Access	WS Percentage of Members With Required Access
PCP, Pediatric	100.0%	100.0%	100.0%
Specialist, Adult	100.0%	100.0%	100.0%
Specialist, Pediatric[1]	100.0%	100.0%	100.0%
Obstetrics and Gynecology (OB/GYN) Providers	100.0%	100.0%	100.0%
Hospitals	100.0%	100.0%	100.0%
Tertiary or Specialized Services: Level I or Level II Trauma Centers	> 99.9%	100.0%	99.6%
Tertiary or Specialized Services: Level III or Level IV Neonatal Intensive Care Unit (NICU)	> 99.9%	99.5%	99.5%
Pharmacies	100.0%	100.0%	100.0%
Mental Health Providers, Adult	100.0%	100.0%	99.9%
Mental Health Providers, Pediatric	> 99.9%	99.4%	98.8%
Individual/Group MLADCs[2]	100.0%	99.3%	99.9%
SUD Programs	100.0%	100.0%	100.0%
Adult Medical Day Care	99.4%	98.8%	99.3%
Hospice	99.9%	99.8%	99.9%
Office-Based Occupational Therapists/ Physical Therapists/Speech Therapists (OT/PT/ST)[3]	100.0%	100.0%	100.0%
OT	> 99.9%	100.0%	100.0%
PT	100.0%	100.0%	100.0%
ST	99.9%	99.8%	100.0%

Note: Red cells indicate that the MCO did not meet the minimum geographic access standards for a specific provider category.
[1] The standard refers to specialists as a group, which includes allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), gastroenterologists, hematologists and oncologists, neurologists, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists. These are combined here and considered separately in Table 3-38.
[2] No group MLADCs were identified in plan data, so all MLADCs are individual providers.
[3] The standard refers to these therapists as a group. However, the three therapist types are also presented separately.

These results indicate that all three MCOs were broadly successful at meeting the time/distance standards set by DHHS. **NHHF** met the 100 percent standard for 13 of the 19 provider categories listed above, while **ACNH** and **WS** met the standard for 12 of the 19 provider categories.

Across all three MCOs, the 100 percent standard was met for the following provider categories:

- PCP, Adult and Pediatric
- Specialist, Adult and Pediatric
- OB/GYN Providers
- Hospitals
- Pharmacies
- SUD Programs
- Office-Based OT/ PT/ST
- PT

For provider categories where MCOs were unable to meet the 100 percent score set by DHHS, very few missed the mark by more than a few tenths of a percent, and no final score was less than 98.8 percent. However, none of the three MCOs met the 100 percent standard in the following provider categories:

- Tertiary or Specialized Services: Level III or Level IV NICU
- Mental Health Providers, Pediatric
- Adult Medical Day Care
- Hospice

Table 3-38 examines access to specialists by provider category and displays the percentage of each MCO's members who have the access to care required by contract standards for applicable adult and pediatric specialist providers. DHHS selected these specialties, and they are not named separately in the access standards. Red shading indicates that the MCO did not meet the minimum geographic access standards for a specific provider category.

Table 3-38—Percentage of Members With Required Access to Care by Adult and Pediatric Specialties and MCO

	ACNH	NHHF	WS
Provider Category	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Allergist, Adult	95.3%	92.7%	95.1%
Allergist, Pediatric	77.0%	99.9%	99.6%
Cardiologist, Adult	100.0%	99.1%	99.5%
Cardiologist, Pediatric	100.0%	100.0%	100.0%
Dermatologist, Adult	99.9%	99.7%	99.9%
Dermatologist, Pediatric	> 99.9%	99.9%	99.9%
Endocrinologist, Adult	99.5%	99.2%	99.6%

	ACNH	NHHF	WS
Provider Category	Percentage of Members With Required Access	Percentage of Members With Required Access	Percentage of Members With Required Access
Endocrinologist, Pediatric	100.0%	99.9%	99.9%
Gastroenterologist, Adult	100.0%	100.0%	100.0%
Gastroenterologist, Pediatric	100.0%	99.9%	99.9%
Hematologists and Oncologists, Adult	100.0%	100.0%	100.0%
Hematologists and Oncologists, Pediatric	> 99.9%	99.9%	99.9%
Neurologist, Adult	100.0%	100.0%	100.0%
Neurologist, Pediatric	> 99.9%	100.0%	99.9%
Ophthalmologist, Adult	97.7%	100.0%	100.0%
Ophthalmologist, Pediatric	0.0%	97.1%	0.0%
Orthopedist, Adult	100.0%	100.0%	100.0%
Orthopedist, Pediatric	> 99.9%	99.9%	99.9%
Otolaryngologist, Adult	100.0%	100.0%	100.0%
Otolaryngologist, Pediatric	> 99.9%	99.9%	92.1%
Pulmonologist, Adult	100.0%	100.0%	100.0%
Pulmonologist, Pediatric	100.0%	99.9%	99.9%
SUD Providers, Adult[1]	100.0%	99.8%	100.0%
SUD Providers, Pediatric[1]	100.0%	100.0%	100.0%
Urologist, Adult	100.0%	100.0%	100.0%
Urologist, Pediatric	100.0%	99.9%	99.9%

Note: Red cells indicate that the MCO did not meet the minimum geographic access standards for a specific provider category.
[1] There was no distinction in plan data between SUD providers who serve pediatric or adult members, so the entire population of SUD providers was used to calculate access to pediatric and adult populations.

Members of all three MCOs often had access to specialty care within the time/distance standards. All **ACNH** members had access within the standard for 15 of the 26 provider specialist categories listed above, while members of **NHHF** and **WS** each had access within the standard for 11 of the 26 provider specialist categories. For provider categories where the MCOs were unable to achieve the 100 percent score set by DHHS, very few missed the mark by more than a few percentage points.

None of the three MCOs were able to provide 100 percent of members access to adult allergists. However, their results were similar, ranging from 92.7 percent to 95.3 percent of members with access

in accordance with standards. This suggests a lack of appropriate available providers, rather than an MCO-specific issue.

On the other hand, several results suggest particular challenges for specific MCOs. Results were widely divergent for levels of access to pediatric ophthalmologists, with two MCOs (**ACNH** and **WS**) appearing to provide no access to these specialists, while **NHHF** provided access to 97.1 percent of its members. **ACNH** had substantially lower levels of access to pediatric allergists than the other MCOs, with only 77.0 percent of members having access (as opposed to **NHHF** with greater than 99.9 percent, and **WS** with 99.6 percent).

Other results that might suggest challenges for particular MCOs are on a smaller scale and less concerning. **WS** provided access to pediatric otolaryngologists for 92.1 percent of members, while the other two MCOs achieved access for at least 99.9 percent of members. **ACNH** provided access to adult ophthalmologists for 97.7 percent of members, while the other two MCOs achieved 100 percent access for that provider category.

Health Plan-Specific Conclusions and Recommendations

Drawing from the results of the SFY 2023 NAV, HSAG provides 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

HSAG recommends that **ACNH** should review the provider categories for which it did not meet the time/distance standards and assess whether this is due to a lack of providers available for contracting in the area, lack of providers willing to contract with the MCO, an inability to identify the providers in the data, or other reasons.

HSAG recommends that **ACNH** should continue to monitor processes for creating the provider network data files and review the files for accuracy prior to submitting to HSAG.

NHHF

HSAG recommends that **NHHF** should review the provider categories for which it did not meet the time/distance standards and assess whether this is due to a lack of providers available for contracting in the area, lack of providers willing to contract with the MCO, an inability to identify the providers in the data, or other reasons.

HSAG recommends that **NHHF** should continue to monitor processes for creating the provider network data files and review the files for accuracy prior to submitting to HSAG.

WS

HSAG recommends that **WS** should review the provider categories for which it did not meet the time/distance standards and assess whether this is due to a lack of providers available for contracting in the area, lack of providers willing to contract with the MCO, an inability to identify the providers in the data, or other reasons.

HSAG recommends that **WS** should continue to monitor processes for creating the provider network data files and review the files for accuracy prior to submitting to HSAG.

For additional information concerning HSAG's methodology for validating network adequacy, see Appendix B. Methodologies for Conducting EQR Activities, page B-18.

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.[3-10]

The CAHPS 5.1H Surveys include a set of standardized items including four global ratings and four composite scores.[3-11] 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 3-39 and Table 3-40. 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.

[3-10] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2022.

[3-11] For this report, the 2023 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 3-39 contains the adult Medicaid CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to the NCQA national averages.

Table 3-39—ACNH, NHHF, and WS Adult Medicaid CAHPS Results

CAHPS Measure	2023 Adult Medicaid Positive Rates	2022 National Average Comparison*	2023 Adult Medicaid Positive Rates	2022 National Average Comparison*	2023 Adult Medicaid Positive Rates	2022 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**74.7%**	—	**80.3%**	—	**78.1%**	—
Rating of All Health Care	**75.8%**	—	**77.8%**	—	**69.5%**	—
Rating of Personal Doctor	**79.9%**	—	**81.0%**	—	**78.0%**	—
Rating of Specialist Seen Most Often	**86.9%+**	—	**83.2%**	—	**77.0%**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**77.3%**	—	**82.8%**	—	**80.5%**	—
Getting Care Quickly	**78.8%**	—	**83.3%**	—	**79.6%**	—
How Well Doctors Communicate	**95.2%**	—	**90.8%**	—	**91.1%**	—
Customer Service	**89.9%+**	—	**88.9%**	—	**88.8%**	—

* The 2022 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 neither statistically significantly higher nor lower than the national average.

Table 3-40 contains the general child CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to NCQA national averages.

Table 3-40—ACNH, NHHF, and WS Child Medicaid CAHPS Results

CAHPS Measure	2023 Child Medicaid Positive Rates	2022 National Average Comparison*	2023 Child Medicaid Positive Rates	2022 National Average Comparison*	2023 Child Medicaid Positive Rates	2022 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**80.9%**	↓	**87.4%**	—	**84.7%**	—
Rating of All Health Care	**83.1%**	—	**81.7%**	↓	**82.2%**	↓
Rating of Personal Doctor	**84.3%**	↓	**91.9%**	—	**86.5%**	↓
Rating of Specialist Seen Most Often	**87.2%+**	—	**89.3%+**	—	**77.8%**	↓
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**85.7%+**	—	**86.2%**	—	**84.5%**	—
Getting Care Quickly	**88.9%**	—	**89.6%**	—	**87.7%**	—
How Well Doctors Communicate	**96.3%**	—	**96.2%**	↑	**94.9%**	—
Customer Service	**96.3%+**	↑	**91.3%+**	—	**90.4%+**	—

* The 2022 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 2023, and members returned 227 completed surveys. After excluding ineligible members, the response rate was 11.3 percent. In 2023, the **ACNH** adult Medicaid response rate was lower than the 2022 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 13.0 percent. Figure 3-1 and Figure 3-2 show **ACNH**'s adult Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.

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

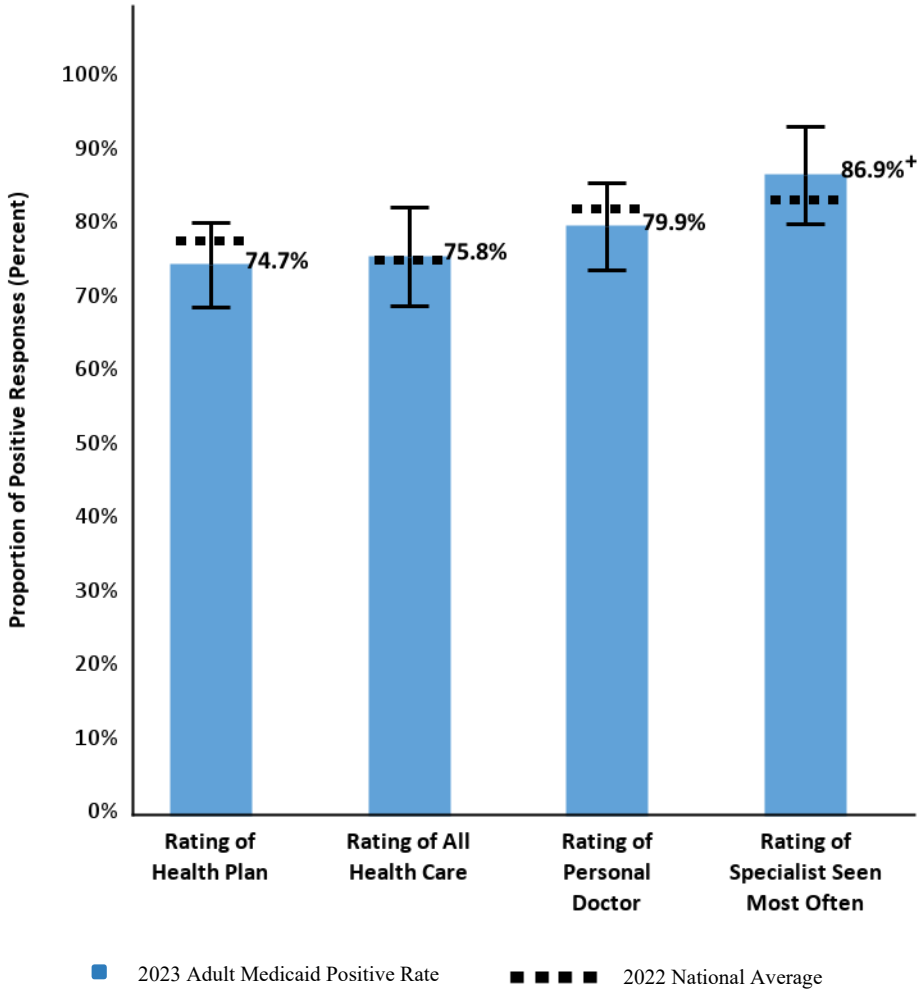
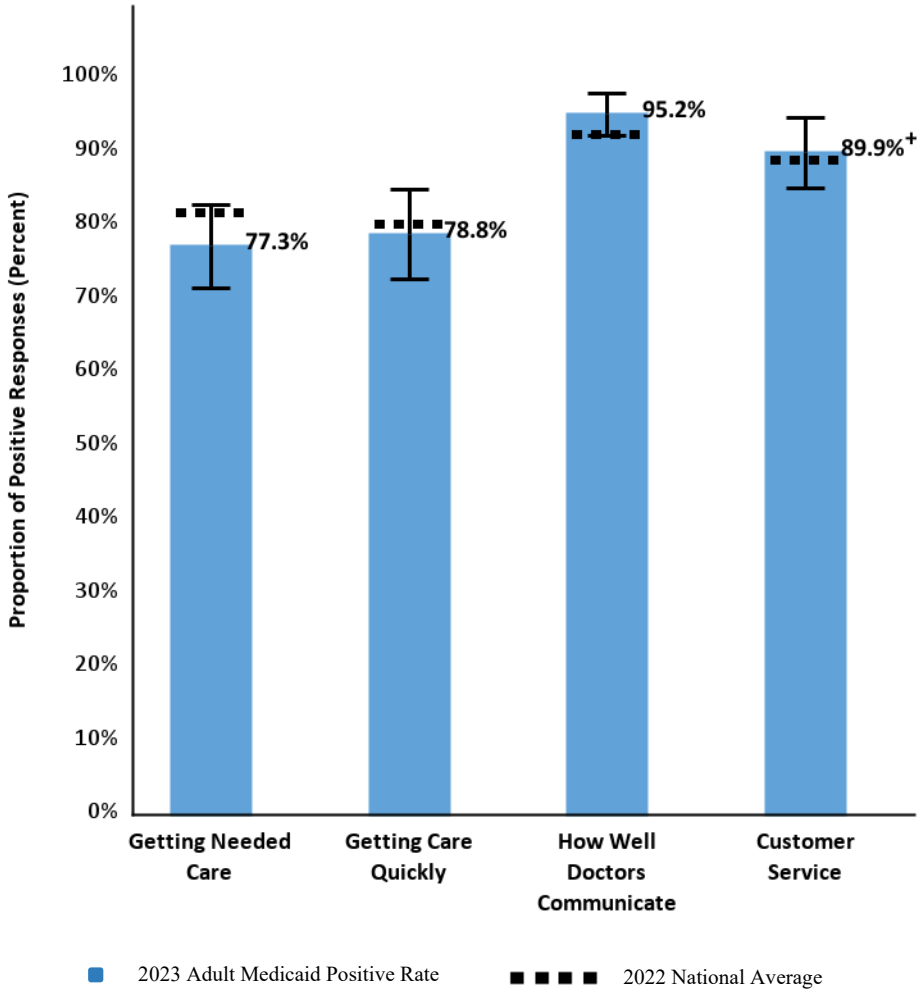


Figure 3-2—ACNH Adult Medicaid CAHPS Results: Composite Measures

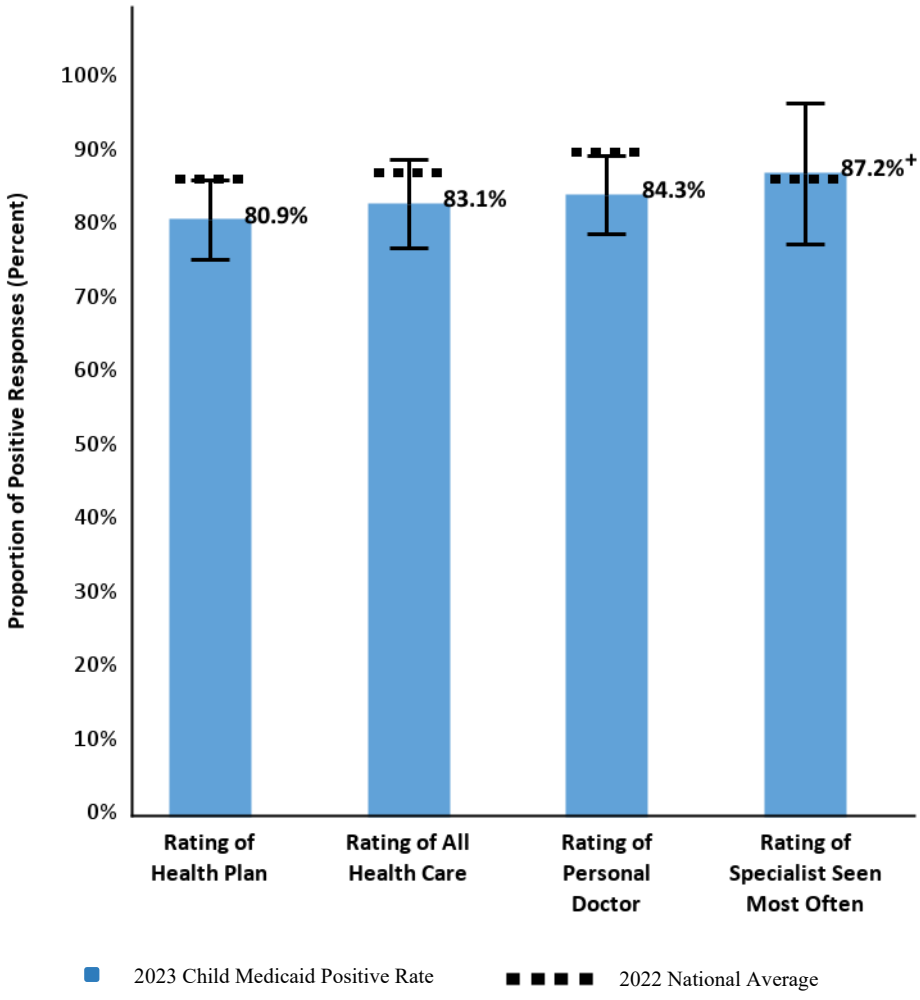


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

For **ACNH**'s adult Medicaid population, four rates, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2022 national averages. However, no measure rates were statistically significantly higher than the national averages.

ACNH surveyed 2,063 general child Medicaid members in 2023, and parents/caretakers of child members returned 216 completed surveys. After excluding ineligible members, the response rate was 10.6 percent. In 2023, the **ACNH** general child Medicaid response rate was lower than the 2022 NCQA national average response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set, which was 12.2 percent.[3-12] Figure 3-3 and Figure 3-4 show **ACNH**'s general child Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.[3-13]

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

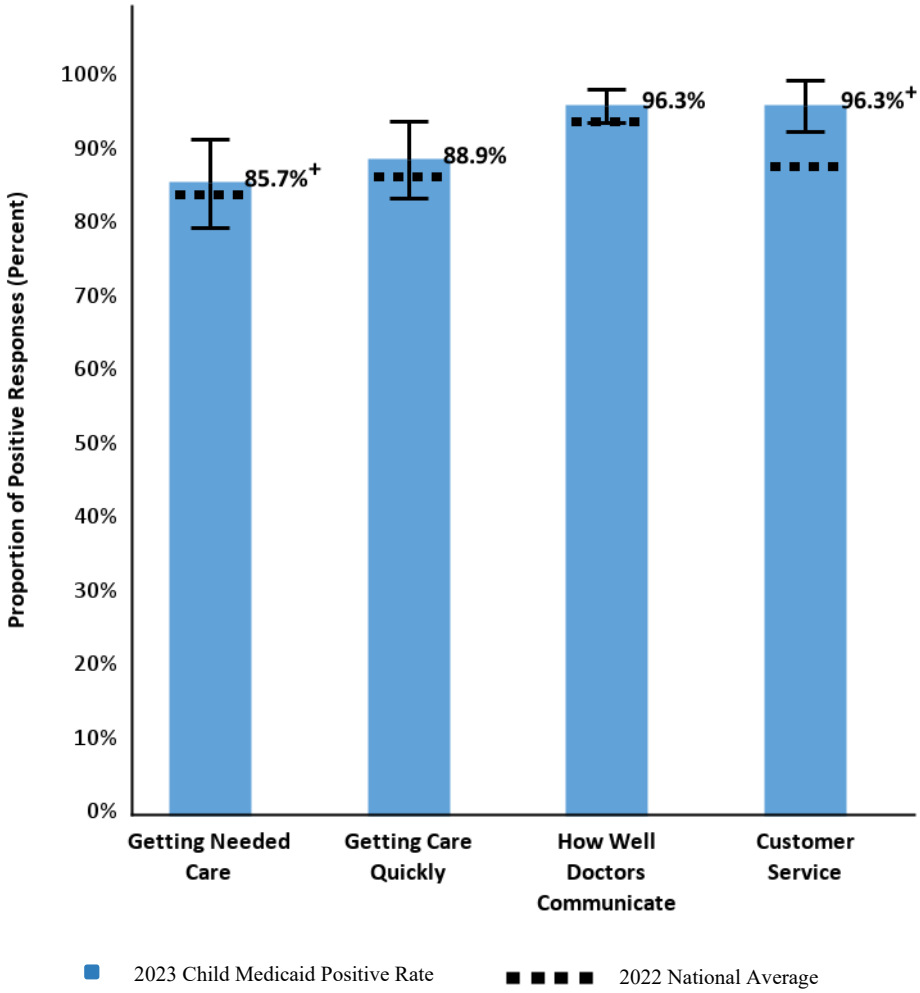


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[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 2023 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, five rates, *Rating of Specialist Seen Most Often, Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* exceeded NCQA's 2022 national averages. The measure rate for *Customer Service* was statistically significantly higher than the national average, while the measure rates for *Rating of Health Plan* and *Rating of Personal Doctor* were statistically significantly lower than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and general child Medicaid populations' 2023 CAHPS survey results to the 2022 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Two of the 2023 measure rates for the general child Medicaid population were statistically significantly lower than the 2022 NCQA Medicaid national averages; therefore, HSAG recommends that **ACNH** focus ***quality of care*** improvement efforts on the *Rating of*

Health Plan and *Rating of Personal Doctor* measures for the general child population. 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* measure for the general child population and the *Rating of Health Plan, Rating of Personal Doctor, Getting Needed Care* and *Getting Care Quickly* measures for the adult population, as these rates also fell below the national averages.

The rates for *Rating of Health Plan*, *Rating of All Health Care*, 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 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. Additionally, **ACNH** could consider any barriers to receiving timely care from specialists that may result in lower levels of experience. 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 and implement QI strategies to address these concerns.

The rates for *Getting Needed Care* and *Getting Care Quickly* could be improved by evaluating the process of care delivery and identifying if there are any operational issues contributing to access to care barriers for members. **ACNH** could explore ways to 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, **ACNH** could consider implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

NHHF

NHHF surveyed 2,376 adult Medicaid members in 2023, and members returned 330 completed surveys. After excluding ineligible members, the response rate was 14.0 percent. In 2023, the **NHHF** adult Medicaid response rate was higher than the 2022 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 13.0 percent. Figure 3-5 and Figure 3-6 show **NHHF**'s adult Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.

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

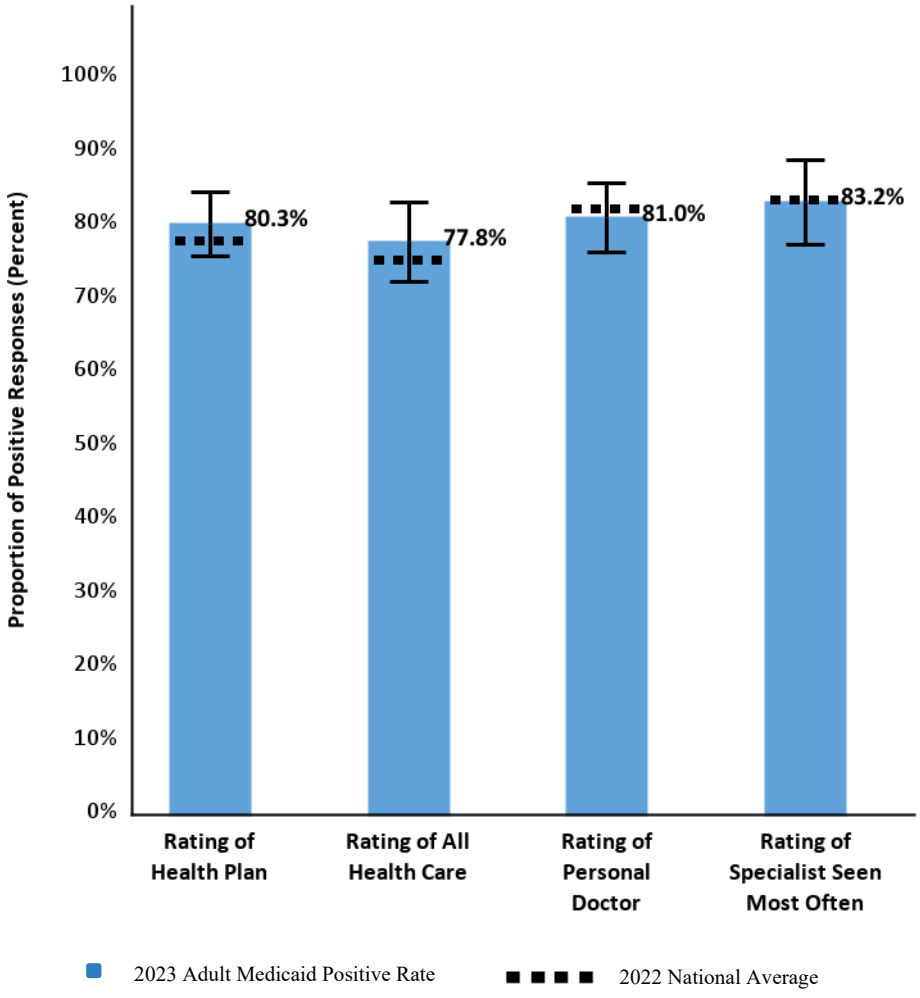
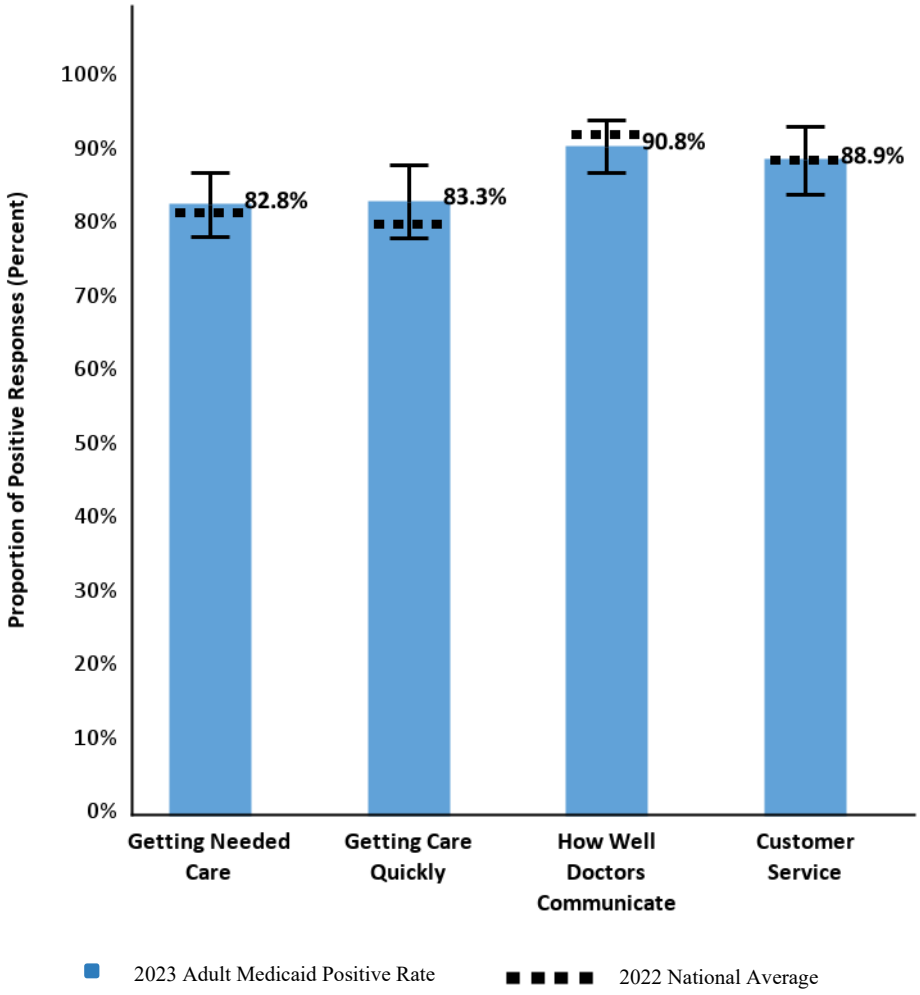


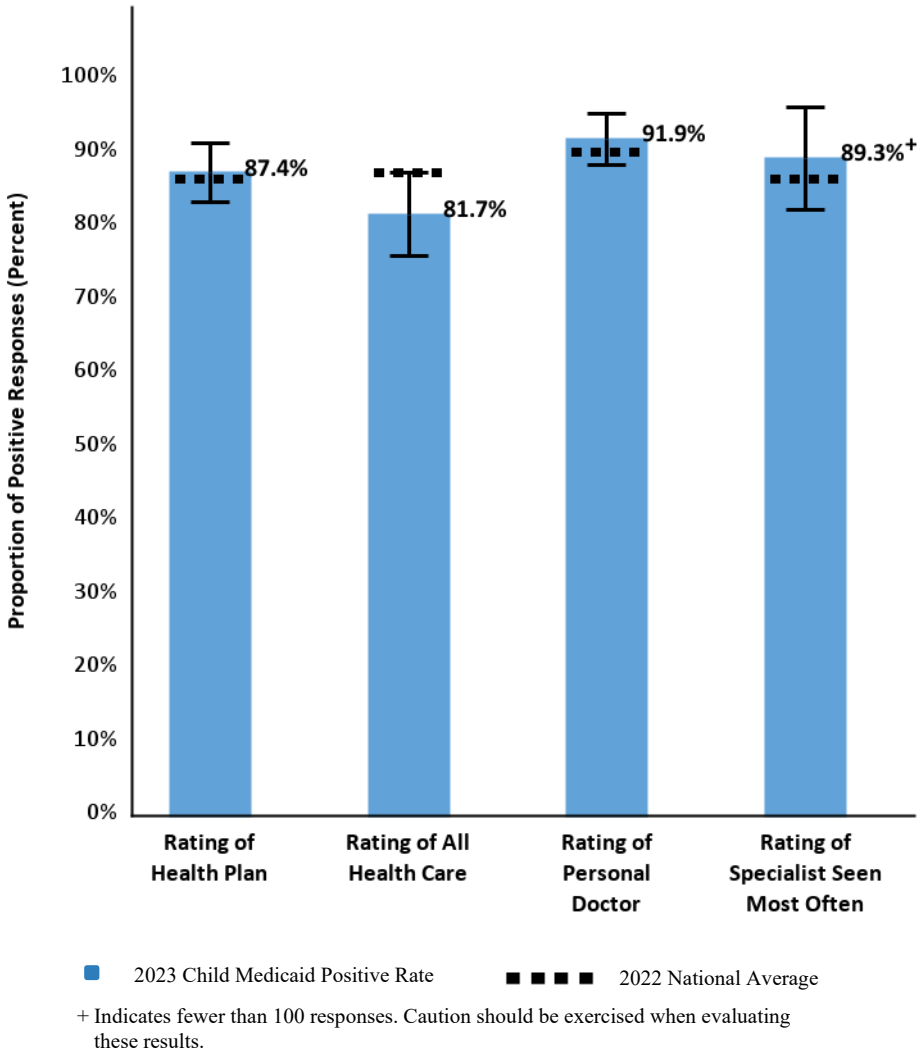
Figure 3-6—NHHF Adult Medicaid CAHPS Results: Composite Measures



For **NHHF**'s adult Medicaid population, four rates, *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*, exceeded NCQA's 2022 national averages. However, no measure rates were statistically significantly higher than the national averages.

NHHF surveyed 2,640 general child Medicaid members in 2023, and parents/caretakers of child members returned 266 completed surveys. After excluding ineligible members, the response rate was 10.2 percent. In 2023, the **NHHF** general child Medicaid response rate was lower than the 2022 NCQA national average response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, which was 12.2 percent.[3-14] Figure 3-7 and Figure 3-8 show **NHHF**'s general child Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.[3-15]

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

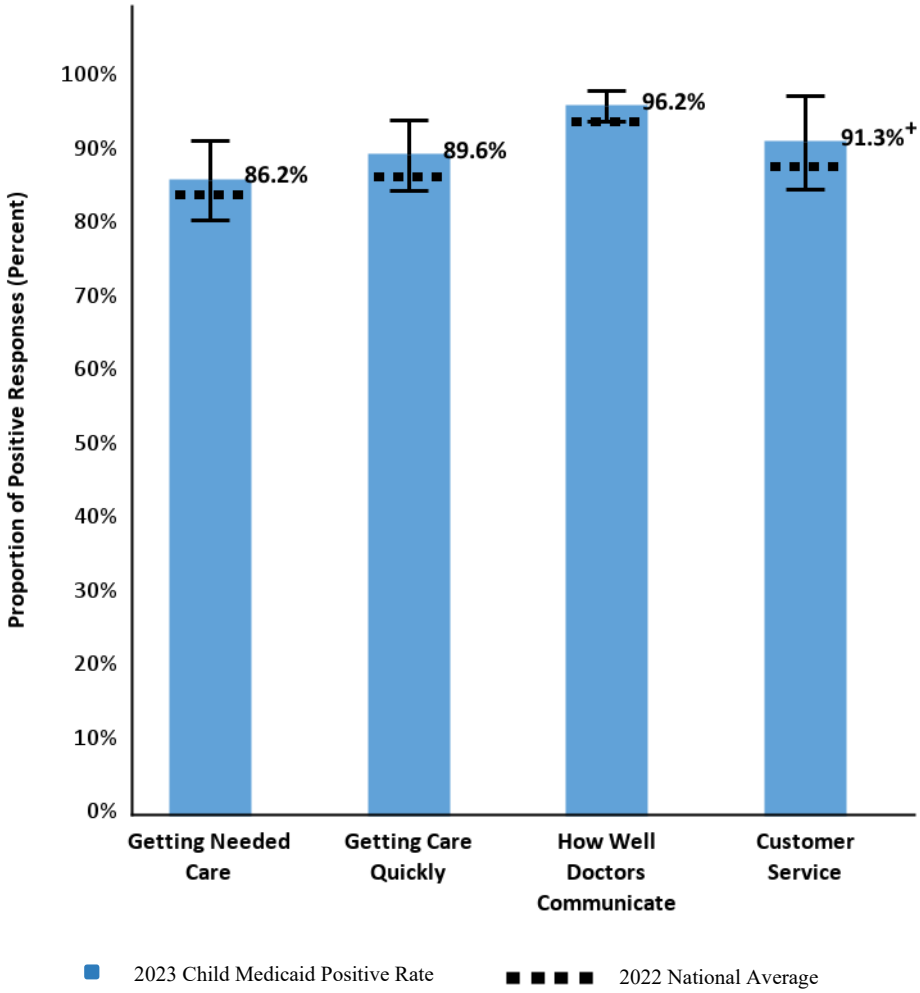


+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[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 2023 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, seven rates, *Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2022 national averages. The measure rate for *How Well Doctors Communicate* was statistically significantly higher than the national average, while the measure rate for *Rating of All Health Care* was statistically significantly lower than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and general child Medicaid populations' 2023 CAHPS survey results to the 2022 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. One of the 2023 measure rates for the general child Medicaid population was statistically significantly lower than the 2022 NCQA Medicaid national average; therefore, HSAG

recommends that **NHHF** focus ***quality of care*** improvement efforts on the *Rating of All Health Care* measure for the general child population. In addition, HSAG recommends that **NHHF** focus ***quality of care*** and ***access to care*** improvement efforts on *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often, How Well Doctors Communicate,* and *Customer Service* for the adult population as these rates fell below the national averages.

The rates for *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **NHHF** could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient experience, 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 and implement strategies to address these concerns.

The rate 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 spending adequate time with the member to provide the quality of care the member anticipates or expects to meet their 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 rate 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. Improving the *Customer Service* rate may 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 3,713 adult Medicaid members in 2023, and members returned 346 completed surveys. After excluding ineligible members, the response rate was 9.5 percent. In 2023, the **WS** adult Medicaid response rate was lower than the 2022 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 13.0 percent. Figure 3-9 and Figure 3-10 show **WS**'s adult Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.

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

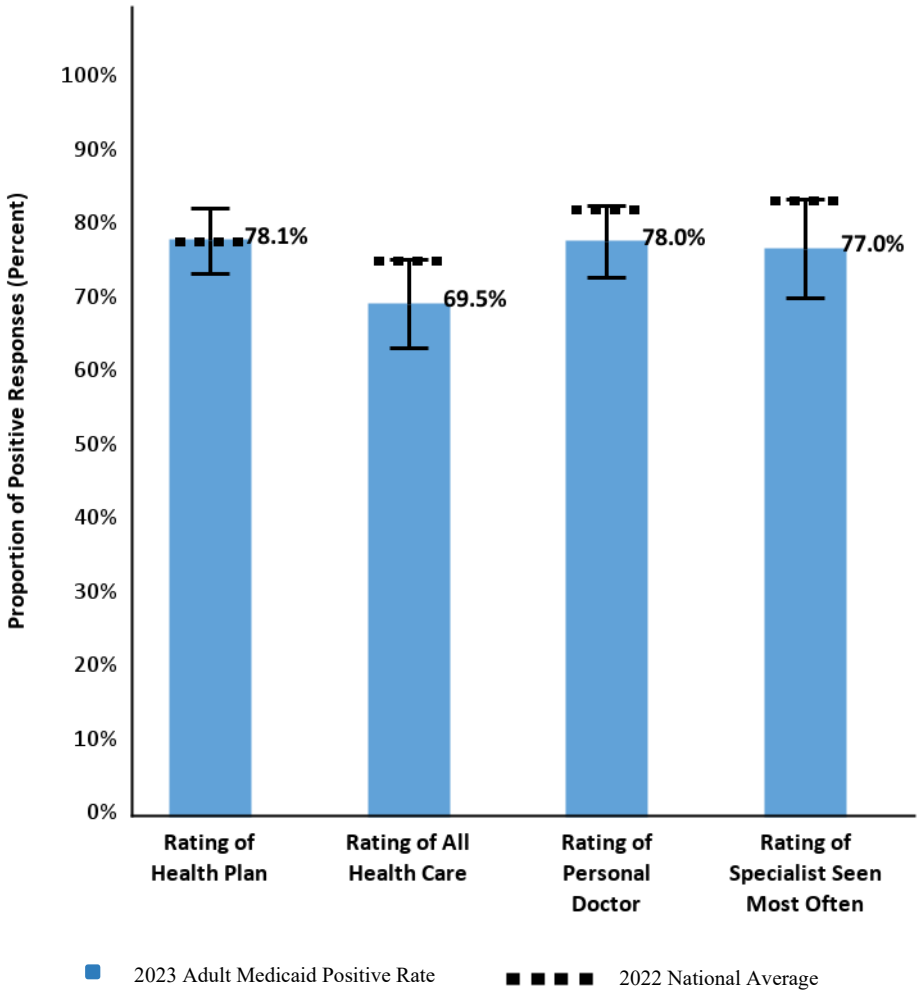
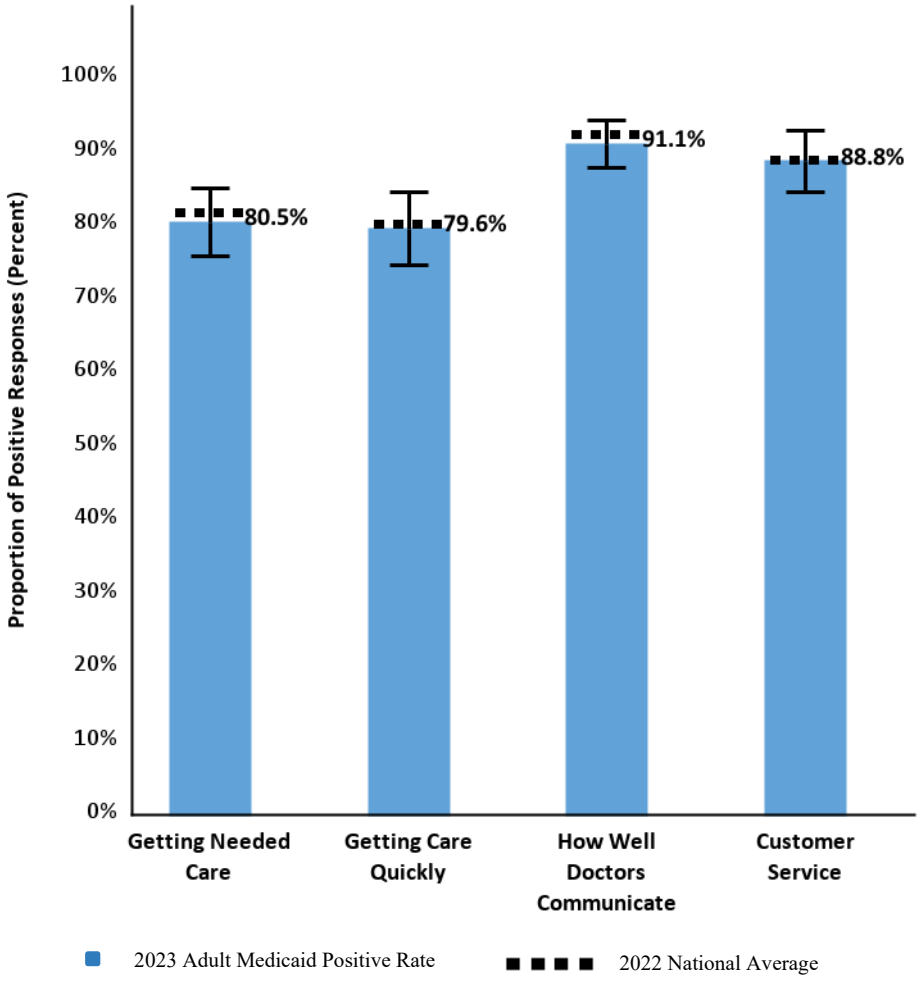


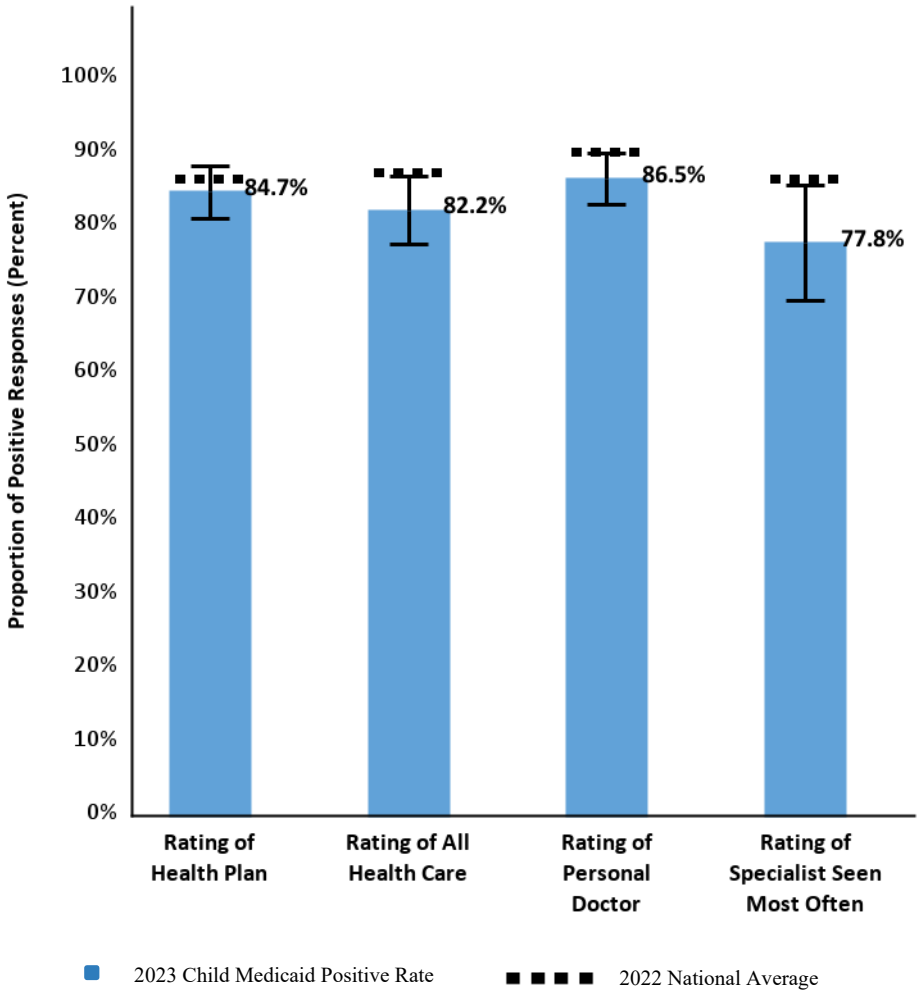
Figure 3-10—WS Adult Medicaid CAHPS Results: Composite Measures



For **WS**'s adult Medicaid population, one rate, *Rating of Health Plan*, exceeded NCQA's 2022 national average. However, no measure rates were statistically significantly higher than the national averages.

WS surveyed 4,538 general child Medicaid members in 2023, and parents/caretakers of child members returned 414 completed surveys. After excluding ineligible members, the response rate was 9.2 percent. In 2023, the **WS** general child Medicaid response rate was lower than the 2022 NCQA national average response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, which was 12.2 percent.[3-16] Figure 3-11 and Figure 3-12 show **WS**'s general child Medicaid 2023 positive rates, and comparisons of the lower and upper confidence intervals to the 2022 NCQA national averages for the global ratings and composite measures, respectively.[3-17]

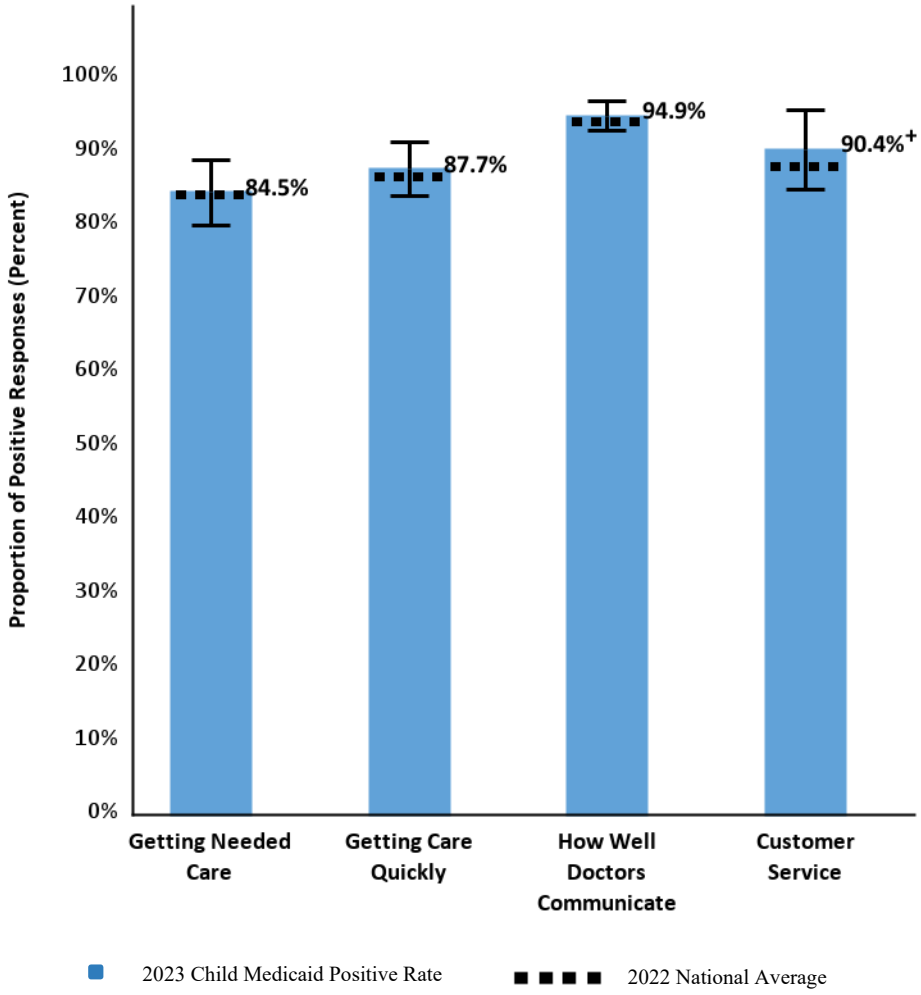
Figure 3-11—WS Child Medicaid CAHPS Results: Global Ratings



[3-16] 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).

[3-17] The 2023 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, four rates, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2022 national averages. The measure rates for *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* were statistically significantly lower than the national averages.

Conclusions and Recommendations for Improvement

HSAG performed a comparison of the adult and general child Medicaid populations' 2023 CAHPS survey results to the 2022 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Three of the 2023 measure rates for the general child Medicaid population were statistically significantly lower than the 2022 NCQA Medicaid national averages; therefore, HSAG recommends that **WS** focus on quality of care improvement efforts for the *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often*

measures for the general child population. In addition, HSAG recommends that **WS** focus on ***quality of care***, ***timeliness of care***, and ***access to care*** improvement efforts for the *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service* measures for the adult 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 All Health Care, 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 experience, 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.

The rates for *Getting Needed Care* and *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. **WS** 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, **WS** could consider implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

The rate for *How Well Doctors Communicate* could be improved by providing literature to doctors and other clinicians containing guidelines for how they can ensure that 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 spending adequate time with members to provide the quality of care that members anticipate or expect to meet their healthcare needs. Improvement in interpersonal skills and doctor communication will positively impact ***quality of care***. **WS** 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 for its members related to how their doctor communicates with them.

The rate for *Customer Service* could be improved by conducting an evaluation of current MCO call center hours and practices to determine if the hours and resources meet members' needs. **WS** could further promote the use of existing after-hours customer service to improve customer service results.

Improving the *Customer Service* rate may 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. **WS** could appoint workgroups comprised of call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

For additional information concerning HSAG's methodology for evaluating CAHPS results, see Appendix B. Methodologies for Conducting EQR Activities, page B-20.

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.[3-18] **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), information systems (IS) compliance tools, and the interactive data submission system (IDSS) files approved by an NCQA-licensed organization (LO).

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 were 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.

[3-18] 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.

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 are 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

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

MCO HEDIS Rates With Statewide Averages

HSAG compared the measurement year (MY) 2022 HEDIS rates for the three MCOs and provided a statewide average.

For four measures, *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD), Plan All-Cause Readmissions (PCR),* 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 2022 rates to national benchmarks that are based on NCQA's Quality Compass[3-19] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2021, the most recent benchmarks available for comparison.

Table 3-41 displays the HEDIS MY 2022 rates for the MCOs, the statewide average rate, and the HEDIS MY 2022 statewide average percentile ranking.

Table 3-41—HEDIS MY 2022 Health Plan Comparison Table

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Prevention					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total	72.01%	77.38%	74.48%	74.88%	25th–49th Percentile
Breast Cancer Screening (BCS)					
Breast Cancer Screening	54.13%	57.06%	49.71%	53.54%	50th–74th Percentile

[3-19] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.42%	59.09%	57.16%	59.28%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	79.10%	77.51%	73.31%	75.95%	75th–89th Percentile
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	65.59%	70.17%	64.19%	66.59%	75th–89th Percentile
12–17 Years	54.19%	61.86%	54.77%	57.57%	50th–74th Percentile
18–21 Years	27.36%	35.76%	29.39%	31.75%	50th–74th Percentile
Total	55.22%	61.15%	55.25%	57.55%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body-Mass Index (BMI) Percentile—Total	63.75%	72.99%	74.93%	73.12%	25th–49th Percentile
Counseling for Nutrition—Total	61.56%	72.99%	71.43%	71.14%	25th–49th Percentile
Counseling for Physical Activity—Total	57.91%	67.40%	65.50%	65.55%	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])	66.42%	72.02%	65.69%	68.08%	50th–74th Percentile

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	42.34%	38.93%	43.80%	41.74%	50th–74th Percentile
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	62.26%	78.83%	73.24%	74.73%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	22.04%	33.33%	27.01%	29.24%	<25th Percentile
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening	47.20%	54.99%	57.65%	54.33%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.11%	0.12%	0.12%	0.12%	≥90th Percentile
Chlamydia Screening in Women (CHL)					
16–20 Years	46.55%	46.58%	42.23%	44.46%	<25th Percentile
21–24 Years	54.58%	56.57%	53.71%	55.00%	<25th Percentile
Total	51.53%	50.25%	46.23%	48.59%	<25th Percentile
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	80.29%	79.32%	85.30%	81.86%	25th–49th Percentile
Postpartum Care	79.81%	78.10%	83.51%	80.62%	50th–74th Percentile
Lead Screening in Children (LSC)					
Lead Screening in Children	69.83%	68.13%	65.69%	67.56%	50th–74th Percentile

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Acute and Chronic Care					
Appropriate Testing for Pharyngitis (CWP)					
Total	79.37%	80.11%	82.17%	80.92%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)					
Total	95.25%	95.80%	96.00%	95.81%	75th–89th Percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)					
Bronchodilator	87.50%	85.57%	95.40%	89.66%	75th–89th Percentile
Systemic Corticosteroid	83.33%	83.51%	88.51%	85.34%	≥90th Percentile
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)					
*Poor HbA1c Control (>9.0%)**	53.77%	37.96%	34.55%	40.12%	25th–49th Percentile
HbA1c Control (<8.0%)	40.39%	49.39%	56.20%	50.08%	25th–49th Percentile
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	57.42%	61.31%	66.91%	62.52%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)					
Total	73.15%	71.53%	72.62%	72.35%	NC
Plan All-Cause Readmissions (PCR)					
*Observed Readmissions—Total**	8.89%	9.60%	10.35%	9.75%	25th–49th Percentile
Asthma Medication Ratio (AMR)					
Total	52.61%	62.96%	65.53%	63.05%	25th–49th Percentile

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Ambulatory Care (AMB)***					
*Emergency Department (ED) Visits—Total**	533.93	521.49	498.53	513.68	50th–74th Percentile
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	57.53%	49.81%	53.70%	53.37%	75th–89th Percentile
30-Day Follow-Up—Total	70.86%	71.64%	71.45%	71.37%	75th–89th Percentile
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***	77.97%	75.00%	76.59%	76.33%	<25th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	62.75%	61.29%	62.96%	25th–49th Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.41%	75.10%	72.64%	72.41%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose Testing—Total	50.88%	57.14%	54.32%	55.29%	50th–74th Percentile
Cholesterol Testing—Total	33.33%	36.25%	30.77%	33.10%	25th–49th Percentile
Blood Glucose and Cholesterol Testing—Total	29.82%	35.18%	29.98%	32.07%	25th–49th Percentile

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
Total	NA	72.67%	61.64%	65.95%	50th–74th Percentile
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	69.99%	66.79%	63.92%	66.38%	75th–89th Percentile
Effective Continuation Phase Treatment	57.89%	50.11%	47.35%	50.82%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	45.78%	53.56%	41.46%	46.11%	75th–89th Percentile
Continuation and Maintenance Phase	NA	56.59%	42.28%	48.86%	25th–49th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)					
Initiation of SUD Treatment—Total	55.24%	44.32%	47.17%	48.36%	NC
*Engagement of SUD Treatment—Total***	27.01%	24.05%	24.37%	24.96%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	65.34%	64.40%	61.68%	63.34%	≥90th Percentile
30-Day Follow-Up—Total	75.46%	73.26%	72.97%	73.54%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)					
7-Day Follow-Up—Total	46.19%	41.94%	46.57%	45.08%	NC
30-Day Follow-Up—Total	56.68%	56.61%	60.53%	58.27%	NC

Performance Measure HEDIS MY 2022	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2022 Statewide Average Percentile
Pharmacotherapy for Opioid Use Disorder (POD)					
Total	28.62%	30.99%	26.35%	28.31%	25th–49th Percentile

* For this indicator, a lower rate indicates better performance.
** This measure was 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 3-42 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 2022 representing MY 2021.

Table 3-42—Summary of the New Hampshire MCM Program Statewide Scores for MY 2022 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	3	8	7	4	**23**
Acute and Chronic Care	2	2	2	4	0	**10**
Behavioral Health	2	6	2	5	1	**16**
All Domains	**5**	**11**	**12**	**16**	**5**	**49**
Percentage	**10.20%**	**22.45%**	**24.49%**	**32.65%**	**10.20%**	**100%**

The New Hampshire statewide Medicaid rates ranked at or above the 50th percentile for 28 measures (57.14 percent), with five of these measures (10.20 percent) meeting or exceeding the 90th percentile. A total of 21 measures (42.86 percent) fell below the 50th percentile, with five of the measures (10.20 percent) falling below the 25th percentile.

The following statewide average rates met or exceeded the HEDIS MY 2022 statewide average 90th percentile:

- One Prevention measure indicator rate: *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Two Acute and Chronic Care measure indicator rates: *Appropriate Testing for Pharyngitis (CWP)—Total* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*

- Two BH measure indicator rates: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

The following statewide average rates fell below the HEDIS MY 2022 statewide average 25th percentile:

- Four Prevention measure indicator rates: *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)* and *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total*
- One BH measure indicator rate: *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

ACNH

Table 3-43 below contains **ACNH**'s HEDIS MY 2022 performance measure rates and **ACNH**'s HEDIS MY 2022 percentile ranking as compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021. 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 3-43—ACNH HEDIS MY 2020, MY 2021, and MY 2022 Rates, and MY 2022 Percentile Rankings

ACNH HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	74.64%	74.75%	72.01%	25th–49th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening	NA	52.69%	54.13%	50th–74th 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%	62.42%	75th–89th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	NA	70.21%	79.10%	≥90th Percentile
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	54.34%	65.66%	65.59%	75th–89th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
12–17 Years	44.71%	56.34%	54.19%	50th–74th Percentile
18–21 Years	23.75%	29.29%	27.36%	50th–74th Percentile
Total	45.58%	55.85%	55.22%	50th–74th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	55.47%	69.34%	63.75%	<25th Percentile
Counseling for Nutrition—Total	61.31%	69.59%	61.56%	<25th Percentile
Counseling for Physical Activity—Total	55.23%	66.91%	57.91%	<25th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)	—	66.18%	66.42%	50th–74th Percentile
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	24.39%	41.12%	42.34%	75th–89th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	NA	61.69%	62.26%	<25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	NA	25.00%	22.04%	<25th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	36.98%	46.23%	47.20%	<25th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.32%	0.00%	0.11%	≥90th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	43.64%	47.26%	46.55%	25th–49th Percentile
21–24 Years	50.89%	60.60%	54.58%	<25th Percentile
Total	48.21%	55.42%	51.53%	25th–49th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	80.94%	82.73%	80.29%	<25th Percentile
Postpartum Care	75.25%	80.78%	79.81%	50th–74th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	—	79.08%	69.83%	50th–74th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	78.05%	78.49%	79.37%	75th–89th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	93.78%	96.23%	95.25%	75th–89th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	72.73%	73.17%	87.50%	50th–74th Percentile
Systemic Corticosteroid	72.73%	78.05%	83.33%	≥90th Percentile
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control (>9.0%)**	44.00%	49.15%	53.77%	<25th Percentile
HbA1c Control (<8.0%)	44.86%	41.12%	40.39%	<25th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	52.90%	52.07%	57.42%	25th–49th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	—	73.15%	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	NA	12.20%	8.89%	50th–74th Percentile
Asthma Medication Ratio (AMR)				
Total	NA	58.42%	52.61%	<25th Percentile
Ambulatory Care (AMB)***				
*Emergency Department (ED) Visits—Total**	515.84	537.95	533.93	50th–74th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	51.47%	59.31%	57.53%	≥90th Percentile
30-Day Follow-Up—Total	68.14%	73.70%	70.86%	75th–89th Percentile

ACNH HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
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%	77.97%	25th–49th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.85%	66.67%	66.41%	50th–74th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	NA	44.74%	50.88%	25th–49th Percentile
Cholesterol Testing—Total	NA	21.05%	33.33%	25th–49th Percentile
Blood Glucose and Cholesterol Testing—Total	NA	21.05%	29.82%	25th–49th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	NA	NA	NA	NC
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	74.66%	70.62%	69.99%	75th–89th Percentile
Effective Continuation Phase Treatment	64.38%	60.51%	57.89%	≥90th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	NA	40.82%	45.78%	75th–89th Percentile
Continuation and Maintenance Phase	NA	NA	NA	NC

ACNH HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	—	55.24%	NC
*Engagement of SUD Treatment—Total***	—	—	27.01%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	71.51%	71.51%	65.34%	≥90th Percentile
30-Day Follow-Up—Total	78.21%	79.23%	75.46%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—Total	—	—	46.19%	NC
30-Day Follow-Up—Total	—	—	56.68%	NC
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	—	34.25%	28.62%	50th–74th Percentile

* For this indicator, a lower rate indicates better performance.
** This measure was 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.
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 2022.

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**:

- Two Prevention measure indicator rates: *Well-Child Visits for Age 15 Months–30 Months (W30)—Two or More Well-Child Visits* and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- One Acute and Chronic Care measure indicator rate: *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*

- Four BH measure indicator rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total*, *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment,* and *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—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**:

- Eight Prevention measure indicator rates: *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)—21–24 Years;* and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- Three Acute and Chronic Care measure indicator rates: *Hemoglobin A1c Control for Patients With Diabetes (HBD)—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%),* and *Asthma Medication Ratio (AMR)—Total*

Recommendations

With 19 of 46 rates (41.30 percent) falling below the 50th percentile, **ACNH** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care, timely prenatal care, cervical cancer screening, and hemoglobin control (HbA1c) for diabetic patients. **ACNH** also should focus on diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications and ensuring young women are appropriately screened for chlamydia. Additional areas of focus for **ACNH** include weight assessment and counseling for BMI, nutrition, and physical activity for children and adolescents; controlling high blood pressure; immunizations for adolescents; asthma medication ratio; 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 3-44 displays **NHHF**'s HEDIS MY 2020, HEDIS MY 2021, and HEDIS MY 2022 performance measure rates, and **NHHF**'s HEDIS MY 2022 percentile ranking. The HEDIS MY 2022 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021. 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 3-44—NHHF HEDIS MY 2021, MY 2022, and MY 2023 Rates, and MY 2022 Percentile Rankings

NHHF HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	78.42%	78.34%	77.38%	50th–74th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening	53.73%	53.52%	57.06%	75th–89th 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	54.92%	55.87%	59.09%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	81.91%	76.80%	77.51%	75th–89th Percentile
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	63.67%	67.07%	70.17%	≥90th Percentile
12–17 Years	54.20%	58.16%	61.86%	75th–89th Percentile
18–21 Years	33.20%	34.41%	35.76%	75th–89th Percentile
Total	55.76%	58.38%	61.15%	75th–89th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	72.75%	69.59%	72.99%	25th–49th Percentile
Counseling for Nutrition—Total	70.80%	67.40%	72.99%	50th–74th Percentile
Counseling for Physical Activity—Total	66.18%	62.04%	67.40%	25th–49th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV))	—	69.34%	72.02%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	51.58%	42.34%	38.93%	50th–74th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	76.89%	73.97%	78.83%	50th–74th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	34.55%	28.95%	33.33%	25th–49th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	59.37%	57.66%	54.99%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.17%	0.09%	0.12%	≥90th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	43.16%	44.37%	46.58%	25th–49th Percentile
21–24 Years	52.38%	52.89%	56.57%	25th–49th Percentile
Total	46.13%	47.15%	50.25%	25th–49th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	81.75%	80.78%	79.32%	<25th Percentile
Postpartum Care	74.21%	76.89%	78.10%	50th–74th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	—	72.67%	68.13%	50th–74th Percentile
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	84.11%	78.81%	80.11%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	93.70%	96.74%	95.80%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	86.49%	84.88%	85.57%	25th–49th Percentile
Systemic Corticosteroid	70.81%	78.49%	83.51%	≥90th Percentile
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control (>9.0%)**	38.93%	39.90%	37.96%	50th–74th Percentile
HbA1c Control (<8.0%)	51.34%	47.45%	49.39%	25th–49th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	58.88%	59.37%	61.31%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	—	71.53%	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	10.91%	10.78%	9.60%	50th–74th Percentile
Asthma Medication Ratio (AMR)				
Total	59.89%	60.09%	62.96%	25th–49th Percentile
Ambulatory Care (AMB)*				
*Emergency Department (ED) Visits—Total**	418.48	451.01	521.49	50th–74th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	62.28%	61.07%	49.81%	75th–89th Percentile
30-Day Follow-Up—Total	76.78%	76.41%	71.64%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
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***	76.62%	77.31%	75.00%	<25th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.82%	61.11%	62.75%	25th–49th Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	77.70%	72.01%	75.10%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	53.19%	58.58%	57.14%	50th–74th Percentile
Cholesterol Testing—Total	34.66%	39.23%	36.25%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	33.86%	38.32%	35.18%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	66.45%	74.18%	72.67%	75th–89th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	63.53%	65.66%	66.79%	75th–89th Percentile
Effective Continuation Phase Treatment	48.17%	48.72%	50.11%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	55.99%	52.04%	53.56%	≥90th Percentile
Continuation and Maintenance Phase	67.34%	56.68%	56.59%	50th–74th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	—	44.32%	NC
*Engagement of SUD Treatment—Total***	—	—	24.05%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	72.41%	70.16%	64.40%	≥90th Percentile
30-Day Follow-Up—Total	80.77%	79.48%	73.26%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	—	41.94%	NC
30-Day Follow-Up—Total	—	—	56.61%	NC
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	—	29.30%	30.99%	50th–74th 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.

Conclusions

NHHF was fully compliant with all NCQA-defined IS standards for HEDIS MY 2022.

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)*
- Two Acute and Chronic Care measure indicator rates: *Appropriate Testing for Pharyngitis (CWP)—Total* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- Four BH measure indicator rates: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA), Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase,* and *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—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**:

- One Prevention measure indicator rate: *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- One BH measure indicator rate: *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

Recommendations

With 13 of 49 rates (26.53 percent) falling below the 50th percentile, **NHHF** should consider focusing efforts on ensuring that children and adolescents are appropriately screened for weight assessment and counseling for BMI and physical activity, combination 2 for adolescent immunizations, and asthma medication ratios. **NHHF** also should focus on ensuring that women are screened for cervical cancer and chlamydia and have access to timely prenatal care. Additionally, **NHHF** should focus on improving pharmacotherapy management of COPD exacerbation using bronchodilators, HbA1c control for diabetic patients, diabetes monitoring for diabetic patients with schizophrenia, and additional screening for diabetic patients with schizophrenia or bipolar disorder who are using antipsychotic mediations. 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 3-45 displays **WS**'s HEDIS MY 2020, HEDIS MY 2021, and HEDIS MY 2022 performance measure rates, and **WS**'s HEDIS MY 2022 percentile ranking. HEDIS MY 2022 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021. 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—WS HEDIS MY 2020, MY 2021, and MY 2022 Rates, and MY 2022 Percentile Rankings

WS HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Prevention				
Adults' Access to Preventive/ Ambulatory Health Services (AAP)				
Total	78.87%	78.41%	74.48%	25th–49th Percentile
Breast Cancer Screening (BCS)				
Breast Cancer Screening	50.09%	47.88%	49.71%	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	55.33%	56.20%	57.16%	50th–74th Percentile
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	79.86%	75.02%	73.31%	75th–89th Percentile
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	62.49%	65.93%	64.19%	75th–89th Percentile
12–17 Years	52.78%	58.02%	54.77%	50th–74th Percentile
18–21 Years	31.08%	32.88%	29.39%	50th–74th Percentile
Total	55.53%	58.56%	55.25%	50th–74th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	57.11%	71.74%	74.93%	25th–49th Percentile
Counseling for Nutrition—Total	62.11%	69.78%	71.43%	25th–49th Percentile
Counseling for Physical Activity—Total	55.79%	66.34%	65.50%	25th–49th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV)	—	66.42%	65.69%	50th–74th Percentile

WS HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Combination 10 (DTaP, IPV, MMR, HIB, HepB, VZV, PCV, HepA, RV, Influenza)	33.58%	44.28%	43.80%	75th–89th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	72.26%	75.18%	73.24%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	28.71%	30.90%	27.01%	<25th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	52.66%	61.71%	57.65%	50th–74th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non-Recommended Cervical Cancer Screening in Adolescent Females**	0.18%	0.22%	0.12%	≥90th Percentile
Chlamydia Screening in Women (CHL)				
16–20 Years	43.26%	44.72%	42.23%	<25th Percentile
21–24 Years	53.97%	54.03%	53.71%	<25th Percentile
Total	46.54%	47.63%	46.23%	<25th Percentile
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	72.02%	83.04%	85.30%	25th–49th Percentile
Postpartum Care	71.53%	79.82%	83.51%	75th–89th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	—	73.24%	65.69%	50th–74th Percentile
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	83.99%	80.87%	82.17%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	93.66%	96.83%	96.00%	75th–89th Percentile

WS HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	85.39%	93.49%	95.40%	≥90th Percentile
Systemic Corticosteroid	79.78%	94.08%	88.51%	≥90th Percentile
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control (>9.0%)**	59.37%	44.04%	34.55%	75th–89th Percentile
HbA1c Control (<8.0%)	33.58%	45.74%	56.20%	75th–89th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	45.99%	56.45%	66.91%	75th–89th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	—	72.62%	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	10.71%	11.35%	10.35%	25th–49th Percentile
Asthma Medication Ratio (AMR)				
Total	61.50%	62.55%	65.53%	50th–74th Percentile
Ambulatory Care (AMB)*				
*Emergency Department (ED) Visits—Total**	445.46	479.56	498.53	50th–74th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	58.15%	59.97%	53.70%	75th–89th Percentile
30-Day Follow-Up—Total	73.30%	73.91%	71.45%	75th–89th Percentile

WS HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
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***	75.14%	74.68%	76.59%	<25th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	58.33%	64.18%	61.29%	25th–49th Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.51%	74.27%	72.64%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	51.66%	55.27%	54.32%	25th–49th Percentile
Cholesterol Testing—Total	28.48%	34.20%	30.77%	25th–49th Percentile
Blood Glucose and Cholesterol Testing—Total	27.32%	33.06%	29.98%	25th–49th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	60.10%	60.33%	61.64%	25th–49th Percentile
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	57.79%	62.48%	63.92%	50th–74th Percentile
Effective Continuation Phase Treatment	43.06%	46.73%	47.35%	50th–74th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	42.36%	37.63%	41.46%	50th–74th Percentile

WS HEDIS Rates	HEDIS 2021 (MY 2020) Rate	HEDIS 2022 (MY 2021) Rate	HEDIS 2023 (MY 2022) Rate	HEDIS MY 2022 Percentile Rankings
Continuation and Maintenance Phase	44.10%	39.53%	42.28%	<25th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	—	47.17%	NC
*Engagement of SUD Treatment—Total***	—	—	24.37%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	68.80%	66.50%	61.68%	≥90th Percentile
30-Day Follow-Up—Total	76.16%	76.18%	72.97%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	—	46.57%	NC
30-Day Follow-Up—Total	—	—	60.53%	NC
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	—	29.04%	26.35%	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.

Conclusions

WS was fully compliant with all NCQA-defined IS standards for HEDIS MY 2022.

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**:

- One Prevention measure indicator rate: *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Three Acute and Chronic Care measure indicator rates: *Appropriate Testing for Pharyngitis (CWP)—Total* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and *Systemic Corticosteroid*
- Two BH measure indicator rates: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Four Prevention measure indicator rates: *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)* and *Chlamydia Screening in Women (CHL)—16–20 Years, 21–24 Years,* and *Total*
- Two BH measure indicator rates: *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* and *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*

Recommendations

With 20 of 49 rates (40.82 percent) falling below the 50th percentile, **WS** should consider focusing efforts on ensuring that adults have access to preventive and ambulatory care, diabetes monitoring for patients diagnosed with diabetes and schizophrenia, and additional diabetic screening for patients with schizophrenia or bipolar disorder who are taking antipsychotic medications. **WS** should also focus on ensuring that women have access to timely prenatal care, breast cancer screening, and chlamydia screening. Additionally, **WS** should focus on ensuring that children and adolescents are appropriately screened for weight assessment and counseling for BMI, physical activity, and nutrition; immunizations for adolescents; metabolic monitoring for children and adolescents on antipsychotics; use of first-line psychosocial care for children and adolescents on antipsychotics; and the continuation and maintenance phase of follow-up care for children prescribed ADHD medications. Additional rates needing improvement include plan all-cause readmissions and pharmacotherapy for opioid disorders. 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.

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

EDV

During SFY 2023, 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*, February 2023,[3-20] HSAG conducted the following three core evaluation activities for the EDV activity:

- IS review—assessment of the MCOs' IS and processes. Since HSAG conducted an IS review for each MCO in prior EDV studies, this IS review focused on areas of interest to DHHS (i.e., changes made by the MCOs since July 1, 2021).
- 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, 2022, and June 30, 2023, HSAG included encounter data with dates of service between July 1, 2021, and June 30, 2022, in the comparative analysis.

Information Systems Review

Health Plan Comparisons

The IS review component of the EDV study provided self-reported qualitative information from all three MCOs regarding the changes made by the MCOs' subcontractors and the MCOs. Based on the MCOs' responses, below are key findings:

- All MCOs made some changes since July 1, 2021. **ACNH** fixed diagnostic-related group (DRG) and diagnosis pointer issues, **NHHF** changed its NEMT subcontractor from Coordinated Transportation Solutions (CTS) to Medical Transportation Management (MTM), and **WS** changed its NEMT subcontractor from One Call to CTS and implemented an encounter data management platform (Edifecs).
- All MCOs performed at least one data quality check to validate the changes, as well as before and/or after submitting encounters to DHHS.
- Two MCOs provided feedback regarding DHHS' edits for rejections. They would like to have a better understanding of the edits or would like to see more timely updates on the edits.

[3-20] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Oct 16, 2023.

Health Plan-Specific Conclusions and Recommendations

Based on the IS review activity, HSAG has the following recommendation for the MCOs:

- **NHHF** should perform more quality checks, such as field-level completeness and validity, reconciliation with financial reports, EDI compliance edits, and claim volume by submission month on the NEMT encounters that are submitted to DHHS.
- **WS** should perform more quality checks, such as reconciliation with financial reports and EDI compliance edits on the NEMT encounters that are submitted to DHHS.

Ongoing Encounter Data Quality Reports

Health Plan Comparison

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 HSAG produces the ongoing reports on a monthly/quarterly basis, Table 3-46 displays aggregate compliance rates for each MCO in relation to the five standards within Exhibit A of the MCO contract.[3-21] The aggregate results are for encounters submitted to DHHS between July 1, 2022, and June 30, 2023.

Table 3-46—Aggregate Rates for Encounter Data Submission and Quality Standards¥

Evaluation Area	Standard	MCO	837P Encounters		837I 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%	99.9%	100%	100%
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%

[3-21] State of New Hampshire Department of Health and Human Services. (2022). Amendment #8 to the Medicaid Care Management Services Contract, Section 5.1.3.34. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Sept 21, 2023.

Evaluation Area	Standard	MCO	837P Encounters		837I Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
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	99.9%		100%		100%	
		NHHF	97.0%		100%		99.7%	
		WS	94.5%**		99.8%		99.7%	

¥ When cells showing "% Present" and "% Valid" are merged, rates for the evaluation area are displayed.
NA indicates that a standard is not applicable to an encounter type.
** Per request from DHHS, the backlog files received from WS's NEMT subcontractor were excluded from the measure calculation.
Green text indicates rates meeting the standards.
= Indicates rates that improved from the SFY 2022 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 0.1 percentage points. Compared to the results in the SFY 2022 EDV Aggregate Report, the difference for all results was no more than 0.1 percentage points 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 2022 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 2022 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 ACNH's institutional and pharmacy encounters and NHHF's institutional encounters. The remaining rates were all at least 94.5 percent (i.e., the lowest rate was for WS's professional encounters primarily due to its BH subcontractor). Compared to the results in the SFY 2022 EDV Aggregate Report, NHHF improved its rate for professional encounters by more than 10.0 percentage points.

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 its 837I and pharmacy encounters.

HSAG recommends that **ACNH** should continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for professional encounters, as it was slightly below the standard.

NHHF

NHHF's submitted encounters met the standards for the X12 EDI edits; the accuracy for member identification numbers, billing providers, and servicing provider 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** continue to work to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for its professional and pharmacy encounters. Of note, compared to the results in the SFY 2022 EDV Aggregate Report, **NHHF** improved its rate for professional encounters by more than 10.0 percentage points.

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. In addition, **lower rates indicate better performance for omission and surplus rates, while higher rates indicate better performance for accuracy rates**.

Record Completeness

Table 3-47 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 but not present in the files submitted by the MCOs (record surplus).

Table 3-47—Record Omission and Surplus Rates by MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
ACNH	0.1%	0.2%	0.4%	1.2%	<0.1%	0.1%
NHHF	0.7%	0.7%	2.8%	2.7%	2.0%	0.2%
WS	1.9%	0.4%	4.5%	3.1%	1.0%	0.1%
Statewide	**1.1%**	**0.5%**	**3.0%**	**2.6%**	**1.2%**	**0.1%**

Red text indicates rates needing the MCOs' attention.

ACNH and NHHF had no rates that required attention, while WS had one rate (i.e., record omission rate for institutional encounters) that required attention.

Element Omission and Surplus

Table 3-48 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 3-48—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)	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Rendering Provider Number/NPI	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Referring Provider Number/NPI	0.0%	1.5%	<0.1%	0.0%	0.0%	0.0%	59.8%	61.4%	68.5%
Primary Diagnosis Code	<0.1%	<0.1%	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%

Key Data Element	Element Omission			Element Surplus			Element Missing Values		
	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Secondary Diagnosis Codes	<0.1%	<0.1%	0.4%	0.0%	0.0%	0.0%	53.6%	54.8%	59.8%
Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Procedure Code Modifiers	<0.1%	<0.1%	0.1%	<0.1%	<0.1%	0.0%	58.3%	55.7%	59.5%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	0.0%	0.0%	0.0%	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%

There were no rates that required the MCOs' attention for professional encounters.

Table 3-49—Data Element Omission, Surplus, and Missing by Data Element: Institutional Encounters

Key Data Element	Element Omission			Element Surplus			Element Missing Values		
	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Beneficiary ID	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Header Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%
Attending Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	<0.1%	<0.1%	0.7%
Referring Provider Number/NPI	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%	83.9%	83.7%	84.8%
Primary Diagnosis Code	0.0%	0.0%	<0.1%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
Secondary Diagnosis Codes	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	21.5%	22.0%	20.9%
Procedure Code	0.1%	0.5%	0.1%	0.1%	0.2%	0.0%	15.5%	15.1%	15.6%
Procedure Code Modifiers	0.1%	0.5%	<0.1%	0.1%	0.5%	0.0%	83.8%	82.4%	83.6%
Surgical Procedure Codes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	93.1%	93.5%	94.5%
Revenue Code	0.0%	<0.1%	<0.1%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
DRG	0.1%	0.2%	0.1%	0.3%	0.3%	0.0%	90.6%	90.4%	92.0%
Header Paid Amount	0.0%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	0.0%	<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%

There were no rates that required the MCOs' attention for institutional encounters.

Table 3-50—Data Element Omission, Surplus, and Missing by Data Element: Pharmacy Encounters

Key Data Element	Element Omission			Element Surplus			Element Missing Values		
	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%	0.0%	0.0%	0.0%	0.0%
Prescribing Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	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%

There were no rates that required the MCOs' attention for pharmacy encounters.

Element Accuracy

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

Table 3-51 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 3-51—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%	100.0%
Detail Service To Date	>99.9%	>99.9%	100.0%
Billing Provider Number/NPI	100.0%	>99.9%	100.0%
Rendering Provider Number/NPI	>99.9%	>99.9%	99.7%
Referring Provider Number/NPI	100.0%	>99.9%	100.0%
Primary Diagnosis Code	>99.9%	99.6%	100.0%

Key Data Element	ACNH	NHHF	WS
Secondary Diagnosis Codes	>99.9%	99.1%	99.9%
Procedure Code	99.9%	99.9%	100.0%
Procedure Code Modifiers	>99.9%	>99.9%	>99.9%
Header Paid Amount	99.7%	99.3%	99.6%
Detail Paid Amount	99.9%	98.9%	100.0%
MCO Carrier ID	100.0%	100.0%	100.0%

The element accuracy rates for all the data elements for all MCOs were at least 98.9 percent; therefore, none of the rates needed the MCOs' attention.

Table 3-52 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 3-52—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%	100.0%
Header Service To Date	>99.9%	>99.9%	100.0%
Billing Provider Number/NPI	100.0%	>99.9%	100.0%
Attending Provider Number/NPI	100.0%	100.0%	100.0%
Referring Provider Number/NPI	100.0%	100.0%	100.0%
Primary Diagnosis Code	100.0%	100.0%	100.0%
Secondary Diagnosis Codes	>99.9%	99.8%	99.7%
Procedure Code	98.6%	92.8%	100.0%
Procedure Code Modifiers	99.2%	99.2%	>99.9%
Surgical Procedure Codes	100.0%	99.2%	96.0%
Revenue Code	99.2%	96.9%	100.0%
DRG	99.8%	99.0%	100.0%
Header Paid Amount	>99.9%	98.9%	100.0%
Detail Paid Amount	98.7%	92.1%	100.0%
MCO Carrier ID	100.0%	100.0%	100.0%

Red text indicates rates needing MCOs' attention.

NHHF needed to improve two rates. There were no rates that required **ACNH**'s or **WS**'s attention.

Table 3-53 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 3-53—Data Element Percent of Accuracy by MCO: Pharmacy Encounters

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

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.

Health Plan-Specific Conclusions and Recommendations

ACNH

ACNH had no rates that needed its attention in the comparative analysis section.

NHHF

Among the 154 rates listed in the comparative analysis section, **NHHF** needed to improve two 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.

Table 3-54—Results Needing Actions From NHHF

Measure	Claim Type	Data Element	Rate
Element Accuracy	Institutional	Procedure Code	92.8%
Element Accuracy	Institutional	Detail Paid Amount	92.1%

WS

Among the 154 rates listed in the comparative analysis section, **WS** needed to improve six rates. Of note, two rates needing improvement were based on the comparative analysis results and four 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.

Table 3-55—Results Needing Actions From WS

Measure	Claim Type	Data Element	Reason	Rate
Record Omission	Institutional	Not applicable	Rate	4.5%
Element Missing	Professional (BH, DME, and Vision)	Referring Provider Number/NPI	File Review	68.5%
Element Missing	Professional (Vision)	Secondary Diagnosis Codes	File Review	NA
Element Missing	Professional (Vision)	Procedure Code Modifiers	File Review	NA
Element Missing	Institutional (BH)	Referring Provider NPI	File Review	NA
Element Missing	Institutional (BH)	Surgical Procedure Codes	File Review	NA

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

Other EQR Activities

Semi-Structured Qualitative Interviews

Fall Semi-Structured Interviews

DHHS conducted an independent qualitative study of women 18 to 25 years of age who were enrolled in the MCM program. Horn Research, HSAG's subcontractor, interviewed 31 members between November 17, 2022, and December 26, 2022. The study explored seven points of inquiry: description of participants, experience with Medicaid managed care, quality of well care, quality of sexual and reproductive healthcare, access to information, experience with telehealth, and suggestions for improvement.

Most participants reported having access to sexual and reproductive healthcare and most often received this care from an OB/GYN. Participants from rural areas mentioned that there were insufficient numbers of reproductive health providers available in their area. Overall, participants were satisfied with the quality of care they received during their most recent sexual and reproductive healthcare appointment. Participants said birth control was routinely addressed by their providers, and a quarter of participants said their providers persuaded them to use birth control even though it made them feel sick. Sexual and reproductive healthcare providers routinely asked participants about their tobacco use, substance use, and mental health.

Participants were most likely to report relying on their mother or their healthcare provider for information and support about their health. Most participants felt confident that their providers answered their questions effectively and in a timely manner. Participants said they prefer to learn about health through one-on-one interactions or by using online tools. Only half of participants said they received healthcare and prevention screening information and reminders from their MCO.

Participants were asked what improvements they would make to their healthcare, including well care and sexual and reproductive care. Participants suggested increasing the number of providers in rural areas and improving the quality of those providers. They also identified a desire for better dental coverage and more access to dental providers. Other suggestions included more information concerning resources and coverage, better out-of-state coverage, CM support, and improved appointment availability for laboratory testing.

Recommendations

Participants offered six recommendations for the MCOs:

- Provide an "Introduction to Health Insurance" geared toward young adults, since many participants relied on their parents to help them navigate their health insurance.
- Furnish training concerning the sexual and reproductive healthcare needs of special populations, especially those with developmental disabilities, by offering parents education and support to prepare them for discussions with their children.

- Improve information and coverage for out-of-state college students by clarifying how those students can access covered care in states other than New Hampshire.
- Increase guidance and information about finding providers, since a third of participants indicated that they switched PCPs within the past year.
- Leverage parental influence to increase the number of members receiving vaccines and using birth control.
- Reinforce the importance of sexually transmitted infection (STI) screening with providers, since nearly half of participants said their provider did not recommend routine screening.

Participants offered one suggestion for DHHS, and that involved improving messaging to parents and young adults concerning their Medicaid enrollment status. Some participants did not understand when and how they would shift from being enrolled on their parents' Medicaid coverage to being enrolled on their own coverage.

Spring Semi-Structured Qualitative Study

At the end of SFY 2023, HSAG was still conducting interviews for the Spring Semi-Structured Qualitative Study. Results from that study will be included in the SFY 2024 New Hampshire External Quality Review Technical Report.

For additional information concerning HSAG's methodology for conducting semi-structured member interviews, see Appendix B. Methodologies for Conducting EQR Activities, page B-35.

Quality Study

At the end of SFY 2023, HSAG was finalizing from the report for the Quality Study. Information from that study will be included in the SFY 2024 New Hampshire External Quality Review Technical Report.

Reveal Caller Provider Survey

At the end of SFY 2023, HSAG was finalizing the report for the Reveal Caller Provider Survey. Information from that study will be included in the SFY 2024 New Hampshire External Quality Review Technical Report.

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

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

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:
  - Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[4-1]
- ***Timeliness***—NCQA defines "timeliness" relative to utilization decisions as follows:
  - "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[4-2] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).
- ***Access***—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:
  - Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[4-3]

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

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 17, 2023.

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 17, 2023.

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

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

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

[4-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Jul 10, 2023.

AmeriHealth Caritas New Hampshire

MCO Contractual Compliance

This was the fourth year that **ACNH** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 98.6 percent on the review. Of the five standards reviewed that included 510 applicable elements, **ACNH** achieved a 100 percent score in BH, SUD, and Financial Management. 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 BH standard by ensuring through its HRA screening, risk scoring, and stratification methodology that members with potential need for BH services, including priority population members, are appropriately and timely referred to BH providers if co-located care is not available. **ACNH**'s policies and procedures explained the process for completing a comprehensive assessment and developing a care plan for members with physical health and BH needs, including inviting all providers engaged in the member's care to participate in the process. **ACNH** worked in collaboration with DHHS and community mental health (CMH) programs/CMH providers to ensure that Assertive Community Treatment (ACT) Teams include at least one certified peer support specialist and were available to Medicaid members 24 hours a day, seven days a week, with on-call availability from 12:00 a.m. to 8:00 a.m. Prior to admission to New Hampshire Hospital or other State-determined institution for mental diseases (IMDs) for mental illness, **ACNH** ensured that a crisis team consultation had been completed for all members evaluated by a licensed physician or psychologist. Meeting these requirements contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in SUD by ensuring that members at risk of experiencing SUD are assessed using a standardized, evidence-based assessment tool consistent with the American Society of Addiction Medicine (ASAM) criteria and by providing access to the full range of services available under the DHHS SUD benefit, including peer recovery support, without regard to whether peer recovery support was an aspect of an additional service provided to the member. **ACNH** established protocols for providers and furnished training to providers to ensure implementation of a standardized screening and treatment protocol for infants at risk of neonatal abstinence syndrome (NAS). **ACNH**'s care coordination staff actively participated in ensuring access to care for members and assisted hospital staff in the development of a written discharge plan for any member who had an ED visit or was hospitalized for an overdose or SUD. **ACNH** ensured that an appointment for treatment (within seven calendar days after discharge) other than evaluation with an SUD program and/or provider for the member was scheduled prior to discharge when possible, and that transportation had been arranged for the appointment. Ensuring that these activities were implemented for members in need of SUD services contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in financial management by ensuring that it submitted information concerning maternity and newborn events to DHHS and followed written policies and procedures, as

developed by DHHS, for receiving, processing, and reconciling maternity and newborn payments. **ACNH** coordinated benefits related to federal and private health insurance resources, dually eligible members, and entered into a Coordination of Benefits Agreement for New Hampshire with Medicare ensuring participation in the automated crossover process. Submitting timely information concerning maternity and newborn payments informs DHHS of pregnancy and births, which affects ensuring that those members receive CM services if needed. These activities may result in improved ***quality of care*** and ***timeliness of care*** for **ACNH**'s members.

To improve the Delegation and Subcontracting standard, **ACNH** must evaluate a subcontractor's ability to perform the activities to be delegated prior to delegation and at least annually after signing an agreement with a subcontracting entity. A review of subcontracts revealed that **ACNH** must include all requirements for subcontractors stipulated in its contract with DHHS in subcontractor agreements. Ensuring that subcontractors comply with DHHS requirements may result in enhanced ***quality of care*** for Medicaid members.

To improve the Network Management standard, **ACNH** must develop and furnish provider education and training materials to ensure that physical health providers know when and how to refer members who need specialty BH services and BH providers know when and how to refer members who need physical health services. Improvements in the referral process between physical health and BH providers may result in improved ***quality of care*** and ***timeliness of care*** for **ACNH**'s members.

After finalization of the SFY 2023 Compliance Review Report, **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* and *Not Met* during the compliance review. **ACNH** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2023 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2023 Compliance Review CAP items during the SFY 2024 compliance audit.

PIPs

ACNH collaborated with DHHS and the other two MCOs to select the topics for the two PIPs that were concluded in SFY 2023 and the two topics that were initiated in SFY 2023. The two concluding 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.

The two new PIP topics initiated during SFY 2023 focused on improving rates for one HEDIS measure (*Improving HPV Vaccinations*) and one New Hampshire MQIS measure (*Improving Health Risk Assessments*). Both measures are related to the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

During SFY 2023, **ACNH** demonstrated the following strengths that positively impacted the three domains of care:

- Tested interventions that resulted in non-statistically significant improvement for both the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* PIPs.
- Successfully initiated methodologically sound new PIPs and is currently testing interventions using incremental PDSA cycles for the *Improving HPV Vaccinations* and *Improving Health Risk Assessment* PIPs.

Based on information from PIPs completed by **ACNH**, HSAG offers the following suggestions to enhance the PIP activities:

- **ACNH** should ensure that the narrative summary of results accurately reflects the reported data.
- Intervention effectiveness measure(s) and testing methodology in the PDSA worksheet should align with the measure(s) and data collection methodology that HSAG validated and approved in Module 3.
- **ACNH** should contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.
- **ACNH** should apply lessons learned throughout the PIP process to future PIPs and QI activities.
- **ACNH** should continue to request technical assistance as often as needed.

During SFY 2023, HSAG made the following recommendations to improve the ***quality of care***, ***timeliness of care***, and ***access to care*** for **ACNH** members as the MCO continues through the PIP process:

- **ACNH** should test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **ACNH** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven decisions based on the intervention testing results.
- **ACNH** should use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.

- Intervention effectiveness data should be real-time data whenever possible so that the MCO can collect and analyze data quickly to make decisions on the status of the intervention and make needed revisions and course corrections quickly.
- **ACNH** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found all 17 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors recommended that **ACNH**:

- Enhance its internal understanding of NIA's UM operations and include confirmation of its understanding within its annual delegation oversight review of NIA to ensure that **ACNH** is appropriately querying from NIA source data for all UM measures in New Hampshire. Improving this requirement will facilitate ***quality of care***.
- Immediately implement a process to calculate provider appeal turnaround times from the date the appeal is received from the provider instead of relying on the date the appeal is opened within its system. Additionally, **ACNH** should improve its internal monitoring process of provider appeals to ensure that the date each appeal is received can be reliably and accurately identified. The *PROVAPPEAL.01* measure must be calculated using the date of receipt of the provider appeal as the start date for reporting turnaround time. Improving this requirement will facilitate ***timeliness of care***.

NAV

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

Strengths

For the network capacity analysis, **ACHN** met both the State and regional requirements for OTPs, met the regional standards for buprenorphine prescribers, and met the statewide standard for residential SUD treatment programs. Based on these findings, members' ***access to care*** is robust for these provider types.

DHHS requires its contracted MCOs to provide access to 100 percent of members within DHHS' time and distance standards. Although **ACNH** did not meet the standards for all the provider categories, **ACNH** met 100 percent of the standards for the following provider categories:

- PCP, Adult
- PCP, Pediatric

- Specialist, Adult
- Specialist, Pediatric
- OB/GYN Providers
- Hospitals
- Pharmacies
- Mental Health Providers, Adult
- Individual/Group MLADCs
- Substance Use Disorder Programs
- Office-based OT/PT/ST
- PT

ACNH provided access for 100 percent of its members to at least two PCPs within the geographical access standards for PCPs. Based on these findings, members' ***access to care*** is robust for PCPs.

For specialists, **ACNH** met the standard for providing access to at least one specialist for 100 percent of its members and met the 100 percent standard for 15 of 26 provider categories (57.7 percent) when applying the standard individually to key types of specialists (as requested by DHHS). Although there were 11 key types of specialists that did not meet the 100 percent requirement, all but four of them achieved 99.5 percent or higher compliance with the required access. Based on these findings, members' ***access to care*** is robust for specialists.

ACNH met the standard for providing access to at least one hospital within 45 minutes travel time for 100 percent of its members. The results for tertiary or specialized services (i.e., Level I or Level II trauma centers and Level III or Level IV NICUs) were slightly lower, but still met the standard for 99.9 percent of members. Based on these findings, members' ***access to care*** is robust for hospitals.

Opportunities for Improvement

Regarding the network capacity standards, **ACNH** should seek to contract with additional SUD providers for the following categories to meet State and regional network capacity standards and improve ***access to care***:

- MLADCs
- Residential SUD treatment programs

ACNH should find alternative access options for residents in Coos County.

Additionally, **ACNH** should seek to contract with additional pediatric allergists and pediatric ophthalmologists in counties where access standards were not met. Improvement for these provider types will facilitate ***access to care***.

CAHPS

Two of the 2023 measure rates representing the ***quality of care*** domain (i.e., *Rating of Health Plan* and *Rating of Personal Doctor*) for **ACNH**'s general child Medicaid population were statistically significantly lower than the 2022 NCQA general child Medicaid national averages, while one measure rate representing the ***quality of care*** domain (i.e., *Customer Service*) was statistically significantly higher than the national average. The 2023 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 2022 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 experience, 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 nondefensively, empathize, handle emotion, solve problems, and follow through to closure.

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 MY 2022 representing MY 2021.

Table 4-1—Summary of ACNH's Scores for MY 2022 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	3	7	3	8	**23**
Acute and Chronic Care	1	2	3	1	3	**10**
BH	4	3	2	4	0	**13**
All Domains	**7**	**8**	**12**	**8**	**11**	**46**
Percentage	**15.22%**	**17.39%**	**26.09%**	**17.39%**	**23.91%**	**100%**

ACNH's rates ranked at or above the 50th percentile for 27 measures (58.70 percent), with seven of these measures (15.22 percent) meeting or exceeding the 90th percentile. The rates for 19 measures (41.30 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 26 of the 44 (59.09 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):

- *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**
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Appropriate Testing for Pharyngitis (CWP)—Total*
- *Appropriate Treatment for Upper Respiratory Infection (URI)—Total*
- *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*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *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 ***quality of care***, with **ACNH**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total†, Counseling for Physical Activity—Total†,* and *Counseling for Nutrition—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†*
- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—Poor HbA1c Control (>9.0%)†* and *HbA1c Control (<8.0%)†*
- *Controlling High Blood Pressure (CBP)*
- *Asthma Medication Ratio (AMR)—Total†*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total*

To improve ***quality of care***, **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; hemoglobin control; and weight assessment, counseling for nutrition, and physical activity for children and adolescents.

ACNH demonstrated strength in measures related to ***timeliness of care***, meeting or exceeding the 50th percentile for 11 of the 13 (84.62 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):

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

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

To improve ***timeliness of care***, **ACNH** should continuously inform members through member newsletters about the importance of timely prenatal and postpartum care and the benefits of those visits for moms and their babies. Additionally, **ACNH** also could inform members of the importance of diabetes screening for people with schizophrenia or bipolar disorder who are also using antipsychotic medications.

ACNH demonstrated strength in measures related to ***access to care***, meeting or exceeding the 50th percentile for 12 of the 15 (80.00 percent) measure indicators related to ***access***. The following measures related to ***access*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *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**
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*†
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

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

EDV

In the IS review activity, **ACNH** made changes since July 1, 2021, including correcting DRG and diagnosis pointer issues. **ACNH** also performed at least one data quality check to validate the changes, as well as before and/or after submitting 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 institutional and pharmacy encounters. **ACNH** should continue to work, however, to improve its percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment for 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 issues.

ACNH also demonstrated strength by showing that it did not have any rates needing to be corrected from the comparative analysis results. This indicates that DHHS' encounter data are complete and accurate compared to the data extracted from **ACNH**'s data systems. Submitting accurate and complete encounter data assists DHHS in monitoring issues concerning ***quality of care*** and ***access to care***.

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

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 Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓			**ACNH** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the Child Medicaid CAHPS results for *Rating of Specialist Seen Most Often.* In the 2022 CAHPS survey (e.g., MY 2021), the rate was statistically significantly lower than the national average; however, in the 2023 CAHPS survey (e.g., MY 2022), after implementing ongoing recruiting efforts to include additional specialist care providers (SCPs) as well as conducting more focus surveys from members engaging with SCPs, the rate improved to being neither statistically significantly higher nor lower than the national average. Improvements in this CAHPS measure positively affected members' perception of the ***quality of care*** received from specialists.
✓			**ACNH** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the MY 2021 HEDIS measure rate for *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*. The MY 2022 HEDIS rate improved from below the 25th percentile to the 50th–74th percentile by implemented daily review of the ADT file by the CM staff to ensure coordination with the inpatient discharge planner and ambulatory providers. **ACNH** also promoted the use of telehealth services for follow-up visits. Improvements in this HEDIS measure positively affected the ***quality of care***.
✓		✓	**ACNH** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the MY 2021 HEDIS measure rate for *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)—Bronchodilator*. The HEDIS rate improved from below the 25th percentile in MY 2021 to the 50th–74th percentile in MY 2022

Quality	Access	Timeliness	Strengths
			by monitoring medication adherence in **ACNH**'s Pharmacy Benefits Management program to determine trends that need to be discussed with the prescribing providers. Network management account executives expanded provider outreach with PCPs to educate providers concerning the use of **ACNH**'s provider portal care gaps inquiry and resolutions and promoted the use of telehealth visits for members to assist with treatment adherence. Improvements in this measure positively affected the ***quality of care*** and ***timeliness of care***.

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

Quality	Access	Timeliness	Weaknesses
✓	✓		For the two concluding PIPs in SFY 2023, **ACNH** tested only one intervention per PIP topic, however, **ACNH** should test as many interventions as possible. If intervention testing results do not produce positive results in a timely manner, **ACNH** should revisit its causal/barrier analysis tools completed and key driver diagram to determine new member, provider, or system-focused interventions to test. Decisions to adopt, adapt, abandon, or continue testing should be data-driven based on the intervention testing results. Testing more interventions to determine activities to increase the rates for **ACNH's** PIPs will have a positive impact on the ***quality of care*** and ***access to care***.
✓			In MY 2021, the Child Medicaid CAHPS results for *Rating of Health Plan* were statistically significantly lower than the national average. Although the Follow-Up to Prior Recommendations section of this report indicates that **ACNH** implemented activities to increase engagement in its Member Advisory Board, conducted focus surveys from members to obtain timely feedback to identify areas for improvement, and opened a community wellness center with new programs and events, the HEDIS rate did not change in MY 2022. **ACNH** should reevaluate those efforts and implement additional programs and activities to improve the rate. Improving the rate for *Rating of Health Plan* will affect members' perception of the ***quality of care*** received at **ACNH**.
✓	✓		During MY 2021, one of the HEDIS measure included as a PIP topic, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*), achieved a national benchmark in the 75th–89th percentile. In MY 2022, however, that HEDIS measure scored in the 25th–49th percentile. **ACNH** achieved statistically significant improvement in the rate for the members included in the narrowed focused rapid-cycle *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*), PIP; however, this achievement should be implemented across all members to improve the HEDIS rate generated for the entire **ACNH** population. Improving the HEDIS rate for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) will positively impact ***quality of care*** and ***access to care***.

New Hampshire Healthy Families

MCO Contractual Compliance

This was the tenth year that **NHHF** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 94.5 percent on the review. Of the five standards reviewed that included 566 applicable elements, **NHHF** achieved a 100 percent score in BH, SUD, and Financial Management. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM program beneficiaries.

NHHF demonstrated strengths in BH by establishing policies and procedures to identify the role of physical health and BH providers in assessing a member's BH needs as part of the comprehensive assessment and developing a care plan. **NHHF** ensured that clinicians conducting or contributing to a comprehensive assessment were certified in the use of New Hampshire's Child and Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA), or an alternative evidence-based assessment tool approved by DHHS and did not impose aggregate lifetime or annual dollar limits on mental health or SUD benefits. **NHHF** worked in collaboration with DHHS and CMH programs/CMH providers to ensure that ACT teams include at least one certified peer support specialist and are available to Medicaid members 24 hours a day, seven days a week, with on-call availability from 12:00 a.m. to 8:00 a.m. These activities contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NHHF**'s members.

NHHF demonstrated strength in providing SUD services by offering the full continuum of care required for members with SUD and ensuring that members at risk of experiencing SUD were assessed using a standardized, evidence-based assessment tool consistent with the ASAM criteria. **NHHF** also provided access to the full range of services available under the DHHS SUD benefit, including peer recovery support without regard to whether peer recovery support was an aspect of an additional service provided to the member. In coordination with CMH programs and CMH providers, **NHHF** actively promoted the delivery of peer recovery support services furnished by Peer Recovery Programs in a variety of settings. The MCO's care coordination staff actively participated and assisted hospital staff members in the development of a written discharge plan for any member who had an ED visit or was hospitalized for an overdose or SUD. **NHHF** reviewed member cases with the applicable SUD program and/or provider to promote strategies for reducing overdoses and increasing engagement in treatment services. The activities and services included in the SUD standard represented activities to improve ***quality of care***, ***timeliness of care***, and ***access to care*** for **NHHF**'s members.

NHHF demonstrated strength in the Financial Management standard by requiring compliance with activities to ensure that **NHHF** submitted information concerning maternity and newborn events to DHHS and followed written policies and procedures for receiving, processing, and reconciling maternity and newborn payments. **NHHF** and its subcontractors performing claims processing duties also were responsible for cost avoidance through the coordination of benefits (COB) relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S. Code §1396a(a)(25) plans, and

workers' compensation. Ensuring that the health plan followed required accounting principles and claims processing activities contributed to the financial stability of **NHHF**, which allowed the health plan to continue to offer services that promoted ***quality of care*** to New Hampshire MCM members.

A review of subcontracts revealed that **NHHF** must include all requirements for subcontractors stipulated in its contract with DHHS in subcontractor agreements. Ensuring that subcontractors comply with DHHS requirements may result in enhanced ***quality of care*** for Medicaid members.

To improve the Network Management standard, **NHHF** must ensure the processing of initial credentialing files to include primary source verification of a provider's malpractice insurance. Initial credentialing files and recredentialing files also must include evidence of hospital privileges by including proof of electronic verification or a hospital letter with the required information. Ensuring that **NHHF** verifies the required information during the credentialing process may improve the ***quality of care*** for **NHHF**'s New Hampshire MCM members.

After finalization of the SFY 2023 Compliance Review Report, **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 2023 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2023 Compliance Review CAP items during the SFY 2024 compliance audit.

PIPs

NHHF collaborated with DHHS and the other two MCOs to select the topics for the two PIPs that were concluded in SFY 2023 and the two topics that were initiated in SFY 2023. The two concluding 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.

The two new PIP topics initiated focused on improving rates for one HEDIS measure (*Improving HPV Vaccinations*) and one New Hampshire MQIS measure (*Improving Health Risk Assessments*). Both measures are related to the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

During SFY 2023, **NHHF** demonstrated the following strengths that positively impacted these domains of care:

- Tested interventions that resulted in non-statistically significant improvement for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total* PIPs.
- Successfully initiated methodologically sound new PIPs and is currently testing interventions using incremental PDSA cycles for the *Improving HPV Vaccinations* and *Improving Health Risk Assessment* PIPs.

Based on information from PIPs completed by **NHHF**, HSAG offers the following suggestions to enhance the PIP activities:

- **NHHF** should ensure that any improvement achieved can be reasonably linked to the interventions initiated and tested.
- **NHHF** should contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.
- **NHHF** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

During SFY 2023, HSAG made the following recommendations to improve the ***quality of care***, ***timeliness of care***, and ***access to care*** for **NHHF** members as the MCO continues through the PIP process:

- **NHHF** should continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.
- **NHHF** should revisit its QI tools and processes throughout the PIP process to determine new interventions to test until the end of the year allowing enough time to complete final analyses and final PDSA worksheets by December 31, 2023. The MCO should test as many interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.
- Intervention effectiveness data should be real-time data whenever possible so that the MCO can collect and analyze data quickly to make decisions on the status of the intervention and make needed revisions and course corrections quickly.
- **NHHF** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found all 17 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors suggest that **NHHF**:

- Continue to explore options to avoid duplicate data entry of appeals in CenPAS and MS SharePoint due to the increased risk of manual documentation errors. Improving this requirement will facilitate ***quality of care***.
- Identify if opportunities exist to simplify the manual steps required to produce the Exhibit O report. **NHHF** relied on manual steps to produce the *WITHHOLD.21.01* measure. Manual steps to track completion of comprehensive medication review and counseling, and to produce the final measure may result in an increased risk of error. While HSAG identified no issues related to producing the *WITHHOLD.21.01* measure, had this measure not been retired, HSAG would have recommended that **NHHF** explore opportunities to simplify the manual steps required to produce the Exhibit O report. Improving this requirement will facilitate ***quality of care***. **NHHF** should ensure that it minimizes or eliminates manual steps in future rate generation processes.

NAV

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

Strengths

For the network capacity analysis, **NHHF** met both the State and regional requirements for OTPs, met the regional standards for buprenorphine prescribers, and met the statewide standard for residential SUD treatment programs. Based on these findings, members' ***access to care*** is robust for these provider types.

DHHS requires its contracted MCOs to provide access to 100 percent of members within DHHS' time and distance standards. Although **NHHF** did not meet the standards for all the provider categories, **NHHF** met 100 percent of the standards for the following provider categories:

- PCP, Adult
- PCP, Pediatric
- Specialist, Adult
- Specialist, Pediatric
- OB/GYN Providers
- Hospitals
- Tertiary or Specialized Services: Level I or Level II Trauma Centers
- Pharmacies
- Mental Health Providers, Adult

- Substance Use Disorder Programs
- Office-based OT/PT/ST
- OT
- PT

NHHF provided access for 100 percent of its members to at least two PCPs within the geographical access standards for PCPs. Based on these findings, members' ***access to care*** is robust for PCPs.

For specialists, **NHHF** met the standard for providing access to at least one specialist for 100 percent of its members and met the 100 percent standard for 11 of 26 provider categories (42.3 percent) when applying the standard individually to key types of specialists (as requested by DHHS). Although there were 15 key types of specialists that did not meet the 100 percent requirement, all but two of them achieved 99.1 percent or higher compliance with the required access. Based on these findings, members' ***access to care*** is robust for these specialists.

NHHF met the standard for providing access to at least one hospital within 45 minutes travel time for 100 percent of its members. The results for tertiary or specialized services (Level I or Level II trauma centers) also met the standard for 100 percent of their members, although slightly fewer members (99.5 percent) had access within the standard to tertiary or specialized services in a Level III or Level IV (NICU) within the standard. Based on these findings, members' ***access to care*** is robust for hospitals.

Opportunities for Improvement

Regarding the network capacity standards, **NHHF** should seek to contract with additional SUD providers for the following categories to meet State and regional standards and improve ***access to care***:

- MLADCs
- Residential SUD treatment programs.

Additionally, **NHHF** should find alternative access options for residents in Coos County.

CAHPS

One of the 2023 measure rates representing the ***quality of care*** domain (i.e., *Rating of All Health Care*) for **NHHF**'s general child Medicaid population was statistically significantly lower than the 2022 NCQA general child Medicaid national average, while one measure rate representing the ***quality of care*** domain (i.e., *How Well Doctors Communicate*) was statistically significantly higher than the national average. The 2023 measure rates representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains for **NHHF**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2022 NCQA adult Medicaid national averages.

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 experience, 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 nondefensively, 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.

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 MY 2022 representing MY 2021.

Table 4-4—Summary of NHHF's Scores for MY 2022 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	6	7	7	1	**23**
Acute and Chronic Care	2	1	4	3	0	**10**
BH	4	5	5	1	1	**16**
All Domains	**8**	**12**	**16**	**11**	**2**	**49**
Percentage	**16.33%**	**24.49%**	**32.65%**	**22.45%**	**4.08%**	**100%**

NHHF's rates ranked at or above the 50th percentile for 36 measures (73.47 percent), with eight of these measures (16.33 percent) meeting or exceeding the 90th percentile. The rates for 13 measures (26.53 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 34 of the 47 (72.34 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):

- *Breast Cancer Screening (BCS)*
- *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*
- *Childhood Immunization Status (CIS)—Combination 3*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Appropriate Testing for Pharyngitis (CWP)—Total**
- *Appropriate Treatment for Upper Respiratory Infection (URI)—Total*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *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**
- *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 ***quality of care***, with **NHHF**'s performance falling below the 50th percentile (a cross † indicates a rate below the 25th percentile) for the following measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total* and *Counseling for Physical Activity—Total*
- *Immunizations for Adolescents (IMA)—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*
- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)*
- *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)*

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. **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 10 of the 14 (71.43 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**
- *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 ***timeliness of care***, with **NHHF**'s performance falling below the 50th percentile for the following measures (a cross † indicates a rate below the 25th percentile):

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

To improve ***timeliness of care***, **NHHF** should continuously inform members through member newsletters about the importance of timely prenatal and postpartum care and the benefits to both moms and babies.

NHHF demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for 14 of the 17 (82.35 percent) measures. 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**
- *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 (a cross † indicates a rate below the 25th percentile):

- *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)*

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/monitoring for people with diabetes, schizophrenia, or bipolar disorder.

EDV

For the IS review activity, **NHHF** noted that it changed its NEMT subcontractor from CTS to MTM and performed at least one data quality check to validate the change, as well as before and/or after submitting encounters to DHHS. However, **NHHF** should perform more quality checks, such as field-level completeness and validity, reconciliation with financial reports, EDI compliance edits, and claim volume by submission month on the NEMT encounters.

NHHF met the standards for the X12 EDI compliance edits; the accuracy for member identification numbers, billing providers, 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. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the timeliness issues.

NHHF had two 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***.

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

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 Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓			**NHHF** improved the Child Medicaid CAHPS results for *How Well Doctors Communicate* from a measure rate that was neither statistically significantly higher nor lower than the national average in SFY 2022 to a rate that is statistically significantly higher than the national average in SFY 2023. Since communicating with providers is an important part of patient-centered care, improvements in this CAHPS measure positively affected members' perception of their ***quality of care***.
✓			**NHHF** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the EDV SFY 2022 rate of 82.8 percent for 837P: Initial submission within 14 days of claim payment. Results of the SFY 2023 activities indicate that **NHHF** improved the rate by more than 10 percentage points to 97.0 percent. Since encounter data can be used to determine services rendered by providers, improvement in the timely submission of **NHHF**'s claims payment information improved the monitoring of ***quality of care*** for Medicaid beneficiaries.
✓		✓	**NHHF** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the MY 2021 HEDIS measure rates for *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* since both rates were below the 25th percentile. The HEDIS MY 2022 *Combination 1 (Meningococcal, Tdap)* rate improved from below the 25th percentile in MY 2021 to the 50th–74th percentile in MY 2022, and the MY 2022 *Combination 2 (Meningococcal, Tdap, HPV)* rate increased to the 25th–49th percentile. **NHHF** conducted an email campaign to parents of members 9–12 years of age who did not meet the HPV vaccine measure and sponsored an educational event for providers to view a film about the HPV vaccine. After viewing the film, **NHHF** held breakout sessions focusing on improving vaccine rates and ways to open discussions about the vaccine with patients and caregivers. **NHHF** also initiated a texting campaign to parents of members turning 13 years of age who had the first dose of the HPV vaccine to remind them to schedule the second dose prior to their adolescent's 13th birthday. Efforts to improve the number of members receiving the two required immunizations for adolescents improved the ***quality of care*** and ***timeliness of care*** for Medicaid beneficiaries.

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

Quality	Access	Timeliness	Weaknesses
✓	✓		HSAG could not reasonably link the interventions to the improvement achieved for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement Total (IET—Engagement)* PIP. **NHHF** should ensure that any improvement achieved in future PIPs can be reasonably linked to the interventions and the QI processes conducted. Improvements in this measure will positively impact ***quality of care*** and ***access to care***.
✓	✓		During MY 2021, one of the HEDIS measure included as a PIP topic, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*), achieved the 50th–74th percentile. In MY 2022, however, that HEDIS measure scored below the 25th percentile. **NHHF** should continue to focus on improving the HEDIS rate for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*) to improve ***quality of care*** and ***access to care***.
✓	✓		In SFY 2022, **NHHF** failed to meet the EDV requirement for accuracy of institutional claims for the procedure code, procedure code modifier, and detail paid amount during the comparative analysis between encounters submitted to DHHS' data warehouse and HSAG. The results generated for those EDV elements during SFY 2023 indicated that the rate for institutional claims for the *procedure code modifier* and *detail paid amounts* met the DHHS requirements. The rate achieved for the *procedure code*, however, was 92.8 percent, which remains below the required DHHS rate (e.g., equal to or greater than 95.0 percent). The Follow-Up to Prior Recommendations section of this report indicates that **NHHF** used bundled service lines; however, the data pull did not use bundled lines. To correct the submissions, **NHHF** worked with DHHS to update encounter submission logic and no longer sent bundled lines. The information submitted by **NHHF** indicated that the change was expected to move into production in late 2022. **NHHF** needs to focus continued efforts on improving the *procedure code* for institutional claims to impact the rates in SFY 2024. 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***.

Well Sense Health Plan

MCO Contractual Compliance

This was the tenth year that **WS** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 97.7 percent on the review. Of the five standards reviewed that included 577 applicable elements, **WS** achieved a 100 percent score in Delegation and Subcontracting, BH, SUD, and Financial Management. 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 strength in the Delegation and Subcontracting standard by ensuring notification to DHHS of a subcontractor's intent to terminate an agreement with the MCO. HSAG found evidence of compliance with this requirement by reviewing documents for a subcontractor that terminated during the compliance review period. **WS** notified DHHS of the subcontractor's intent to terminate and implemented a transition plan that DHHS approved, and **WS** completed annual audits of its subcontractors' activities to ensure compliance with State and federal requirements. **WS** scored 100 percent on the Delegation and Subcontracting standard review and the file reviews.

WS demonstrated strength in BH by ensuring through its HRA screening, risk scoring, and stratification methodology that members with a potential need for BH services, particularly priority population members, were appropriately and timely referred to BH providers if co-located care was not available. Policies and procedures clearly identified the role of physical health and BH providers in assessing a member's BH needs as part of the comprehensive assessment and developing a care plan. **WS** also coordinated care with CMH centers to ensure that the centers delivered services in the least restrictive community-based environment possible and based on a person-centered approach. The MCO considered the member and his or her family's personal goals and needs when developing an individualized service plan. **WS** worked with members discharged from a facility into homelessness by assigning a care manager to assist with medical, housing, transportation, safety, and food insecurities.

WS demonstrated strength in SUD requirements by furnishing the full continuum of care required of members with SUD. Those services included assessing members at risk for experiencing SUD using a standardized evidence-based assessment tool consistent with ASAM criteria and providing access to the full range of services available to members as required by DHHS. **WS** provided peer recovery support to members as both a standalone service (regardless of an assessment) and as part of other treatment and recovery services. **WS** established protocols for providers by creating a standardized screening and treatment protocol for infants at risk of NAS and furnished training to providers serving infants with NAS. **WS**'s care coordination staff actively participated and assisted hospital staff members in the development of a written discharge plan for any member who had an ED visit or was hospitalized for an overdose or SUD. The care coordination staff also worked with those members to ensure communication and follow-up treatment for SUD.

WS demonstrated strength in the Financial Management standard by requiring compliance with activities to ensure that **WS** submitted information concerning maternity and newborn events to DHHS and followed written policies and procedures for receiving, processing, and reconciling maternity and newborn payments. **WS** and its subcontractors performing claims processing duties also were responsible for cost avoidance through the COB relating to federal and private health insurance resources, including but not limited to Medicare, private health insurance, the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S. Code 1396a(a)(25) plans, and workers' compensation. Ensuring that the health plan followed required accounting principles and claims processing activities contributed to the financial stability of **WS**, which allowed the health plan to continue to offer services that promote ***quality of care*** to New Hampshire MCM beneficiaries.

To improve the Network Management standard, **WS** must ensure that delegated entities for credentialing produce evidence of hospital privileges by including proof of electronic verification or a hospital letter with the required information. **WS** also must ensure that all initial credentialing files contain a copy of a signed attestation statement and attestation concerning the correctness and completeness of the application. Ensuring that providers submit the required information during the credentialing process may improve the ***quality of care*** for **WS**'s New Hampshire MCM members.

After finalization of the SFY 2023 Compliance Review Report, **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 2023 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2023 Compliance Review CAP items during the SFY 2024 compliance audit.

PIPs

WS collaborated with DHHS and the other two MCOs to select the topics for the two PIPs that were concluded in SFY 2023 and the two topics that were initiated in SFY 2023. The two concluding 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 *Continued Engagement of Opioid Abuse or Dependence Treatment*. The two measures are related to the domains of ***quality of care*** and ***access to care***. The selection of these topics suggests that the MCO has opportunities for improvement in these domains. For the PIP focused on improving the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* HEDIS measure, there is an opportunity to improve ***quality of care*** and ***access to care*** for members who are being treated for schizophrenia or bipolar disorder by ensuring these members receive appropriate screening for diabetes. For the PIP topic focused on improving the *Continued Engagement of Opioid Abuse or Dependence Treatment* measure, there is an opportunity to improve the ***quality of care*** and ***access to care*** for members newly diagnosed with opioid dependency who engaged in ongoing treatment within 34 days of the initiation visit.

The two new PIP topics initiated focused on improving rates for one HEDIS measure (*Improving HPV Vaccinations*) and one New Hampshire MQIS measure (*Improving Health Risk Assessments*). Both measures are related to the domains of ***quality of care***, ***timeliness of care***, and ***access to care***.

During SFY 2023, **WS** demonstrated the following strengths that positively impacted these domains of care:

- Tested interventions that resulted in non-statistically significant improvement for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* and *Continued Engagement of Opioid Abuse or Dependence Treatment* PIPs.
- Successfully initiated methodologically sound new PIPs and is currently testing interventions using incremental PDSA cycles for the *Improving HPV Vaccinations* and *Improving Health Risk Assessment* PIPs.

Based on information from PIPs completed by **WS**, HSAG offers the following suggestions to enhance the PIP activities:

- **WS** should ensure that any improvement achieved can be reasonably linked to the interventions initiated and tested.
- **WS** should ensure that it includes the SMART Aim measure data in the final module and reports these data accurately.
- **WS** should contact HSAG if it encounters methodological challenges and/or barriers when determining and testing interventions.
- **WS** should apply lessons learned throughout the PIP process to future PIPs and QI activities.

During SFY 2023, HSAG made the following recommendations to improve the ***quality of care***, ***timeliness of care***, and ***access to care*** for **WS** members as the MCO continues through the PIP process:

- **WS** should continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. 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 or improvement over the baseline performance.
- **WS** should revisit its QI tools and processes throughout the PIP process to determine new interventions to test until the end of the year allowing enough time to complete final analyses and final PDSA worksheets by December 31, 2023. The MCO should test as many interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.
- Intervention effectiveness data should be real-time data whenever possible so that the MCO can collect and analyze data quickly to make decisions on the status of the intervention and make needed revisions and course corrections quickly.
- **WS** should use and complete the supplemental Intervention Progress Form as it tests interventions. This form can be used to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur.

PMV

HSAG's PMV activities found all 17 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors recommended that **WS**:

- Maintain monitoring of its updated *PROVAPPEAL.01* query that was implemented following the SFY 2023 PMV, which includes identification of negative TAT for provider appeal resolutions. This will allow **WS** to detect data entry errors that occur in documenting the dates for the measures. Improving this requirement will facilitate ***quality of care***.
- Implement additional quality assurance steps to identify any situations where the delivery occurs on a date after the initial hospital admission to adjust the *WITHHOLD.21.05* reporting accordingly. **WS**'s source code used the member's hospital admission date associated with the delivery, but the actual date reported was the admission date itself, even if delivery occurred later during the hospital stay. Improving this requirement will facilitate ***timeliness of care***.

NAV

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

Strengths

For the network capacity analysis, **WS** met both the State and regional requirements for OTPs. Based on these findings, members' ***access to care*** is robust for OTPs.

DHHS required its contracted MCOs to provide access to 100 percent of members within DHHS' time and distance standards. Although **WS** did not meet the standards for all the provider categories, **WS** met 100 percent of the standards for the following provider categories:

- PCP, Adult
- PCP, Pediatric
- Specialist, Adult
- Specialist, Pediatric
- OB/GYN Providers
- Hospitals
- Pharmacies
- Substance Use Disorder Programs
- Office-based OT/PT/ST
- OT
- PT

WS provided access for 100 percent of its members to at least two PCPs within the geographical access standards for PCPs. Based on these findings, members' ***access to care*** is robust for PCPs.

For specialists, **WS** met the standard for providing access to at least one specialist for 100 percent of its members and met the 100 percent standard for 11 of 26 provider categories (42.3 percent) when applying the standard individually to key types of specialists (as requested by DHHS). Although there were 15 key types of specialists that did not meet the 100 percent requirement, all but three of them achieved 99.5 percent or higher compliance with the required access. Based on these findings, members' ***access to care*** is robust for these specialists.

WS met the standard for providing access to at least one hospital within 45 minutes travel time for 100 percent of its members. The results for tertiary or specialized services (i.e., Level I or Level II trauma centers and Level III or Level IV NICUs) were slightly lower but met the standard for 99.5 percent of members. Based on these findings, members' ***access to care*** is robust for hospitals.

Opportunities for Improvement

Regarding the network capacity standards, **WS** should seek to contract with additional SUD providers for the following categories to meet State and regional standards and improve ***access to care***:

- MLADCs
- OTPs
- Residential SUD treatment programs.

WS should find alternative access options for residents in Coos County.

Additionally, **WS** should seek additional pediatric ophthalmologists in counties where access standards were not met. Additional providers will facilitate ***access to care***.

CAHPS

Three of the 2023 measure rates representing the ***quality of care*** domain (i.e., *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often*) for **WS**'s general child population were statistically significantly lower than the 2022 NCQA general child Medicaid national averages. None of the 2023 measure rates representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains, however, were statistically significantly higher than the 2022 NCQA general child Medicaid national averages. The 2023 measure rates representing the ***quality of care***, ***timeliness of care***, and ***access to care*** domains for **WS**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2022 NCQA adult Medicaid national averages.

To improve CAHPS rates related to ***quality of care***, **WS** could consider involving MCO staff members at every level to assist in improving the member experience. **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 experience, 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.

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 MY 2022 representing MY 2021.

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	1	4	7	7	4	**23**
Acute and Chronic Care	3	4	2	1	0	**10**
BH	2	3	3	6	2	**16**
All Domains	**6**	**11**	**12**	**14**	**6**	**49**
Percentage	**12.24%**	**22.45%**	**24.49%**	**28.57%**	**12.24%**	**100%**

WS's rates ranked at or above the 50th percentile for 29 measures (59.18 percent), with six of these measures (12.24 percent) meeting or exceeding the 90th percentile. The rates for 20 measures (40.82 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 28 of 47 (59.57 percent) measures related to ***quality of care***. The following measures related to ***quality of care*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the First 30 Months of Life (W30)—15 Months–30 Months—Two or More Visits*
- *Child and Adolescent Well-Care Visits (WCV)—3–11 Years*
- *Childhood Immunization Status (CIS)—Combination 10*

- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *Appropriate Testing for Pharyngitis (CWP)—Total**
- *Appropriate Treatment for Upper Respiratory Infection (URI)—Total*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator** and *Systemic Corticosteroid**
- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)*
- *Controlling High Blood Pressure (CBP)*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*
- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* †
- *Chlamydia Screening in Women (CHL)—16–20 Years*†, *21–24 Years*†, and *Total*†
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Plan All-Cause Readmissions (PCR)—Observed Readmissions—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* †
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total*
- *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 Maintenance Phase†*
- *Pharmacotherapy for Opioid Use Disorder (POD)—Total*

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. Ensuring that all PCPs and specialists follow clinical practice guidelines for diabetes will positively impact the *Hemoglobin A1c Control for Patients With Diabetes* 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 9 of the 14 (64.29 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):

- *Well-Child Visits in the First 30 Months of Life (W30)—15 Months–30 Months—Two or More Visits*
- *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*
- *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 ***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)— 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, care for diabetics with a bipolar or schizophrenia diagnosis who are using antipsychotic medications, and diabetes monitoring for people with diabetes and schizophrenia.

WS demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for 12 of the 17 (70.59 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*
- *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*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *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)—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

For the IS review activity, **WS** changed its NEMT subcontractor from One Call to CTS and implemented an encounter data management platform (Edifecs). **WS** performed at least one quality check to validate the changes, as well as before and/or after submitting encounters to DHHS. However, **WS** should perform more quality checks, such as reconciliation with financial reports and EDI compliance edits on the NEMT encounters.

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 (e.g., invalid member identification numbers usually had less than 11 digits) 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. Appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission will assist in correcting the timeliness issues.

WS has six rates listed in Table 3-55 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 four 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***.

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

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 Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
✓	✓	✓	**WS** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the Child Medicaid CAHPS results for *Rating of Personal Doctor* since that measure scored statistically significantly lower than the national average in SFY 2022. **WS** determined that adult members with open care gaps may report negative CAHPS scores concerning access and provider satisfaction. Between July and December 2022 and January and February 2023, **WS** outreached to members by telephone to remind them to make appointments for preventive health screenings. Some members requested answers to healthcare questions and others requested assistance in finding a new PCP. In February 2023, **WS** mailed benefit reminders to adult members and encouraged members to schedule annual checkups and respond to a survey if one was received in the mail. These efforts improved the rate to neither statistically significantly higher nor lower than the national average, which positively affected ***quality***, ***timeliness of care***, and ***access to care***.
✓	✓	✓	**WS** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the MY 2021 HEDIS measure rate for *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase* since the score for that measure was below the 25th percentile. **WS** CMs reviewed members' gaps in care and encouraged members to receive appropriate follow-up. **WS** also

Quality	Access	Timeliness	Strengths
			determined that ADHD medications frequently were managed by a PCP, and **WS** continues to explore opportunities to conduct provider education concerning best practices for follow-up care for these members. The MY 2022 HEDIS measure achieved the 50th–74th percentile, which positively affected ***quality***, ***timeliness of care***, and ***access to care***.
✓			In SFY 2022, the comparative analysis between encounters submitted to DHHS' data warehouse and to HSAG included a record surplus for the pharmacy vendor of 4.4 percent. **WS** reported efforts in its Follow-Up to Prior Year's Recommendations section of this report to improve the record surplus by receiving guidance from DHHS concerning voided encounters and researching a reoccurring error code. The SFY 2023 results for surplus pharmacy encounters indicated that **WS** corrected the issues. Submitting accurate and timely encounter data improved the monitoring of ***quality of care*** for Medicaid beneficiaries.

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

Quality	Access	Timeliness	Weaknesses
✓			Results from **WS's** MY 2021HEDIS indicated that one chlamydia screening rate, *Chlamydia Screening in Women (CHL)—16–20 Years,* was in the 25th–49th percentile, while the other two chlamydia screening rates (e.g., *21–24 Years* and *Total)* were below the 25th percentile. The results from MY 2022 HEDIS, however, indicated that all three rates are now below the 25th percentile. Although the Follow-Up to Prior Recommendations section of this report includes activities conducted by **WS** to improve chlamydia screening rates (e.g., creating online resources for providers to include a free mobile app with STI treatment guides, a pocket guide, and a wall chart), two rates remained in the same percentile and one rate decreased to a lower percentile. Improving the HEDIS rate for *Chlamydia Screening in Women (CHL)* will positively impact the ***quality of care*** for **WS**'s New Hampshire Medicaid members.
✓	✓		Results from the EDV comparative analysis for **WS** in SFY 2022 indicated that professional claims did not meet the standard established by DHHS for BH, DME, and vision, and did not contain the NPI for the referring provider. The Follow-Up to Prior Year's Recommendations section of this report indicates that **WS** focused efforts on improving the rates with the BH, DME, and vision vendors; however, those efforts did not result in a rate that achieved the percentage required by DHHS. 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***.

Quality	Access	Timeliness	Weaknesses
✓	✓		In SFY 2022, all the child CAHPS measures scored equal to or higher than the national average. In SFY 2023, however, three **WS** child CAHPS measures scored statistically significantly lower than the national average: *Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often.* One child HEDIS measure, *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Continuation and Maintenance Phase,* scored below the 25th percentile in SFY 2022 and remained below the 25th percentile in SFY 2023. Improving the perception of personal doctors and specialists may improve the likelihood of child members returning for follow-up care for ADHD which in turn could improve ***quality of care*** and ***access to care***. **WS** could consider focusing on patient-centered activities with the goal of improving the child members' experience of care and determining specific areas of dissatisfaction with the child members' health care, personal doctor, and specialists. Implementing brief member telephonic, email, or mailed surveys after visits with providers may furnish valuable information to improve the members experience and impact the ***quality of care*** and ***access to care*** for **WS**'s child members.

5. Assessment of the New Hampshire MCM Quality Strategy

Background

DHHS developed the New Hampshire MCM Quality Strategy dated SFY 2023 in June of 2022 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 Revision #6 of the New Hampshire MCM Quality Strategy for SFY 2023 dated June 30, 2022.[5-2] After receiving the document, HSAG reviewed the goals of the New Hampshire MCM Quality Strategy and defined 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.*[5-3]

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-chi ldrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Oct 17, 2023.

5-2 New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy for SFY 2023*. Available at: Care Management Quality Strategy | NH Medicaid Quality Accessed on: Oct 17, 2023.

5-3 U. S. Government Publishing Office. 2023. *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Oct 17, 2023.

Findings

The New Hampshire MCM Quality Strategy dated SFY 2023 included specific goals for six preventive care measures (i.e., Objective 1.1) and five treatment measures (i.e., Objective 1.2). The three-letter description of those HEDIS measures matches those listed in the HEDIS section of this technical report.

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 by the end of SFY 2025.

The 11 HEDIS measures noted in the New Hampshire Medicaid Care Management Quality Strategy dated SFY 2023 are shown below:

- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)*
- *Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)*
- *Weight Assessment and Counseling in Adolescents/Children-Body Mass Index (BMI)—WCC*
- *Chlamydia Screening in Women (CHL)—Total*
- *Prenatal and Postpartum Care (PPC)—Prenatal Care*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *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 Maintenance Phase*
- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)—HbA1c Control <8%*
- *Controlling High Blood Pressure—Total (CBP)*
- *Pharmacotherapy for Opioid Use Disorder (POD)—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 2020, MY 2021, and MY 2022.

Table 5-1—Comparison of MY 2020 HEDIS Statewide Rates to MY 2021 and MY 2022 HEDIS Statewide Rates for the New Hampshire MCM Program

DHHS New Hampshire MCM Quality Strategy Objective and HEDIS Measures	NH MY 2020 Rate and Percentile	NH MY 2021 Rate and Percentile	NH MY 2022 Rate and Percentile
Objective 1.1: Preventive Care Measures			
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	74.3% <25th Percentile	74.0%. <25th Percentile	74.7% 25th–49th Percentile
Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)	31.4% 25th–49th Percentile	29.8% <25th Percentile	29.2% <25th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total	63.9% <25th Percentile	70.7% 25th–49th Percentile	73.1% 25th–49th Percentile
Chlamydia Screening in Women (CHL)—Total	46.5% <25th Percentile	48.3% 25th–49th Percentile	48.6% <25th Percentile
Prenatal and Postpartum Care (PPC)—Postpartum Care[1]	73.1% 25th–49th Percentile	79.0% 50th–74th Percentile	80.6% 50th–74th Percentile
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care[1]	77.1% <25th Percentile	82.1% 25th–49th Percentile	81.9% 25th–49th Percentile
Objective 1.2: Treatment Measures			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total	62.4% 25th–49th Percentile	65.5% 50th–74th Percentile	66.0% 50th–74th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase	53.6% 25th–49th Percentile	46.5% 25th–49th Percentile	48.9% 25th–49th Percentile
Controlling High Blood Pressure (CBP)	52.7% NC[1]	57.0% 50th–74th Percentile	62.5% 50th–74th Percentile
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (HBD)[1] *HbA1c Control (<8.0%)*	42.8% <25th Percentile	45.7% 25th–49th Percentile	50.1% 25th–49th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)—Total	28.0% 25th–49th Percentile	30.1% 25th–49th Percentile	28.3% 25th–49th Percentile

[1] In prior years this measure was *Comprehensive Diabetes Care (CDC)*

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 2020 and MY 2021 were established during restrictions mandated by 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 until May 11, 2023. The health emergency lifted many restrictions in MY 2021, however, it may have impacted beneficiaries' ability to schedule appointments with providers and their willingness to 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, immunizations, or a screening test.

Rates increased for eight measures from 0.3–5.5 percentage points; however, the percentile ranking increased for only one measure: *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap).* The percentile ranking for that measure increased from under the 25th percentile to the 25th–49th percentile.

Rates decreased for three measures from 0.2–1.8 percentage points; however, only one rate decreased by a percentile: *Chlamydia Screening in Women (CHL)—Total.* Although the actual rate increased 0.3 percentage points, the percentile ranking for that measure decreased from the 25th–49th percentile to under the 25th percentile.

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

In this section, HSAG 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: Consider endorsing the distribution of the CDC's brochure *A Guide to Taking a Sexual History* to improve the chlamydia screening rates for females 16–24 years of age.

Farrell, Spolyar, and Greehnalgh reported in 2023 that chlamydia is the most common STI in the United States with "a staggering 1.8 million incidences,"[5-4] and the U.S. Preventive Services Task Force reports that the rates of infection are highest "among adolescents and young adults of both sexes."[5-5]

[5-4] Farrell J, Spolyar, O, Greehnalgh, S. The effect of screening on the health burden of chlamydia: An evaluation of compartmental models based on person-days of infection. *Mathematical Biosciences and Engineering*. 2023: 20(9): 16131–16147. Available at: EBSCO HOST database. Accessed on: Oct 16, 2023.

[5-5] U.S. Preventive Services Task Force. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. *Journal of the American Medical Association*. 2021:326(10):949–956. Available at EBSCO HOST database. Accessed on: Oct 16, 2023.

In the past five years (i.e., 2019–2023), the HEDIS statewide rate for New Hampshire Medicaid members for the *Chlamydia Screening in Women (CHL)—Total*[5-6] measure has been below the 25th percentile four times and in the 25th–49th percentile once. The current rate for MY 2022 is below the 25th percentile.

The U.S. Preventive Services Task Force recommends chlamydia screening for all sexually active women at the age of 24 years or younger and for women who are 25 years or older with an increased risk for infection.[5-7] Screening patients for chlamydia is the first step to detecting the infection; however, one of the greatest struggles continues to be implementing a process to ensure that all patients receive chlamydia screening. Screening for chlamydia is vitally important, since a large proportion of reported cases are asymptomatic. Complications of undiagnosed chlamydia can include acute or chronic pain and pelvic inflammatory disease. Chlamydia has been a worldwide problem for many years. In 2006, Lloyd, Malin, Pugsley, et.al recognized that women in England presenting with lower abdominal pain should be screened for chlamydia since "there has been a steady increase in the incidence of chlamydia infections and pelvic inflammatory disease among the general population."[5-8]

An article recently published in the *Journal of the American Association of Nurse Practitioners* recommended using the *CDC's 5 Ps Approach* to obtain a sexual health history from patients.[5-9] The *Guide to Taking a Sexual History* brochure offers suggestions for statements providers can use to begin dialogue with their patients concerning sexual history.[5-10] The five areas recommended to be discussed include partners, practices, protection from STIs, past history of STIs, and pregnancy intention.

During an annual meeting organized by DHHS in 2023 and attended by representatives from DHHS, the MCOs, and providers' offices, the participants defined the three greatest barriers to chlamydia screening as education, comfort discussing STIs, and screening. Participants identified the discomfort and stigma associated with discussing STIs as a significant barrier. Many clinicians and patients feel uncomfortable when discussing sexual health, which presents a challenge to having open conversations concerning the need for screening for chlamydia.[5-11] *A Guide to Taking a Sexual History* offers clinicians discussion points and nonthreatening questions to begin dialogue with patients concerning each of the 5 Ps:

[5-6] The HEDIS measure *Chlamydia Screening in Women (CHL)* is defined by NCQA.

[5-7] U.S. Preventive Services Task Force. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. *Journal of the American Medical Association*. 2021:326(10):949–956. Available at EBSCO HOST database. Accessed on Oct 16, 2023.

[5-8] Lloyd TDR, Malin G, Pugsley H, et al. Women presenting with lower abdominal pain: A missed opportunity for chlamydia screening? *The Surgeon.* 2006*:4:1;15–19.* Available at EBSCO HOST database. Accessed on: Oct 16, 2023.

[5-9] Gautam R, Orrino J. Improving chlamydia risk screening by using the CDC's 5 Ps approach to sexual health history. *Journal of the American Association of Nurse Practitioners.* 2023: 35(7): 441–448. Available at: EBSCO HOST database. Accessed on Oct 17, 2023.

[5-10] Centers for Disease Control and Prevention. A Guide to Taking a Sexual History. CDC Publication 30-0166. Available at: https://www.cdc.gov/std/treatment/sexualhistory.htm. Accessed on: Oct 18, 2023.

[5-11] Health Services Advisory Group, Inc. New Hampshire Quality Meeting. 2023. DHHS Roundtable: Increasing Medicaid Member Chlamydia Screening Rates. May 23, 2023. Virtual meeting.

partners, practices, protection from STIs, past history of STIs, and pregnancy intention.[5-12] Encouraging the use and distribution of this brochure may improve the chlamydia screening rates in New Hampshire.

Recommendation 2: Consider establishing minimum performance standards for the HEDIS measures included in the New Hampshire MCM Quality Strategy to decrease the gap in rates between the MCOs' current HEDIS rate and the rate established by DHHS.

In Revision #6 of the New Hampshire MCM Quality Strategy, DHHS established Objectives 1.1 and 1.2 to ensure that by the end of SFY 2025, annual preventive care measure rates and annual treatment measure rates are equal to or higher than 75th percentile of national Medicaid managed care health plan rates.[5-13] Currently, of the 11 preventive care and treatment measures listed in the quality strategy, three rates are in the 50th–74th percentile. The remaining eight rates are either in the 25th–49th percentile (i.e., six rates) or below the 25th percentile (i.e., two rates). While achieving the 75th percentile is a laudable objective, it is unlikely that the eight rates under the 25th or 49th percentile will improve to the 75th percentile by SFY 2025.

In the late 1990s, the U.S. Department of Health & Human Services identified the need to create an interim system to monitor and improve compliance with established performance goals. The methodology included steps to *close the gap* between the current performance of an MCO and achieving an established performance rate. The methodology included closing the gap by a certain percentage each year until achieving the established performance rate. DHHS could establish interim goals and label those goals as the minimum performance standard. For instance, the MCOs could be required to *close the gap* between a rate of 50 percent and the established performance rate of 80 percent by 10 percent each year (e.g., 10 percent of 30, or three points a year). Of the eight rates that improved in SFY 2023, the range of improvement from SFY 2022 was from 0.3 percentage points to 5.5 percentage points. Only two rates increased three percentage points from the rate achieved in SFY 2022.

To be able to use minimum performance standards, DHHS would need to revise the objective of achieving a percentile ranking for each measure to achieving a certain percent of performance for each of the 11 rates. DHHS could consider establishing minimum performance standards to *close the gap* in performance between the current rate and the goal rate and monitor improvement as the MCOs increase the rates between their current performance and achieving an established performance rate.

[5-12] Centers for Disease Control and Prevention. *A Guide to Taking a Sexual History.* CDC Publication 30-0166. Available at: https://www.cdc.gov/std/treatment/sexualhistory.htm. Accessed on: Oct 18, 2023.

[5-13] New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy for SFY 2023.* Available at: Care Management Quality Strategy | NH Medicaid Quality Accessed on: Oct 17, 2023.

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 2022 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**	**27.3%**	**54.5%**	**18.2%**	**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 (i.e., 27.3%), while the remaining eight measure scored below the 50th percentile (i.e., 72.7%). Achieving the DHHS defined objective of all rates scoring in the 75th percentile would 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 2022 EQR Technical Report) and an assessment of the actions implemented by the MCOs to correct the areas requiring improvement. The results include follow-up activities for **ACNH**, **NHHF**, and **WS**.

AmeriHealth Caritas New Hampshire

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in contract compliance, NAV, CAHPS, HEDIS, EDV, and the reveal caller telephone survey. Except for contract compliance, the following tables display the self-reported activities conducted by **ACNH** during SFY 2023 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2022 EQR Technical Report contained opportunities for improvement in contract compliance for **ACNH**. HSAG included any element that did not receive a score of *Met* in a CAP document sent to **ACNH**. Prior to the completion of the CAP process, which was approved by DHHS, **ACNH** submitted 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 activities implemented by **ACNH** during SFY 2023 to improve the contract compliance results are shown below.

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

ACNH's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard X—Access	99.1%	100%
ACNH's Contract Compliance Response			
ACNH updated its provider orientation training slides and revised the Provider Manual. The documents included the requirement to ensure that PCPs and SCPs furnish consultation to the Department of Children, Youth, and Families (DCYF) regarding medical and psychiatric matters for members who are children in State custody/guardianship. This element is *Met*.			

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

ACNH's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XV—Fraud, Waste, and Abuse (FWA)	91.7%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element requiring MCO and subcontractors to cooperate with all State and federal agencies investigating FWA and implement and maintain written policies for all employees and any subcontractor or agent of the entity that provides detailed information about the False Claims Act (FCA) and other federal and State laws. To correct the deficiency, **ACNH** submitted a revised subcontractor agreement and policy and procedure containing the requirement. This element is *Met*.			

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

ACNH's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XV—FWA	91.7%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element concerning reporting and recovering overpayments and acknowledging that DHHS may recover overpayments not recovered by or returned to the MCO within 60 calendar days of notification by DHHS to pursue. Although not presented during the compliance review, **ACNH** furnished a copy of a subcontract that contained the required information and confirmed that all subcontracts included the requirements. This element is *Met*.			

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

ACNH's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XV—FWA	91.7%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element requiring the MCO to establish a pre-payment review in the following circumstances without approval: Upon new participating provider enrollment and for delayed payment during provide education. **ACNH** submitted an updated policy attachment, Attachment A – Prepayment Review State Contract Requirements Applicable to Policy and Procedure, to correct this deficiency. This element is *Met*.			

NAV

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in the NAV report. The activities implemented by **ACNH** during SFY 2023 to improve those results are shown below.

Table 6-5—NAV—Opportunities for Improvement and MCO Response

ACNH's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%
ACNH's NAV Response			
ACNH reviewed the data mismatches for the provider directory validation (PDV) indicators scoring below 90 percent and the recommendations and case-level PDV results file. **ACNH** then compared the information received from the provider and the information indicated on the **ACNH** provider directory. **ACNH** provider network manager (PNM) account executives outreached to providers to verify and correct the following information to ensure the accuracy of the information displayed on the **ACNH** provider directory: • Provider addresses including suite number with an emphasis on specialists • Provider phone number with an emphasis on specialists • Accommodates for physical disabilities with an emphasis on specialists • Non-English speaking BH providers (including American Sign Language) Account executives also furnished education to providers concerning how to submit demographic updates. **ACNH** completed any provider data updates based on the information provided by DHHS and confirmed by the providers. **ACNH** continues to educate providers concerning the importance of informing **ACNH** of all changes within their practice (address, phone, providers accepting new patients, etc.) to ensure the accuracy of the provider directory.			

CAHPS

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in the CAHPS measures. The activities implemented by **ACNH** during SFY 2023 to improve those results are shown below.

Table 6-6—CAHPS—Opportunities for Improvement and MCO Response

ACNH's CAHPS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
CAHPS	Child Medicaid CAHPS Results: *Rating of Health Plan*	Statistically significantly lower than the national average	Equal to or higher than the national average
ACNH's CAHPS Response			
ACNH implemented a more comprehensive approach to outreach to members to encourage participation in the **ACNH** Member Advisory Board. **ACNH** also conducted additional focus surveys from members to obtain timely feedback and collaboration to identify areas for improvement. **ACNH** also opened a community wellness center and implemented several programs and events due to the feedback obtained.			

Table 6-7—CAHPS—Opportunities for Improvement and MCO Response

ACNH's CAHPS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
CAHPS	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
ACNH's CAHPS Response			
To expand member options and preference, **ACNH** implemented interventions including ongoing recruitment efforts to include additional SCPs in its network. **ACNH** also conducted focus surveys from members engaging with SCP's.			

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

HEDIS

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in the HEDIS measures. The activities implemented by **ACNH** during SFY 2023 to improve those results are shown below.

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**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
ACNH's HEDIS Response			
HEDIS measurement year 2022 *Immunizations for Adolescents (IMA)* results indicated an increase of 0.57 percentage points over the prior measurement year rate. This measure is highly dependent on medical records with 80 percent of the numerator compliant members being identified through medical record review. The State of New Hampshire does not provide the State immunization registry data to MCOs for HEDIS reporting. **ACNH** implemented several interventions including both member and provider outreach via email, texting campaigns, fax, mailing, and telephone to address identified gaps in care. **ACNH** also implemented significant financial member incentives for adolescents who completed the necessary vaccination series. In addition, this measure is included in the **ACNH** provider value-based payment program for providers.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Cervical Cancer Screening (CCS)*	Below the 25th Percentile	Equal to or higher than the national average
ACNH's HEDIS Response			
During the third full year of operations, measurement year 2022, the *Cervical Cancer Screening* rate demonstrated an increased rate of 1 percentage point over the prior measurement year rate. Interventions implemented included the following activities: A woman's health value-based payment program for providers and outreach by **ACNH**'s CM staff to include reminders to members who did not have a cervical cancer screening. Reminders also were included in outreach efforts to new members to encourage them to schedule well visits with their PCP and manage their chronic conditions. The **ACNH** PNM team expanded outreach efforts with PCPs to educate them concerning the use of the **ACNH** provider portal for care gaps inquiry and resolutions as well as available data exchange options. **ACNH** continues to promote HEDIS data exchange with providers to collect needed information for the measure.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)—Bronchodilator*	Below the 25th Percentile	Equal to or higher than the national average
ACNH's HEDIS Response			
HEDIS measurement year 2022 *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)-Bronchodilator* rate achieved an increase of 14.33 percentage points over the prior HEDIS measurement year rate. Interventions continued for PCE-Bronchodilator which included increased monitoring of medication adherence by the pharmacy benefits management program, PerformRx. Each month the medication adherence data was reviewed by the **ACNH** director of pharmacy services for trends and development of outreach to the prescribing providers. PNM expanded provider outreach with PCPs to educate providers about using the **ACNH** provider portal for care gaps inquiry and resolutions, promoting utilization of telehealth visits for members to assist with treatment adherence, and calling the members' pharmacy to order their prescriptions. In addition, **ACNH** CM staff created a detailed protocol for members' transition of care from inpatient to ambulatory care that included follow-up of medications.			

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

ACNH's HEDIS Opportunities for Improvement			
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			
Interventions to reduce readmissions within 30 days included increasing CM staff awareness of inpatient episodes during the member's inpatient stay by routine daily review of the ADT file for identification of admissions and to coordinate discharge follow-up services with the inpatient discharge planner and ambulatory providers. In addition, **ACNH** promoted the use of telehealth services for follow-up after hospitalization and monitored the utilization of those services. **ACNH** continued the UM reporting process for readmissions.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
HEDIS	*Asthma Medication Ratio (AMR)—Total*	Below the 25th Percentile	Equal to or higher than the national average
ACNH's HEDIS Response			
ACNH implemented interventions such as increased monitoring of medication adherence by the pharmacy benefits management program, PerformRx. Each month the **ACNH** director of pharmacy services reviewed medication adherence data for trends and development of outreach to the prescribing providers. PNMs expanded provider outreach with PCPs to educate them concerning the use of the **ACNH** provider portal for care gaps inquiry and resolutions and to promote the utilization of telehealth visits for members to assist with treatment adherence. In addition, **ACNH** CM staff created a detailed protocol for members' transition of care from inpatient to ambulatory care including follow-up of medications as well as outreach for engagement in programming and education for members with identified chronic conditions and gaps in care.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure Standard**	**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
ACNH's HEDIS Response			
The HEDIS measurement year 2022 *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Cholesterol Testing—Total and Blood Glucose and Cholesterol Testing—Total* (APM-combined) rate showed an increase of 8.77 percentage points over the prior HEDIS measurement year rate. Interventions included outreach by **ACNH** staff to members with identified gaps in care and member incentive rewards for healthy behaviors such as routine well-visits. Reminders also were included in outreach efforts to new members to encourage them to schedule well visits with their PCP and manage their chronic conditions. **ACNH** CM staff created a detailed protocol for members transitioning care from inpatient to ambulatory care which included follow-up of medications and outreach for engagement into programming and provision of education for members with identified chronic conditions and gaps in care. The **ACNH** PNM team expanded provider outreach with PCPs to educate providers concerning the use of the **ACNH** provider portal care gaps inquiry and resolutions.			

EDV

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in EDV. The activities implemented by **ACNH** during SFY 2023 to improve those results are shown below.

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

ACNH's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Encounter Data Validation (EDV)	Record Omission Professional (P) Claims	4.7%	≤4.0%
	Record Omission Pharmacy Claims	6.9%	≤4.0%
ACNH's EDV Response			
ACNH identified the issue for detail paid amount values equal to $0 that involved including denied services in the professional dataset. Based on EDV requirements, only final paid status claims should be included, and **ACNH** made the necessary adjustments to the queries to address this issue. **ACNH** also identified the issue involving DHHS missing some of the dates of service for the members as compared to the data provided by **ACNH**. **ACNH** included reversals in its pharmacy dataset. Based on EDV requirements, only final paid status claims should be included, and **ACNH** made the necessary adjustments to the queries to address this issue.			

Reveal Caller Telephone Survey

The SFY 2022 EQR Technical Report contained opportunities for improvement for **ACNH** in the results from the Reveal Caller Telephone Survey. The activities implemented by **ACNH** during SFY 2023 to improve those results are shown below.

Table 6-15—Reveal Caller Telephone Survey—Opportunities for Improvement and MCO Response

ACNH's Opportunities for Improvement Reveal Caller Telephone Survey			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%

ACNH's Reveal Caller Telephone Survey Response

ACNH reviewed the data mismatches for the PDV indicators supplied by DHHS scoring below 90 percent. **ACNH** reviewed the recommendations and case-level PDV results file and conducted research concerning the information received from the provider and the information indicated on the **ACNH** provider directory. **ACNH** PNM account executives outreached to providers to verify, collect, and correct the following information to ensure the accuracy of the information on the **ACNH** provider directory:

- Provider addresses including suite number with an emphasis on specialists
- Provider phone number, especially specialists
- Accommodates for physical disabilities with an emphasis on specialists
- Non-English speaking BH providers (including American Sign Language)

Account executives also furnished education to providers concerning how to submit provider demographic updates to **ACNH** and completed any provider data updates based on the information furnished by DHHS and confirmed by the providers. **ACNH** continued to educate providers concerning the importance of updating **ACNH** of all changes within their practice (address, phone, providers accepting new patients, etc.) to ensure the accuracy of the provider directory.

New Hampshire Healthy Families

The SFY 2022 EQR Technical Report contained opportunities for improvement for **NHHF** in contract compliance, NAV, HEDIS, EDV, and the reveal caller telephone survey. Except for contract compliance, the following tables display the follow-up required from the self-reported activities conducted by **NHHF** during SFY 2023 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2022 EQR Technical Report contained opportunities for improvement for **NHHF** in the contract compliance activity. HSAG included any element that did not receive a score of *Met* in a CAP document sent to **NHHF**. Prior to the completion of the CAP process, which was approved by DHHS, **NHHF** submitted 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 activities implemented by **NHHF** during SFY 2023 to improve the contract compliance results are shown below.

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard X—Access	99.1%	100%
NHHF's Contract Compliance Response			
NHHF submitted an updated policy indicating that the MCO will, in instances where **NHHF** is provided with advance notice of a provider termination, send letters to members 30 calendar days before the provider's termination takes effect. This element is *Met*.			

Table 6-17—Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XV—FWA	97.2%	100%
NHHF's Contract Compliance Response			
NHHF created an updated version of the **NHHF** Medicaid Subcontractor Attachment indicating that the MCO and its subcontractors will 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. This element is *Met*.			

NAV

The SFY 2022 EQR Technical Report contained opportunities for improvement for **NHHF** in the NAV activity. The activities implemented by **NHHF** during SFY 2023 to improve those results are shown below.

Table 6-18—NAV—Opportunities for Improvement and MCO Response

NHHF's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%

NHHF's NAV Response

NHHF reviewed each deficiency on the case-level NAV study analytic data results file supplied by DHHS and addressed all deficiencies scoring below 90 percent as shown below:

- Provider addresses including provider suite number and ZIP codes with a focus on PCPs and specialists
- Provider phone number for PCPs, specialists, and BH providers
- Provider accepting new patients with a focus on PCPs and specialists
- Accommodates for physical disabilities for PCPs, specialists, and BH providers
- Non-English language speaking providers (including American Sign Language) with a focus on PCPs and BH providers

In the future **NHHF** will continue to audit internal data and provider data submitted by an external vendor. **NHHF** updated the provider online portal as of December 2022 to allow providers to update their own demographic information to ensure more timely and accurate directory information. **NHHF** also is working with the plan's reporting analyst to ensure that data files are generated according to DHHS updated guidance (i.e., only include directory facing data).

HEDIS

The SFY 2022 EQR Technical Report contained opportunities for improving **NHHF**'s HEDIS measures. The activities implemented by **NHHF** during SFY 2023 to improve those results are shown below.

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

NHHF's HEDIS Opportunities for Improvement			
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

NHHF's HEDIS Response

The HPV component of the *IMA* has been the focus of a performance improvement project in 2023. Activities implemented include:

- An email campaign to parents of members aged 9–12 who have not met the HPV vaccine measure.
- An educational event for providers that included viewing the film "Someone You Love" and two breakout sessions. One session focused on improving clinic processes for the HPV vaccine and another focused on how to have the conversation about the HPV vaccine during a clinic appointment.
- A texting campaign to parents of members turning 13 who have had the first dose of the HPV vaccine and still have time to complete the second dose prior to their 13th birthday in 2023.

Activities planned for the remainder of 2023 included:

- Outreach to identify clinics to share the American Cancer Society/National HPV Vaccination Roundtable toolkit for improving HPV vaccine rates.
- An educational event for practice managers to discuss way to improve clinic workflow to increase HPV vaccine rates.

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

NHHF's HEDIS Opportunities for Improvement			
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			
Activities conducted to improve chlamydia screening rates included: • Preparing a provider tip sheet summarizing why screening for chlamydia is important and posting the information to **NHHF**'s provider resources webpage in August 2023. • Sharing the provider tip sheet and scheduling meetings with the **NHHF** provider quality liaison team and network provider groups to discuss their chlamydia screening rates. • Preparing a Provider Newsletter focusing on quality measures. This newsletter will include information concerning the importance of chlamydia screening and a link to additional reference material about chlamydia.			

EDV

The SFY 2022 EQR Technical Report contained opportunities for improvement for NHHF in EDV. The activities implemented by NHHF during SFY 2023 to improve those results are shown below.

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

NHHF's EDV Opportunities for Improvement Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	82.8%	100%
EDV	837 Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
NHHF's EDV Response			
NHHF changed transportation subcontractors in September 2020. At the direction of DHHS, NHHF held all transportation encounters for this subcontractor until DHHS was ready to initiate the implementation. After joint testing in August 2021, NHHF began submitting encounter data from the new transportation subcontractor. NHHF worked with DHHS to submit the backlog of held encounters in batches from August through September 2021. Most of the untimely encounters were in the backlog of held encounters submitted during that time. NHHF implemented additional data corrections in Spring 2022 which required a void and resubmit of all historical encounters. This effort required an additional hold of new encounters during cleanup.			

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

NHHF's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Record Omission for Institutional (I)	11.4%	≤4.0%
NHHF's EDV Response			
NHHF identified two items leading to the record omissions. 1) NHHF encounter submissions used bundled service lines where the data pull did not use bundled lines. NHHF worked with DHHS to update encounter submission logic to no longer send bundled lines. That change moved into production in late 2022. 2) NHHF reviewed the examples not tied to bundled lines and identified a submission issue tied to adjusted claims that were voided but never resubmitted as paid/denied. DHHS has been made aware of this and NHHF is currently working to correct this issue. NHHF has identified that this issue was present in the former encounter data management system and is not present in the system that replaced it in February 2022. NHHF identified all missing encounters related to this issue and completed resubmission of replacement paid/denied encounters on December 21, 2022. NHHF also implemented a process to monitor encounter submission iterations to identify claims not in the appropriate finalized status.			

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

NHHF's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Record Omission for Pharmacy	5.5%	≤4.0%
NHHF reviewed examples provided and confirmed that B2 (void) transactions were submitted for those encounters after the original submission. **NHHF** is working with CVS Pharmacy to improve future data pulls and exclude adjusted/voided records in subsequent encounter submissions. Per the specifications, these should not have been included. **NHHF** will continue to work with the pharmacy vendor to identify opportunities to improve this metric.			

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

NHHF's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Element Accuracy (I)–Procedure Code, Procedure Code Modifier, and Detail Paid Amount	92.7%–93.5%	≥95.0%
NHHF's EDV Response			
NHHF encounter submissions used bundled service lines where the data pull did not use bundled lines. **NHHF** worked with DHHS to update encounter submission logic to no longer send bundled lines. **NHHF** identified two items leading to procedure code modifier inaccuracy. 1) **NHHF** encounter submissions used bundled service lines where the data pull did not use bundled lines. **NHHF** worked with DHHS to update encounter submission logic to no longer send bundled lines. 2) **NHHF** reviewed the examples that were not tied to bundled lines and found that the modifiers were present in both data sets but ordered differently in the **NHHF** data pull from how they were sent on the encounter file. **NHHF** will adjust the data pull logic to ensure it pulls encounter submissions to correct this on future studies. **NHHF** has identified two items leading to detail paid amount inaccuracy. 1) **NHHF** encounter submissions used bundled service lines where the data pull did not use bundled lines. **NHHF** worked with DHHS to update encounter submission logic to no longer send bundled lines. 2) **NHHF** reviewed the examples that were not tied to bundled lines and found that the data pull did not account for interest amounts paid on the claim. **NHHF** will adjust the data pull logic to ensure encounters are pulled to correct this on future studies.			

Reveal Caller Telephone Response

The SFY 2022 EQR Technical Report contained opportunities for improvement for **NHHF** in the reveal caller telephone survey results. The activities implemented by **NHHF** during SFY 2023 to improve those results are shown below.

Table 6-25—Reveal Caller Telephone Survey —Opportunities for Improvement and MCO Response

NHHF's Reveal Caller Telephone Survey Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%
NHHF's Reveal Caller Telephone Survey Response			
NHHF reviewed each deficiency on the case-level analytic data results file supplied by DHHS and addressed the following deficiencies related to PDV indicators that scored below 90 percent: • Provider addresses including provider suite number and ZIP code with a focus on PCPs and specialists • Provider phone number for PCPs, specialists, and BH providers • Provider accepting new patients, with a focus on PCPs and specialists • Accommodates for physical disabilities for PCPs, specialists, and BH providers • Non-English language speaking providers (including American Sign Language) with a focus on PCPs and BH providers			

Well Sense Health Plan

The SFY 2022 EQR Technical Report contained opportunities for improvement for **WS** in contract compliance, NAV, CAHPS, HEDIS, EDV, and the reveal caller telephone survey. Except for contract compliance, the following tables display the follow-up required from the self-reported activities conducted by **WS** during SFY 2023 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2022 EQR Technical Report contained opportunities for improvement for **WS** in the contract compliance activity. HSAG included any element that did not receive a score of *Met* in a CAP document sent to **WS**. Prior to the completion of the CAP process, which was approved by DHHS, **WS** submitted 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 activities implemented by **WS** during SFY 2023 to improve the contract compliance results are shown below.

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

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard IX—Grievances and Appeals Systems	99.3%	100%
WS's Contract Compliance Response			
WS updated the Member Appeals policy. The update included the requirement that if the MCO extends the timeframe not at the request of the member, the MCO gives the member prompt oral notice of the delay by 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 the MCO's decision to extend the timeframe. This element is *Met*.			

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

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard IX—Grievances and Appeals Systems	99.3%	100%
WS's Contract Compliance Response			
WS submitted an updated Members Appeals policy. The policy specified that upon notice of an expedited State fair hearing request from DHHS, **WS** will furnish to DHHS and the member (and/or authorized representative) upon request within 24 hours, all plan-held documentation related to the appeal, including but not limited to any transcripts, records, or written decisions from participating providers or delegated entities. This element is *Met*.			

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

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard X—Access	97.3%	100%
WS's Contract Compliance Response			
WS submitted two policies and two member communications to address the requirements to inform members of their PCP termination and describe in the notice the procedures for selecting an alternative PCP. This element is *Met*.			

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

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard X—Access	97.3%	100%
WS's Contract Compliance Response			
WS revised a policy to include the requirement to address how the MCO will ensure continuity of care for members who are in an ongoing course of treatment, have a special condition, or are children with special health care needs during transitions between home and foster care placement, foster care and independent living, foster care placement to the community, or change in legal status from foster care to adoption. This element is *Met*.			

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

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XV—FWA	97.2%	100%
WS's Contract Compliance Response			
WS updated the Fraud, Waste, and Abuse policy to include the requirement 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 an MCO oversight review. This element is *Met*.			

NAV

The SFY 2022 EQR Technical Report contained opportunities for improvement for WS in the NAV activity. The activities implemented by WS during SFY 2023 to improve those results are shown below.

Table 6-31—NAV—Opportunities for Improvement and MCO Response

WS's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%
WS's NAV Response			
WS reviewed the provider data and conducted outreach to each provider's office to review the errors found. Updates were made to the system to correct the deficiencies. WS reviewed the BH-individual provider data and scored 92.4 percent which was above the 90 percent DHHS threshold as shown below: • Provider address including suite number: 98.8 percent met for address match, and 98.2 percent met for suite number • Provider accepting new patients: 98.2 percent met • Provider accommodates physical disabilities: 92.4 percent met • Non-English language speaking provider (including American Sign Language): 97.6 percent met			

CAHPS

The SFY 2022 EQR Technical Report contained opportunities for improvement for WS in the CAHPS measures. The activities implemented by WS during SFY 2023 to improve those results are shown below.

Table 6-32—CAHPS—Opportunities for Improvement and MCO Response

WS's CAHPS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
CAHPS	Adult Medicaid CAHPS Results: *Rating of Personal Doctor*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average

WS's CAHPS Response

WS's efforts to improve the performance on this measure during SFY 2023 included the following:

- Utilizing a data-driven approach to identify adult members with open care gaps who are likely to report negative CAHPS scores for access and provider satisfaction measures. WS proactively identified those members and outreached to them telephonically between July and December 2022 to improve member engagement and close important HEDIS clinical care gaps. Outreached members reported being grateful for the call and the reminder to make an appointment for important screenings. Some members did not need help scheduling appointments, while others received assistance with healthcare questions or finding a new PCP.
- Outreaching telephonically to New Hampshire Medicaid adult members between January and February 2023 as part of our CAHPS "Just in Time" effort targeting outreach calls to high-risk members to resolve access issues and improve members' overall perception of their healthcare experience. Members who were successfully outreached received healthcare assistance from member services regarding PCP selection, appointment scheduling, or benefits education.
- Mailing benefit reminders to New Hampshire Medicaid adult members in early February 2023 to remind them about covered services, the important role of the PCP, and available member rewards for healthy behaviors. The reminders also encouraged members to schedule an annual checkup and respond to a survey if they received one in the mail.

HEDIS

The SFY 2022 EQR Technical Report contained opportunities for improvement for WS in HEDIS measures. The activities implemented by WS during SFY 2023 to improve those results are shown below.

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

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Breast Cancer Screening (BCS)*	Below the 25th Percentile	Equal to or higher than the national average
WS's HEDIS Response			
WS conducted year-round chart audit to assist with gap closure. CM reviewed and contacted members who had open gaps to encourage compliance.			

Table 6-34—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years* and *Total*	Below the 25th Percentile	Equal to or higher than the national average
WS's HEDIS Response			
WS researched vetted guidelines, solicited input from internal medical directors, and worked with the marketing department to craft and share an appropriate document to all WS's New Hampshire Medicaid providers. The information included online resources from the CDC for providers to appropriately screen for STIs, and a free mobile app with STI treatment guides, a pocket guide, and a wall chart.			

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

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Use of Imaging for Low Back Pain (LBP)*	Below the 25th Percentile	Equal to or higher than the national average

WS's HEDIS Opportunities for Improvement
WS's HEDIS Response
WS will be conducting a review of providers/facilities with low compliance to evaluate targeted intervention needs. Additionally, when members enroll in CM and this condition presents, CMs will have clinically appropriate discussions with members regarding their low back pain management.

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

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*Plan All Cause Readmissions (PCR) —Observed Readmissions—Total*	Below the 25th Percentile	Equal to or higher than the national average
WS's HEDIS Response			
WS UM clinicians reviewed cases for potential readmission risk utilizing the following criteria: • Two inpatient admissions in last 3 months • NICU admissions for all members less than 30 weeks of gestation at time of notification • Readmission risk based on clinical judgement • Admissions to hospital for: – Diabetes complications (e.g., diabetes-related ketoacidosis, hypoglycemia, amputation, sepsis, cardiac event) – COPD/asthma – Heart failure/congestive heart failure – Dehydration or admissions related to chronic kidney disease – Pneumonia complications – Cellulitis and musculoskeletal infections associated with SUD – BH: Three or more inpatient visits due to psychiatric or SUD (including pancreatic disorders) If the member meets any of the above criteria, the UM clinician reviews the case to determine if the member is already participating in CM. If not already enrolled with a CM Plan, the UM clinician will refer the claim information to CM: "Referral to CM – Readmission Risk," detailing the current situation. If the member is already enrolled into CM, the UM clinician sends an activity directly to the CM episode owner.			

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

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Elements Needing Improvement**	**MCO Results**	**Standard**
HEDIS	*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

WS's HEDIS Opportunities for Improvement
WS's HEDIS Response
Members in the CM program have open gaps reviewed during interactions to encourage appropriate follow-up. While **WS** does manage and support this measure via CM activities, it is commonly found that ADHD meds are managed with PCPs and the CM prevalence is lower than other childhood conditions. For this reason, **WS** is exploring opportunities for pediatric and family medicine provider education concerning best practices.

EDV

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

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

WS's EDV Opportunities for Improvement Information System Review			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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
WS's EDV Response			
For NEMT, WS is currently testing the 837 submissions with DHHS for the new vendor, CTS. This will be a pass-through file and contractually the vendor is required to attest to the accuracy and completeness of the data prior to submission. WS is implementing 15 data quality (DQ) rules that will be run against the NEMT data when loading into the data warehouse. For the previous vendor, OneCall, WS is running nine DQ rules against the data loaded into the WS data warehouse. For Vision claims, WS does not have DQ rules specific for these types of claims due to the volume which is relatively small. However, some of DQ rules in place today do not have any condition for claim source, and WS runs these rules against all claim types including vision claims. WS is implementing a new data warehouse and because vision claims are included in the medical claims table. Any DQ rules categorized as 'Medical', which are many, will be run against the vision claims. Additionally, WS has a DQ goal for FY 2023 to identify and implement DQ rules for vision claims.			

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

WS's EDV Opportunities for Improvement Information System Review			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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

WS's EDV Opportunities for Improvement Information System Review
WS's EDV Response
WS is currently developing reconciliation and attestation processes and is in the requirements gathering stage with both IT and business partners.

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

WS's EDV Opportunities for Improvement Information System Review			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Understand the purpose of the denied response files	Confusion regarding the purpose of the denied response files	NA
WS's EDV Response			
WS is actively working on the response file each week. Once the response file is received, it is loaded to Edifecs, and the business operation team completes a review. **WS** has established two paths. The first involves determining if there are any data quality issues, and if there are, the claims is adjusted and resubmitted. The second path is to work with DHHS on the exception requests process where there are no data issues in the encounter data. We will work with DHHS to obtain clarification and adjust this process as needed based on DHHS guidance.			

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

WS's EDV Opportunities for Improvement Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional (P): Validity of Member Identification Number—Percent Valid	99.9%	100%
EDV	837 Institutional (I) Encounters: Validity of Member Identification Number—Percent Valid	99.8%	100%
WS's EDV Response			
It appears that there is an issue with communication between the provider, member, and enrollment team. Member enrollment team members indicated that they make several attempts to get this information but often are waiting for a response from the provider or member. To improve data accuracy for member identifications (ID's), **WS** is recommending a meeting with DHHS to potentially stream-line communication when a newborn is enrolled to reduce gaps. **WS** also will work with Public Partnerships to schedule a discussion for guidance/direction.			

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

WS's EDV Opportunities for Improvement Ongoing Encounter Data Quality Reporting System			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	97.9%	100%
EDV	837I: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
EDV	837 Pharmacy: Initial Submission Within 14 Days of Claim Payment*	91.1%	100%
WS's EDV Response			
WS staff members acknowledge and agree that they should continue to improve the percentage of initial encounter submissions. This will be supported by **WS**'s current initiative to develop and implement an attestation process.			

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

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Record Surplus Pharmacy	4.4%	≤4.0%
WS's EDV Response			
WS and its pharmacy vendor (Express Scripts) are actively working on multiple solutions to the surplus claims concern. First, our pharmacy vendor is waiting for guidance from the State of New Hampshire Medicaid agency regarding void/reversals reported encounter claims being incorrectly rejected (error code 1C006) by the State. The State is not recognizing and matching the void encounter ID to the original paid encounter ID, as required on the encounter file layout. The second largest encounter rejection (3U092 - previous fill date invalid) has a solution pending with the pharmacy vendor. The solution is bundled with the concern related to the above error code 1C006. The two items above represent nearly 99 percent of the "surplus" claims identified.			

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

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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	
WS's EDV Response			
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. DME: Northwood is not currently sending **WS** the referring provider NPI. **WS** is planning to address this issue with Northwood. Northwood reviewed **WS** data and did not identify claims with referring physician present; hence **WS** does not have this information on the claim. Vision: For the procedure code modifier, **WS** submitted a request for a system revision. Because the **WS** vision plan includes routine vision, Vision Service Plan (VSP) does not require a referring provider on the claim. **WS** also is aware of the issue with the secondary diagnosis code and has submitted a request for a system revision.			

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

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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.
WS's EDV Response			
WS is aware of this issue and has submitted a request for a system revision.			

Reveal Caller Telephone Survey

The SFY 2022 EQR Technical Report contained opportunities for improvement for WS in the reveal caller telephone survey results. The activities implemented by WS during SFY 2023 to improve this activity are shown below.

Table 6-46—Reveal Caller Telephone Survey—Opportunities for Improvement and MCO Response

WS's Reveal Caller Telephone Survey Opportunities for Improvement Reveal Caller Telephone Survey			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
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%
WS's Reveal Caller Telephone Survey Response			
WS reviewed the provider data and conducted outreach to each provider's office to review the errors found. WS made updates to the system to correct the deficiencies. WS reviewed the BH-individual provider data and scored 92.4 percent which was above the 90 percent DHHS threshold as shown below: • Provider address including suite number: 98.8 percent met for address match and 98.2 percent met for suite number • Provider accepting new patients: 98.2 percent met • Provider accommodates physical disabilities: 92.4 percent met • Non-English language speaking provider (including American Sign Language): 97.6 percent met			

Appendix A. Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

- **AAP**—Adults' Access to Preventive/Ambulatory Health Services; American Academy of Pediatrics
- **ACNH**—AmeriHealth Caritas New Hampshire
- **ACT**—assertive community treatment
- **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
- **ANSA**—Adult Needs and Strengths Assessment
- **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
- **ASAM**—American Society of Addiction Medicine
- **BBA**—Federal Balanced Budget Act of 1997
- **BCS**—Breast Cancer Screening
- **BH**—behavioral health
- **BMI**—body mass index
- **CAHPS**—Consumer Assessment of Healthcare Providers and Systems
- **CANS**—Child and Adolescent Needs and Strengths Assessment
- **CAP**—corrective action plan
- **CBP**—Controlling High Blood Pressure
- **CCC**—Children with Chronic Conditions
- **CCS**—Cervical Cancer Screening
- **CDC**—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; case management
- **CMH**—community mental health
- **CMS**—Centers for Medicare & Medicaid Services
- **COB**—coordination of benefits
- **COPD**—chronic obstructive pulmonary disease
- **COVID-19**—coronavirus disease 2019
- **CPT**—current procedural terminology
- **CSV**—comma separated values
- **CTS**—Coordinated Transportation Solutions
- **CWP**—Appropriate Testing for Children with Pharyngitis
- **CY**—calendar year
- **DAV**—data aggregator validation
- **DCYF**—Department of Children, Youth, and Families
- **DHHS**—State of New Hampshire, Department of Health and Human Services
- **DME**—durable medical equipment
- **DNR**—do not report
- **DOJ**—Department of Justice
- **DQ**—data quality
- **DRA**—Deficit Reduction Act
- **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
- **EDW**—enterprise data warehouse

- **ENT**—ears, nose, throat; otolaryngologist
- **EPSDT**—Early and Periodic Screening, Diagnostic, and Treatment
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **ERISA**—Employee Retirement Income Security Act of 1974
- **FAR**—final audit report
- **FCA**—False Claims Act
- **FFCRA**—Families First Coronavirus Response Act
- **FFS**—fee-for-service
- **FMEA**—failure modes and effects analysis
- **FUA**—Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence
- **FUH**—Follow-up After Hospitalization for Mental Illness
- **FUM**—Follow-Up After Emergency Department Visit for Mental Illness
- **FWA**—fraud, waste, and abuse
- **HbA1c**—hemoglobin A1c; a measure of longer-term glucose management
- **HBD**—Hemoglobin A1c (HbA1c) Control for Patients With Diabetes
- **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
- **ICD**—International Classification of Diseases
- **ID**—identification
- **IDSS**—Interactive Data Submission System
- **IET**—Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
- **IMA**—Immunizations for Adolescents
- **IMD**—Institution for Mental Diseases
- **IPV**—polio vaccine

- **IS**—information systems
- **ISCAT**—Information System Capability Assessment Tool
- **LBP**—Use of Imaging Studies for Low Back Pain
- **LO**—National Committee for Quality Assurance-Licensed Organization
- **LSC**—Lead Screening in Children
- **MAT**—medication assisted treatment
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MFCU**—Medicaid Fraud Control Unit
- **MLADC**—Master's Level Alcohol and Drug Counselor
- **MMR**—measles, mumps, and rubella vaccine
- **MOUD**—medication for opioid use disorder
- **MQIS**—Medicaid Quality Information System
- **MS**—Microsoft
- **MTM**—Medical Transportation Management
- **MY**—measurement year
- **NA**—not applicable; for HEDIS, small denominator
- **NAS**—neonatal abstinence syndrome
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NCS**—Non-Recommended Cervical Cancer Screening in Adolescent Females
- **NDC**—national drug code
- **NDR**—notification of diagnosis and/or referral
- **NEMT**—non-emergency medical transportation
- **NHHF**—New Hampshire Healthy Families
- **NIA**—National Imaging Associates
- **NICU**—neonatal intensive care unit
- **NPI**—National Provider Identifier
- **NR**—not reported
- **OB/GYN**—obstetrics/gynecology
- **OIG**—Office of Inspector General
- **OT**—occupational therapist
- **OUD**—opioid use disorder
- **OTP**—opioid treatment provider

- **P**—professional
- **PAHP**—prepaid ambulatory health plan
- **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
- **PNM**—provider network management
- **POD**— Pharmacotherapy for Opioid Use Disorder
- **POM**—proactive outreach manager
- **POS**—place of service
- **PPC**—Prenatal and Postpartum Care
- **PSV**—primary source verification
- **PT**—physical therapy
- **QAPI**—quality assessment and performance improvement
- **QI**—quality improvement
- **QR**—quick response
- **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
- **SCP**—specialty care provider
- **SFTP**—secure file transfer protocol
- **SFY**—state fiscal year
- **SMART**—specific, measurable, attainable, relevant, and time-bound
- **SMD**—Diabetes Monitoring for People With Diabetes and Schizophrenia

- **SPHA—**Symphony Performance Health Analytics
- **SSD—**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **ST—**speech therapist
- **STI—**sexually transmitted infection
- **SUD—**substance use disorder
- **TAT—**turnaround time
- **TBD—**to be determined
- **Tdap—**tetanus, diphtheria, and acellular pertussis vaccine
- **TOB—**type of bill
- **TOC—**transition of care
- **TPL—**third-party liability
- **UM**—utilization management
- **URI—**Appropriate Treatment for Children with Upper Respiratory Infection
- **VSP—**Vision Service Plan
- **VZV**—varicella (chicken pox) vaccine
- **W30—**Well-Child in the First 30 Months of Life
- **WCC—**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- **WCV—**Child and Adolescent Well-Care Visits
- **WS—**Well Sense Health Plan

Appendix B. Methodologies for Conducting EQR Activities

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

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:
  - Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[B-1]
- ***Timeliness***—NCQA defines "timeliness" relative to utilization decisions as follows:
  - "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[B-2] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).
- ***Access***—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:
  - Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[B-3]

[B-1] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Nov 17, 2023.

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

[B-3] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 17, 2023.

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*, February 2023,[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

The CMS External Quality Review (EQR) Protocols published in February 2023[B-9] define the five activities included in the review of compliance with Medicaid and CHIP managed care regulations. Table B-1 displays the activities and indicates the process HSAG uses to ensure compliance with those requirements.

B-4 U. S. Government Printing Office. (2019). *Activities related to external quality review.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 17, 2023.

B-5 State of New Hampshire Department of Health and Human Services (2022). Amendment #8 to the Medicaid Care Management Services Contract. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Sept 21, 2023.

B-6 Department of Health and Human Services. (2016). 42 CFR §438. Available at: https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-part438.pdf. Accessed on: Nov 17, 2023.

B-7 Centers for Medicare & Medicaid Services. (2018). Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf. Accessed on: Nov 17, 2023.

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*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 11, 2023.

B-9 Ibid.

Table B-1—Protocol 3 Activities Performed for the Review of Compliance With Managed Care and State Regulations

Activity 1:	Establish Compliance Thresholds
	• Determine the timeline and agendas for conducting the compliance reviews with DHHS • Begin developing the compliance review tool consistent with CMS protocols approximately six months prior to the review date • Collect information from DHHS concerning State-specific requirements found in the New Hampshire MCM Contract • Define scoring mechanisms used as benchmarks to quantify results from the compliance activities • Send draft compliance tool to DHHS for review and comment • Receive approval of draft compliance tool from DHHS • Determine the point of contact for the compliance reviews from each MCO and schedule the review • Send the compliance tool and additional pre-site documents to the MCOs with details concerning the preliminary data needed from the MCOs, the timeline for posting the information, and the secure website address for posting the information • Conduct webinars with MCOs requesting additional information about the compliance review activities • Respond to MCO questions concerning the requirements established to evaluate MCO performance during the compliance reviews
Activity 2:	**Perform Preliminary Review**
	• Receive requested pre-site documents and data files from the MCOs • Begin completing compliance tool with information obtained from the pre-site documents • Evaluate the MCOs' information to gain insight into ***quality of care***, ***timeliness of care***, and ***access to care***, and the organizations' structure, services, operations, resources, IS, quality program, and delegated functions • Determine preliminary findings before the site visit from documents submitted by the MCOs • Specify areas and issues requiring further clarification or follow-up during the review to ensure receiving information concerning the identified gaps in the documentation sent with the pre-site information

Activity 3:	Conduct the Compliance Review
	• Conduct an opening conference that includes 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 to obtain complete information concerning the MCO's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the pre-site documents, and increase HSAG reviewers' overall understanding of MCO's performance • Collect additional documents required for the compliance review including, but 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 • Discuss the organization's IS data collection process and reporting capabilities related to the standards included in the review • Summarize findings at a closing conference to provide the MCO's staff members and DHHS with a high-level summary of HSAG's preliminary findings • Provide information concerning next steps and the projected date the MCOs will receive the draft compliance report
Activity 4:	**Compile and Analyze Findings**
	• Complete compliance tools with findings from interviews and documents received during the site review • Evaluate and analyze the MCOs' performance complying with the requirements in each of the standards contained in the review tool • Delineate findings and designate scores (e.g., *Met*, *Partially Met*, *Not Met*, or *Not Applicable*) to document the degree the MCOs comply with each of the requirements • Calculate a percentage of compliance rate for each individual standard and an overall percentage of compliance score across all standards
Activity 5:	**Report Results to the State**

	• Prepare a draft report describing HSAG's compliance review findings to include:
	  − Scores assigned for each element within each standard
	  − Assessments of each MCO's strengths and areas requiring corrective action
	  − Identification of best practices to share with DHHS
	  − Suggested ways to further enhance the MCO's performance
	• Forward the draft report to DHHS for review and comment
	• Receive approval of the draft report from DHHS
	• Send the draft report to the MCOs for comment
	• Respond to any comments made by the MCOs
	• Issue a final report that includes an appendix with the compliance tool and an appendix with elements included in the CAP
	• Collaborate with the MCOs to correct all elements scoring below 100 percent compliance until the revisions meet the requirements

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 2023 compliance review:

- MCO Questionnaire sent to the MCO with the pre-site documents
- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents
- 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
- Financial documents
- Subcontractor agreements
- Subcontract, initial credentialing, and recredentialing file reviews

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 draws 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 in each standard for each of the three years. Each year HSAG established a level of confidence rating for the compliance review based on the overall score as shown 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 2021–2023 Compliance Review Results

HSAG conducts the compliance review for all standards over a three-year period. Table B-2 through Table B-4 present information concerning the compliance reviews conducted in SFY 2021–SFY 2023. The tables display the CFR reference, the standard name as listed in 42 CFR §438, the name of the standards as listed in the New Hampshire MCM program contract with the MCOs, and the rates achieved during the three-year cycle. The years HSAG reviewed the standards and the rates achieved by the MCOs are also included in the tables.

ACNH

Table B-2 includes the rates achieved by **ACNH** during the most recent three-year period of reviews.

Table B-2—Standards and Scores Achieved by ACNH in the Compliance Reviews From SFY 2021–SFY 2023

	42 CFR	Standard Name	2021	2022	2023
		§438.358(b)(iii)			
I.	§438.230	Subcontractual Relationships and Delegation			88.6%
		Delegation and Subcontracting			
II.	§438.114	Emergency and Post-Stabilization Care		100%	
III.	§438.208	Coordination and Continuity of Care	100%		
		Care Management/Care Coordination			
IV.	NA	Wellness and Prevention		100%	
V.	NA	BH			100%
VI.	§438.56	Disenrollment: Requirements and Limitations	97.1%		
		Member Enrollment and Disenrollment			
VII.	§438.100 §438.224	Enrollee Rights	99.0%		
		Member Services			
VIII.	NA	Cultural Considerations		100%	
IX.	§438.228	Grievances and Appeals Systems		100%	
X.	§438.206	Availability of Services		99.1%	
		Access to Care			
XI.	§438.214 §438.207	Provider Selection			99.5%
		Assurance of Adequate Capacity and Services			
		Network Management			
XII.	§438.210 §438.224	Coverage and Authorization of Services	96.9%		
		UM			

	42 CFR	Standard Name	2021	2022	2023
		§438.358(b)(iii)			
XIII.	§438.236 §438.224 §438.330	Practice Guidelines	100%		
		Confidentiality			
		Quality Assessment and Performance Improvement Program			
		Quality Management			
XIV.	NA	SUD			100%
XV.	NA	FWA		91.7%	
XVI.	NA	Financial			100%
XVII.	NA	Third Party Liability (TPL)*	100%		
XVIII	§438.242	Health IS**		100%	
OVERALL RESULTS			**98.4%**	**99.2%**	**98.6%**
CONFIDENCE LEVEL			**High**	**High**	**High**

*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 2023 to the previous year (i.e., 2022) indicates that **ACNH** decreased its score by 0.6 percentage points.

NHHF

Table B-3 includes the rates achieved by **NHHF** during the most recent three-year period of reviews.

Table B-3—Standards and Scores Achieved by NHHF in the Compliance Reviews From SFY 2021–SFY 2023

	CFR	Standard Name	2021	2022	2023
		§438.358(b)(iii)			
I.	§438.230	Subcontractual Relationships and Delegation			79.5%
		Delegation and Subcontracting			
II.	§438.114	Emergency and Post-Stabilization Care		100%	
III.	§438.208	Coordination and Continuity of Care	100%		
		Care Management/Care Coordination			
IV.	NA	Wellness and Prevention		100%	
V.	NA	BH			100%
VI.	§438.56	Disenrollment: Requirements and Limitations	100%		
		Member Enrollment and Disenrollment			

	CFR	Standard Name	2021	2022	2023
		§438.358(b)(iii)			
VII.	§438.100	Enrollee Rights	98.0%		
		Member Services			
VIII.	NA	Cultural Considerations		100%	
IX.	§438.228	Grievances and Appeals Systems		100%	
X.	§438.206	Availability of Services		99.1%	
		Access to Care			
XI.	§438.214 §438.207	Provider Selection			94.8%
		Assurance of Adequate Capacity and Services			
		Network Management			
XII.	§438.210	Coverage and Authorization of Services	100%		
		UM			
XIII.	§438.236 §438.224 §438.330	Practice Guidelines	100%		
		Confidentiality			
		Quality Assessment and Performance Improvement Program			
		Quality Management			
XIV.	NA	SUD			100%
XV.	NA	FWA		97.2%	
XVI.	NA	Financial			100%
XVII.	NA	TPL	100%		
XVIII.	NA	Health IS		100%	
OVERALL RESULTS			**99.5%**	**99.6%**	**94.5%**
CONFIDENCE LEVEL			**High**	**High**	**High**

A comparison of the overall results from the compliance review score from 2023 to the previous year (i.e., 2022) indicates that **NHHF**'s score decreased by 5.1 percentage points.

WS

Table B-4 includes the rates achieved by **WS** during the most recent three-year period of reviews.

Table B-4—Standards and Scores Achieved by WS in the Compliance Reviews From SFY 2021–SFY 2023

	WS	Standard Name	2021	2022	2023
		§438.358(b)(iii)	Three Year Period		
I.	§438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting			100%
II.	§438.114	Emergency and Post-Stabilization Care		100%	
III.	§438.208	Coordination and Continuity of Care Care Management/Care Coordination	88.2%		
IV.	NA	Wellness and Prevention		100%	
V.	NA	BH			100%
VI.	§438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment	94.1%		
VII.	§438.100	Enrollee Rights Member Services	100%		
VIII.	NA	Cultural Considerations		100%	
IX.	§438.228	Grievances and Appeals Systems		99.3%	
X.	§438.206	Availability of Services Access to Care		97.3%	
XI.	§438.214 §438.207	Provider Selection Assurance of Adequate Capacity and Services Network Management			96.9%
XII.	§438.210 §438.224	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	SUD			100%
XV.	NA	FWA		97.2%	
XVI.	NA	Financial			100%
XVII.	NA	TPL	100%		

	WS	Standard Name	2021	2022	2023
		§438.358(b)(iii)	Three Year Period		
XVIII.	NA	Health IS		100%	
OVERALL RESULTS			**96.4%**	**98.8%**	**97.7%**
CONFIDENCE LEVEL			**High**	**High**	**High**

A comparison of the overall results from the compliance review score from 2023 to the previous year (i.e., 2022) indicates that **WS** decreased its score by 1.1 percentage points.

PIPs

Validation of PIPs, as set forth in 42 CFR §438.358(b)(1)(i),[B-10] 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-11] 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.

[B-10] 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 17, 2023.
[B-11] Ibid.

Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. Because these PIPs were initiated in SFY 2020, 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,* February 2023.[B-12]

HSAG used a rapid-cycle PIP framework for validation, based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[B-13] 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 and has the opportunity to resubmit the module for a final validation.

B-12 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 17, 2023.

B-13 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 17, 2023.

For all PIP topics, all three MCOs used claims data or data warehouse data specific to the SMART Aim measure. The numerators are divided by the denominators to produce the percentages reported.

How Conclusions Were Drawn

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement is related to the QI strategies and activities conducted by the MCO during the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirms that any improvement achieved could be reasonably linked to the QI strategies implemented by the MCO.

For both the concluding PIPs and new PIPs, Confidence Levels for modules 1 through 3 (PIP Initiation, Intervention Determination, and Intervention Testing) were determined as follows:

- 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.

For the concluding PIPs in SFY 2023, HSAG used a standardized scoring methodology and assigned a level of confidence and reported 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.

At the request of DHHS, for the newly initiated PIPs in SFY 2023, HSAG revised the rapid-cycle PIP approach. The PIPs continued to be 18 months in duration; however, HSAG streamlined the module submission timeline to have modules 2 and 3 submitted together rather than individually. Additionally, the MCOs did not select a narrowed focus for the eligible population. The MCOs used the entire eligible population, following the applicable specifications for each PIP. Using a standardized scoring methodology at the conclusion of the new PIPs, HSAG will assign a level of confidence and report 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 the 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 of care domain*** from all PIPs. HSAG may also draw conclusions about the remaining domains of care and services—***timeliness of care*** and ***access to care***—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-14] 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-5 presents the 17 State-selected performance measures for the SFY 2023 validation activities in New Hampshire. HSAG completed the reports for this activity in May 2023.

Table B-5—Performance Measures Audited by HSAG for SFY 2023

Performance Measures
AA.2022.02: Follow-Up After Discharge from MCO Care Management
ACCESSREQ.05: Requests for Assistance Accessing MCO Designated Primary Care Providers by County
CMS_A_CUOB: Concurrent Use of Opioids and Benzodiazepines
CMS_A_OUD.01: Use of Pharmacotherapy for Opioid Use Disorder—Total
CMS_A_OUD.02: Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine
CMS_A_OUD.03: Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone
CMS_A_OUD.04: Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone
CMS_A_OUD.05: Use of Pharmacotherapy for Opioid Use Disorder—Methadone
HRA.08: Successful Completion of MCO Health Risk Assessment
NHHDISCHARGE.16: New Hampshire Hospital Discharges—New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days of Discharge

[B-14] 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 17, 2023.

Performance Measures
PDN.05: Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter
PHARMUTLMGT.02: Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands
PROVAPPEAL.01: Resolution of Provider Appeals Within 30 Calendar Days
SERVICEAUTH.14: Service Authorization Denials for Waiver & Non-HCBC Waiver Populations
TIMELYCRED.02: Timely Provider Credentialing—Specialty Providers
WITHHOLD.21.01: Percent of All Members in the eligible population who completed a Comprehensive Medication Review and Counseling
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*, February 2023.[B-15]

HSAG followed the same process for each PMV conducted in New Hampshire 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.

Each measure verified by the HSAG review team received an audit result consistent with one of the three designation categories listed in Table B-6.

Table B-6—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.

[B-15] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 17, 2023.

Description of Data Obtained

HSAG used numerous 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 for each MCO detailing the PMV findings and any associated recommendations. DHHS and the MCOs received copies of the reports. 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 purpose of the SFY 2023 NAV was to determine if the MCOs complied with the State's network adequacy standards as outlined in their contracts and the DHHS MCM Quality Strategy for SFY 2023.

The objective of the network capacity analysis was to determine whether the MCOs' provider data files included the required minimum number of licensed and practicing providers in the State and in each public health region for five specific SUD provider types. The objective of the geographic network distribution analysis was to compare providers' service locations to the locations of member residences to determine the percentage of members with a provider available within the minimum time and distance standards.

Technical Methods of Data Collection and Analysis

HSAG used three main data sources to address the objective of the NAV: (1) DHHS-provided Medicaid member demographic information and enrolled provider information (2) DHHS-provided lists of MLADCs, buprenorphine prescribers, OTPs, residential SUD programs, and peer recovery programs, and (3) MCO-submitted provider network files.

With DHHS' approval, HSAG submitted detailed data requirement documents to DHHS and the MCOs requesting data as of December 1, 2022. In agreement with DHHS, HSAG also downloaded additional information on buprenorphine prescribers, OTPs, and residential SUD treatment programs from SAMHSA.[B-16, B-17]

Each MCO submitted provider data reflecting contracted providers actively enrolled with the MCO to serve New Hampshire MCM program members and their service locations. HSAG calculated and reported the percentage of providers licensed and practicing within New Hampshire and the number per public health region that were contracted with each MCO for five specific provider types considered in the network capacity analysis.

HSAG used software from Quest Analytics to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to two providers for all

B-16 U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration. Opioid Treatment Program Directory. Available at: https://dpt2.samhsa.gov/treatment/directory.aspx, Accessed on: Apr 25, 2023.

B-17 U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration. Buprenorphine Practitioner Locator. Available at: https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator. Accessed on: Apr 25, 2023.

provider categories identified in the analysis. HSAG then calculated the percentage of members with required access according to standards.[B-18]

Description of Data Obtained

HSAG received DHHS and MCO's data submissions containing the MCO's current provider network and DHHS Medicaid member data on January 13, 2023 (network data as of December 1, 2022). The MCO-submitted data files and DHHS Medicaid member data 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 created data review documents for each MCO and provided them to each MCO on February 17, 2023. The data review document provided the MCOs with the opportunity to provide clarifications or resubmit information identified as potential or critical issues within the document.

How Conclusions Were Drawn

HSAG cleaned, processed, and used the data submitted to define unique lists of providers, provider locations, and members for inclusion in the analyses. HSAG standardized and geocoded all Medicaid member and provider addresses using Quest Analytics software. Analyses for pediatric specialists were limited to members younger than 18 years of age, and analyses for adult specialists were limited to members 18 years of age and older. Analyses for OB/GYN providers were limited to female members 13 years of age and older. The analysis for NICU providers was limited to female members 15 to 49 years of age.

Contracted provider locations in New Hampshire and in neighboring states (Massachusetts, Maine, Vermont, New York, Connecticut, and Rhode Island) were included in time/distance analyses. All locations associated with a given provider were included in the analyses. For example, if a single provider practiced at three locations, each location was considered a unique location for the analyses.

Each MCO is obligated to contract with a network of providers that meets network capacity and GeoAccess standards. The results of the analysis speak directly to members' ***access to care*** as defined by their ability to obtain needed care within the State's network capacity and time and distance standards.

[B-18] The percentage of members within predefined standards was calculated for provider categories with predefined access standards.

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 2023 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-19] Adult members and parents/caretakers of child members completed the surveys in 2023, 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-20] 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 a positive experience rating (i.e., a response value of 8, 9, or 10 on a scale of 0 to 10). 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" or "Always." HSAG presented the

[B-19] 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-20] For this report, the 2023 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.

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 2022 NCQA CAHPS adult and general child Medicaid national averages.[B-21]

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/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 2022).

The MCOs' CAHPS vendors administered the surveys from February to May 2023. 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-22] 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 general child 2023 CAHPS survey results

[B-21] National data were obtained from NCQA's 2022 Quality Compass.

[B-22] 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.

to the 2022 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 2023 CAHPS rates for **ACNH**, **NHHF**, and **WS** revealed that one child measure rate for **ACNH** and one child measure rate for **NHHF** were statistically significantly higher than the national averages. Conversely, two child measure rates for **ACNH**, one child measure rate for **NHHF**, and three measure rates for **WS** were 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 higher than the national averages for subsequent surveys. HSAG drew conclusions concerning ***quality of care***, ***timeliness of care***, and/or ***access to 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. This assignment to domains is depicted in Table B-7.

Table B-7—Assignment of CAHPS Measures to the Quality of, Timeliness of, and Access to Care Domains

CAHPS Topic	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

HEDIS

Objectives

HSAG's primary objectives in completing the HEDIS section of the New Hampshire EQR Technical Report are to:

1. Verify that **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 2022 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 2022 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 2022 audit review season, including:
  - Audit Team Information
  - Organization Information
  - Audit Information
  - Survey Sample Frame
  - Supplemental Data (if applicable)
  - Source Code Review (if applicable)
  - Medical Record Review Validation
  - IS Standards Compliance
  - Audit Design Reference Tool
  - Final Audit Opinion
  - Audit Review Table
- The HEDIS MY 2022 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-8 The measures marked NA relate to utilization of services.

Table B-8—HEDIS MY 2022 Measures Activity Components Assessing Quality, Timeliness, and Access

Performance Measures	Quality	Timeliness	Access
Prevention			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			✓
Breast Cancer Screening (BCS)	✓		
Well-Child Visits in the First 30 Months of Life (W30)	✓	✓	✓
Child and Adolescent Well-Care Visits (WCV)	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓		
Childhood Immunization Status (CIS)	✓		
Immunizations for Adolescents (IMA)	✓		
Cervical Cancer Screening (CCS)	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✓		
Chlamydia Screening in Women (CHL)	✓		
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Lead Screening in Children (LSC)	✓		
Acute and Chronic Care			
Appropriate Testing for Pharyngitis (CWP)	✓		
Appropriate Treatment for Upper Respiratory Infection (URI)	✓		
Pharmacotherapy Management of COPD Exacerbation (PCE)	✓	✓	
Hemoglobin A1c Control for Patients With Diabetes (HBD)	✓		
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
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)	✓		

Performance Measures	Quality	Timeliness	Access
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)	✓	✓	✓
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 2023, 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*, February 2023,[B-23] HSAG conducted the following three core evaluation activities for all three MCOs:

- IS review—assessment of the 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. Since HSAG conducted an IS review for each MCO in historical EDV studies, the IS review focused on areas of interest to DHHS (i.e., changes made by the MCOs since July 1, 2021).
- 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, 2022, and June 30, 2023, HSAG included encounter data with dates of service between July 1, 2021, and June 30, 2022, in the comparative analysis. The following sections describe the methodology for each activity.

[B-23] 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*, February 2023 Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Oct 16, 2023.

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 CMS EQR Protocol 5*.[B-24]

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 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. Since HSAG conducted an IS review for each MCO in historical EDV studies, this questionnaire focused on areas of interest to DHHS (i.e., changes made by MCOs since July 1, 2021).

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.

[B-24] Ibid.

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 CMS EQR Protocol 5, the 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*.[B-25]

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

[B-25] Ibid.

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 2023 study, DHHS focused on the following measures:

- **Study Indicator SAC.2**—Percentage of confirmed MCO file submissions

Measure Element	Specification
Numerator	Number of files, attested by the MCOs, that were confirmed during encounter data import processing
Denominator	Total number of files submitted within a month
File Type	Paid and denied encounters
Reporting Frequency	Monthly, but with weekly results
Reporting Level(s)	File-Level—by encounter type, MCO, and statewide

- **Study Indicator SAC.4**—Percentage of professional and institutional records passing X12 EDI compliance edits

Measure Element	Specification
Numerator	Number of professional and institutional records passing X12 EDI compliance edits
Denominator	Total number of professional and institutional records submitted within a month
File Type	Paid and denied professional and institutional encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, MCO, and statewide

- **Study Indicator EDA.1**—Percentage of records with values present for key data element (see Table B-9)

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-9).

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-9 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-9—Key Data Elements for Measures EDA.1 and EDA.2

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Beneficiary ID	✓	✓	✓	In beneficiary file
Billing Provider Number	✓	✓	✓	In provider file
Rendering/Attending/Prescribing Provider Number	✓	✓	✓	In provider file
Primary Diagnosis Code	✓	✓		In national International Classification of Diseases, Tenth Revision, Clinical Modification (International Classification of Diseases [ICD-10-Clinical Modification [CM]) diagnosis code sets
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Code	✓	✓		In national CPT and HCPCS diagnosis code sets
Surgical Procedure Code		✓		In national ICD-10-CM surgical procedure code sets
Revenue Code		✓		In national revenue code sets
National Drug Code (NDC)			✓	In national NDC code sets

- **Study Indicator EDT.2**—Percentage of 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
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 2022 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 2022 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, 2022, and June 30, 2022, and submitted to DHHS by August 31, 2022) 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, 2022, and June 30, 2022, and submitted to DHHS by August 31, 2022)
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, 2022, and June 30, 2023. 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 10, 2023.

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-26]

- Standard 5.1.3.34.2.1 specifies that "Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the New Hampshire Medicaid Management Information System 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."

[B-26] New Hampshire Department of Health and Human Services. (2022). Medicaid Care Management Services Contract, Amendment #8. Available at: https://sos.nh.gov/media/gzgppfzr/020a-gc-agenda-06012022.pdf. Accessed on: Nov 17, 2023.

- 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 ***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 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-10. The analyses focused on an element-level comparison for each data element.

Table B-10—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Beneficiary ID	✓	✓	✓
Detail Service From Date	✓		

Key Data Elements	Professional	Institutional	Pharmacy
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 Codes	✓	✓	
Procedure Code	✓	✓	
Procedure Code Modifiers	✓	✓	
Surgical Procedure Codes		✓	
NDC			✓
Drug Quantity			✓
Revenue Code		✓	
DRG		✓	
Header Paid Amount	✓	✓	✓
Detail Paid Amount	✓	✓	
MCO Carrier ID	✓	✓	✓

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in DHHS' data warehouse (element omission)
- The number and percentage of records with values present in DHHS' data warehouse but not in the MCOs' submitted files (element surplus)
- The number and percentage of records with values missing from both DHHS' data warehouse and the MCOs' submitted files (element missing values)

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and DHHS' data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCOs' submitted files and DHHS' data warehouse (element accuracy).

For the records present in both DHHS' and the MCOs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (all-element accuracy).

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, 2021, and June 30, 2022, 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, 2022, and submitted to DHHS on or before December 31, 2022. This anchor date allowed sufficient time for the SFY 2023 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-11 displays the criteria used. In addition, HSAG noted a few recommendations based on the file review responses from the MCOs.

Table B-11—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 the fall of 2022, DHHS requested a study involving semi-structured qualitative interviews with females enrolled in the MCM program who were 18–25 years of age. The study explored seven Key Points of Inquiry: description of participants, experience with Medicaid managed care, quality of well care, quality of sexual and reproductive healthcare, access to information, experience with telehealth, and suggestions for improvement. 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

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 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 25–30 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 31 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 New Hampshire 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***.