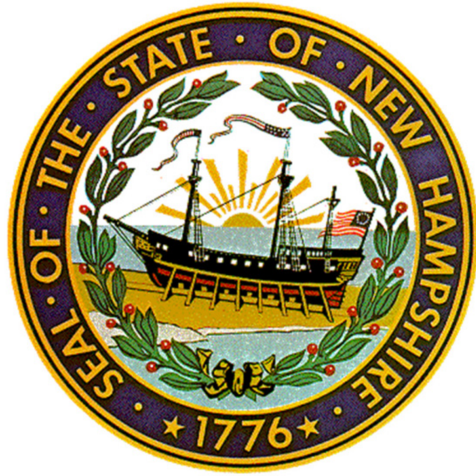

State of New Hampshire
Department of Health and Human Services

2024 New Hampshire Managed Care Organization External Quality Review Technical Report

March 2025

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Health Services Advisory Group, Inc., confirms that no one conducting 2024 external quality review organization activities had a conflict of interest with **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), or **WellSense 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) 2023, there were 178,790 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[1]

During state fiscal year (SFY) 2024, 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 **WellSense Health Plan (WS)**. All three health plans coordinate and manage their members' care through dedicated staff and a network of qualified providers. There were no MCOs considered exempt from the New Hampshire external quality review (EQR) activities during SFY 2024 (i.e., July 1, 2023–June 30, 2024).

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 2024, 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®)[2] survey and the Healthcare Effectiveness Data and Information Set (HEDIS®).[3] HSAG also conducted semi-structured member interviews at the MCM program level, quality studies, and Revealed Caller Provider Surveys.

The SFY 2024 New Hampshire Managed Care Organization External Quality Review 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 2023 EQR Technical Report. Appendices to this report list abbreviations and acronyms (Appendix B) and the methodology for conducting all activities included in the report (Appendix C).

[1] The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of June 24, 2024 (data loaded through May 2024).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
[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 **ACNH** was fully compliant with the compliance reviews, the MCO did not have a corrective action plan (CAP). In addition, there were no recommendations for the EDV activity; therefore, targeted improvement activities for **ACNH** should focus on measures that did not meet the standard for PMV, NAV, CAHPS, and HEDIS.

Table 1-1—Opportunities for Improvement for ACNH

EQR Activity	Measure Standard	ACNH's Results	Standard
Performance Measure Validation (PMV)	Correct reporting of the service authorization categories (i.e., standard or expedited) on DHHS reports	Errors found due to manual entries of information	100% accuracy of service authorization categories
Network Adequacy Validation (NAV)	**ACNH** did not meet the 90 percent time and distance standards for three provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists.	Time and Distance <90%	Time or Distance ≥90%
CAHPS	Adult Medicaid: *Rating of Health Plan*	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*	< 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	< 25th Percentile	Equal to or higher than the national average
	Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	< 25th Percentile	Equal to or higher than the national average
	Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)	< 25th Percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years	< 25th Percentile	Equal to or higher than the national average

EQR Activity	Measure Standard	ACNH's Results	Standard
	Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years	< 25th Percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—Total	< 25th Percentile	Equal to or higher than the national average
	Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	< 25th Percentile	Equal to or higher than the national average
	Asthma Medication Ratio (AMR)—Total	< 25th Percentile	Equal to or higher than the national average
	Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase	< 25th Percentile	Equal to or higher than the national average

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 and there were no recommendations for the EDV activity, targeted improvement activities for **NHHF** should focus on measures that did not meet the standard for PMV, NAV, CAHPS, and HEDIS.

Table 1-2—Opportunities for Improvement for NHHF

EQR Activity	Measure Standard	NHHF's Results	Standard
Contract Compliance Audit	Utilization Management (UM)	99.2%	100%
PMV	Ensuring non-duplication of information on DHHS reports	Duplicate data entries of appeals	No duplicate entries
	Oversight of vendor reporting	Improvement needed in vendors' knowledge of reporting requirements	Enhanced oversight required by **NHHF** of vendor reporting
NAV	HSAG observed that **NHHF** had minimal programmer staff trained and capable of supporting network adequacy data analysis and oversight of contracted vendors performing network adequacy calculations.	NA	HSAG recommends that **NHHF** enhance its vendor oversight to ensure vendors are knowledgeable and can support network adequacy analyses and consider cross-training **NHHF** staff to increase internal knowledge and capabilities to support ongoing network adequacy data monitoring.
	NHHF did not meet the 90 percent time and distance standard for one provider category, pediatric ophthalmologist.	Time and Distance <90%	Time or Distance ≥90%
CAHPS	Adult Medicaid: *Rating of All Health Care*	Statistically significantly lower than the national average	Equal to or higher than the national average

EQR Activity	Measure Standard	NHHF’s Results	Standard
HEDIS	*Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years*	< 25th Percentile	Equal to or higher than the national average
	Chlamydia Screening in Women (CHL)—Total	< 25th Percentile	Equal to or higher than the national average
	Use of Imaging Studies for Low Back Pain (LBP)—Total	< 25th Percentile	Equal to or higher than the national average

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 and there were no recommendations for CAHPS, targeted improvement activities for **WS** should focus on measures that did not meet the standard for PMV, NAV, HEDIS, and EDV.

Table 1-3—Opportunities for Improvement for WS

EQR Activity	Measure Standard	WS's Results	Standard
Contract Compliance Audit	Utilization Management	95.3%	100%
PMV	Correct information in Facets customer service text fields	Call center text field notes did not align with the selection of the drop-down fields	Agreement between information in text fields and selection of drop-down fields
	Call categorization crosswalk aligns with PROVCOMM.07 submeasures	Selection of incorrect drop-down fields for submeasures on PROVCOMM.07 reports	Agreement between information in text fields and selection of drop-down fields
NAV	HSAG observed that **WS** had minimal programmer staff trained and capable of supporting network adequacy data analysis and oversight of contracted vendors performing network adequacy calculations.	NA	HSAG recommends that **WS** enhance its vendor oversight to ensure vendors are knowledgeable and can support network adequacy analyses and consider cross-training **WS** staff to increase internal knowledge and capabilities to support ongoing network adequacy data monitoring.
	WS did not meet the 90 percent time and distance standard for one provider category, pediatric ophthalmologist.	Time and Distance <90%	Time or Distance ≥90%

<table>
<tr><th>EQR Activity</th><th>Measure Standard</th><th>WS's Results</th><th>Standard</th></tr>
<tr><td rowspan="5">HEDIS</td><td>Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years</td><td>< 25th Percentile</td><td>Equal to or higher than the national average</td></tr>
<tr><td>Chlamydia Screening in Women (CHL)—Total</td><td>< 25th Percentile</td><td>Equal to or higher than the national average</td></tr>
<tr><td>Use of Imaging Studies for Low Back Pain (LBP)—Total</td><td>< 25th Percentile</td><td>Equal to or higher than the national average</td></tr>
<tr><td>Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase</td><td>< 25th Percentile</td><td>Equal to or higher than the national average</td></tr>
<tr><td>Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase</td><td>< 25th Percentile</td><td>Equal to or higher than the national average</td></tr>
<tr><td rowspan="12">EDV</td><td colspan="3">Information System Review</td></tr>
<tr><td colspan="3">On the DME encounters that it submits to DHHS, WS should perform more quality checks such as the following:
• Reconciliation With Financial Reports: Evaluates whether the payment fields in the claims align with the financial reports from an entity.
• Timeliness: Evaluates whether the source entity submits claims in a timely manner.</td></tr>
<tr><td colspan="3">WS should consistently submit reconciliation files to DHHS and HSAG when submitting its 837P/I encounter files.</td></tr>
<tr><td colspan="3">Ongoing Encounter Data Quality Reports</td></tr>
<tr><td>837 Institutional (I): Member Identification Number—Percent Valid</td><td>99.9%</td><td>100%</td></tr>
<tr><td>837P: Initial Submission Within 14 Days of Claim Payment</td><td>99.7%</td><td>100%</td></tr>
<tr><td>837I: Initial Submission Within 14 Days of Claim Payment</td><td>99.5%</td><td>100%</td></tr>
<tr><td>Pharmacy: Initial Submission Within 14 Days of Claim Payment</td><td>99.8%</td><td>100%</td></tr>
<tr><td colspan="3">Comparative Analysis Between Encounters Submitted to DHHS' Data Warehouse and to HSAG</td></tr>
<tr><td>Record Omission: 837P (Vision)</td><td>13.4%</td><td>≤4.0%</td></tr>
<tr><td>Record Surplus: 837P (Vision)</td><td>47.5%</td><td>≤4.0%</td></tr>
</table>

EQR Activity	Measure Standard	WS's Results	Standard
	Element Omission: 837P (DME)—Referring Provider Number/National Provider Identifier (NPI)	>99.9%	≤5.0%
	Element Missing: 837P (Behavioral Health [BH] and Vision)—Referring Provider Number/NPI	NA	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS
	Element Missing: 837I (BH)—Referring Provider Number/NPI	NA	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS
	Element Accuracy: 837P—Rendering Provider Number/NPI	80.7%	≥95.0%
	Element Accuracy: 837P—Header Paid Amount	87.2%	
	Element Accuracy: 837P—Detail Paid Amount	88.3%	
	Element Accuracy: 837I—Header Paid Amount	90.1%	≥95.0%
	Element Accuracy: 837I (BH)—Attending Provider Number/NPI	<0.1%	≥95.0%

2. Overview of the MCM Program

The New Hampshire statewide MCM program is the primary method of service delivery covering 96 percent[4] of the New Hampshire Medicaid population as of December 1, 2023. At the end of CY 2023, there were 178,790 New Hampshire Medicaid beneficiaries enrolled in the MCM program.[5] That number represents a decrease of 63,739 beneficiaries from the end of CY 2022.

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 Alaska 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
- Old Age Assistance Recipients

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

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

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4 The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of June 24, 2024 (data loaded through May 2024).

5 Ibid.

The MCM program covers all New Hampshire Medicaid services with the exception of 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
- Nursing Facility Services

New Hampshire contracted with the following MCOs to provide statewide coverage for the New Hampshire MCM Program in SFY 2024:

- **ACNH**
- **NHHF**
- **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.

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.”[6] HSAG is currently the EQRO in 19 states and has contracted with DHHS to perform EQR activities for New Hampshire since 2013.

The SFY 2024 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), or prepaid ambulatory health plan (PAHP) entity.”[7] 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 2024.

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

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

This section of the report provides information concerning the New Hampshire EQR tasks conducted by HSAG during SFY 2024. The tasks include MCO contractual compliance, PIPs, PMV, NAV, CAHPS, HEDIS, EDV, semi-structured qualitative interviews, two quality studies, and a Revealed Caller Provider Survey.

[6] 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: Jan 13, 2025.

[7] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358. Accessed on: Jan 13, 2025.

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.[8,9,10] To create the process, tools, and interview questions used for the reviews, HSAG followed the guidelines set forth in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (referred to as the CMS EQR Protocol 3 in this report).[11] 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 2022 to the present, see Appendix C. Methodologies for Conducting EQR Activities, page C-2.

The complete New Hampshire compliance tool contains 18 standards, and in SFY 2024, HSAG reviewed six 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 2024 Compliance Review

Standard	42 CFR	CFR Standard Name	New Hampshire Standard Name
III.	§438.208	Coordination and Continuity of Care	Care Management/Care Coordination
VI.	§438.56	Disenrollment: Requirements and Limitations	Member Enrollment and Disenrollment
VII.	§438.100	Enrollee Rights	Member Services
XII.	§438.210	Coverage and Authorization of Services	Utilization Management
XIII.	§438.330	Quality Assessment and Performance Improvement Program	Quality Management
XVI.	NA*	NA*	Third Party Liability

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

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[8] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #10 to the Medicaid Care Management Services Contract.* Available at: https://www.dhhs.nh.gov/documents/mcm-services-contract-amendment-10. Accessed on: Jan 13, 2025.

[9] Department of Health and Human Services. (2024). 42 CFR §438. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438. Accessed on: Jan 13, 2025.

[10] Centers for Medicare & Medicaid Services. (2024). Medicaid Program; Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457?toc=1. Accessed on: Jan 13, 2025.

[11] 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: Jan 13, 2025.

The six 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 2023. 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., 12/31/2023)
- The member handbook and additional documents sent to members
- The provider manual and other MCO communication to providers/subcontractors
- The automated member and provider portal
- Automated Provider Directory
- Third-party liability documents
- Denials file review
- Narrative and/or data reports across a broad range of performance and content areas
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG scheduled the three two-day compliance reviews in April 2024. 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 2024 compliance review activity and the level of confidence associated with the overall scores.

Table 3-2—Rates Achieved by the MCOs for the SFY 2024 Compliance Review

Standard	Standard Name	ACNH	NHHF	WS
II.	Care Management/Care Coordination	100%	100%	100%
VI.	Member Enrollment and Disenrollment	100%	100%	100%
VII.	Member Services	100%	100%	100%
XII.	Utilization Management	100%	99.2%	95.3%
XIII.	Quality Management	100%	100%	100%
XVI.	Third Party Liability	100%	100%	100%
Overall Results		**100%**	**99.7%**	**98.4%**
Level of Confidence		**High**	**High**	**High**

All three MCOs demonstrated strengths, with very strong compliance with the federal and State requirements, by achieving overall scores of 98.4 percent or higher. The scores for the individual standards ranged from 95.3 percent to 100 percent for the three MCOs.

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCO's performance complied with the requirements. A designation of *Not Applicable (NA)* was used when a requirement was not applicable to the MCO during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3. 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 2025 compliance review to ensure continued compliance by each MCO.

Conclusions and Recommendations for MCO Contractual Compliance

ACNH

HSAG conducted the compliance review for **ACNH** on April 8 and 9, 2024. Table 3-3 details the scores achieved by **ACNH** for the six standards included in the SFY 2024 review.

Table 3-3—SFY 2024 Compliance Review Scores for ACNH

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II.	Care Management/Care Coordination	34	34	34	0	0	100%
VI.	Member Enrollment and Disenrollment	18	18	18	0	0	100%
VII.	Member Services	49	49	49	0	0	100%
XII.	Utilization Management	64	64***	64	0	0	100%
XIII.	Quality Management	19	19	19	0	0	100%
XVI.	Third Party Liability	9	9	9	0	0	100%
Overall Results		**193**	**193**	**193**	**0**	**0**	**100%**

* There were no ***Partially Met*** or ***Not Met*** elements for **ACNH** to address in the CAP.
** 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., 30 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 six standards representing 193 applicable elements. **ACNH** *Met* the requirements for all 193 elements. **ACNH** achieved an overall score of 100 percent.

The six 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 denial files. HSAG included the file review results in the scores for the Utilization Management standard.

NHHF

HSAG conducted the compliance review for **NHHF** on April 11 and 12, 2024. Table 3-4 details the scores achieved by **NHHF** for the six standards included in the SFY 2024 review.

Table 3-4—SFY 2024 Compliance Review Scores for NHHF

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II.	Care Management/Care Coordination	34	34	34	0	0	100%
VI.	Member Enrollment and Disenrollment	18	18	18	0	0	100%
VII.	Member Services	49	49	49	0	0	100%
XII.	Utilization Management	64	64***	63	1	0	99.2%
XIII.	Quality Management	19	19	19	0	0	100%
XVI.	Third Party Liability	9	9	9	0	0	100%
Overall Results		**193**	**193**	**192**	**1**	**0**	**99.7%**

* ***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., 30 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 six standards representing 193 applicable elements. **NHHF** *Met* the requirements for 192 elements and scored *Partially Met* for the requirements in one element. **NHHF** achieved an overall score of 99.7 percent. Of the six standard areas reviewed, **NHHF** achieved 100 percent compliance on five standards, demonstrating adherence to all requirements within:

- Care Management/Care Coordination
- Member Enrollment and Disenrollment
- Member Services
- Quality Management
- Third Party Liability

NHHF received a score of 99.2 percent on the Network Management standard, representing an area of relative strength.

The six 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 denial files. HSAG included the file review results in the scores for the Utilization Management standard.

To improve the standard that scored below 100 percent, **NHHF** and its delegates must:

- Have only one level of appeal.
- Notify members of their State fair hearing rights if a denial decision is upheld upon appeal.

WS

HSAG conducted the compliance review for **WS** on April 4 and 5, 2024. Table 3-5 details the scores achieved by **WS** for the six standards included in the SFY 2024 review.

Table 3-5—SFY 2024 Compliance Review Scores for WS

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
II.	Care Management/Care Coordination	34	34	34	0	0	100%
VI.	Member Enrollment and Disenrollment	18	18	18	0	0	100%
VII.	Member Services	49	49	49	0	0	100%
XII.	Utilization Management	64	64***	61	0	3	95.3%
XIII.	Quality Management	19	19	19	0	0	100%
XVI.	Third Party Liability	9	9	9	0	0	100%
Overall Results		**193**	**193**	**190**	**0**	**3**	**98.4%**

* ***Partially Met*** and ***Not Met*** elements were addressed in the CAP completed by **WS**.
** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.
***This standard included elements from the contract file reviews (i.e., 30 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 six standards representing 193 applicable elements. **WS** *Met* the requirements for 190 elements and scored *Not Met* for the requirements in three elements. **WS** achieved an overall score of 98.4 percent. Of the six standard areas reviewed, **WS** achieved 100 percent compliance on five standards, demonstrating adherence to all requirements within:

- Care Management/Care Coordination
- Member Enrollment and Disenrollment
- Member Services
- Quality Management
- Third Party Liability

WS received a score of 95.3 percent on the remaining standard, representing areas of relative strength in Utilization Management.

The six 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 denial files. HSAG included the file review results in the scores for the Utilization Management standard.

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

- Make determinations for post-service authorizations within 30 days of the date of filing. If the member fails to provide sufficient information to determine the request, **WS** is to notify the member within 15 calendar days of the date of filing regarding what additional information is required to process the request, and **WS** must give the member at least 45 calendar days to provide the required information. Additionally, the 30-calendar-day period for determination is to be tolled until the member submits the required information.
- Send notice of a denial of payment to the member at the time of any action affecting the claim.

For additional information concerning HSAG's methodology for conducting compliance reviews, see Appendix C. Methodologies for Conducting EQR Activities, page C-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 2024, the MCOs concluded the last two PIPs for this multi-year, rapid-cycle PIP approach. The MCOs collaborated with DHHS to select the 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 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 2024 are displayed in Table 3-6.

Table 3-6—ACNH PIP Confidence Levels

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	Completed and did not achieve all validation criteria.	*Low*
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	Completed and achieved all validation criteria.	*High*

The confidence levels for modules 1–3 for **NHHF**'s new PIP activities in SFY 2023 are displayed in Table 3-7.

Table 3-7—NHHF PIP Confidence Levels

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*

PIP Topic	Module	Status	Confidence Level
	3. Intervention Testing	Completed and achieved all validation criteria. PDSA worksheets submitted for review and feedback.	*High*
	4. PIP Conclusions	Completed and achieved all validation criteria.	*High*
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	Completed and achieved all validation criteria.	*High*

The confidence levels for modules 1–3 for **WS**'s new PIP activities in SFY 2024 are displayed in Table 3-8.

Table 3-8—WS PIP Confidence Levels

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	Completed and achieved all validation criteria.	*High*
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	Completed and did not achieve all validation criteria.	*Moderate*

Table 3-9 through Table 3-17 present a summary of the SFY 2024 final intervention testing results and validation findings from Module 4 (PIP Conclusions).

AmeriHealth Caritas New Hampshire

In SFY 2024, HSAG completed the final three scheduled intervention check-ins and received Module 4, PIP Conclusions, for each PIP topic. Table 3-9 summarizes **ACNH**'s interventions 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
HRA Completion		
Member-focused: Provide telephonic outreach to members requesting child car seats and assist members with completion of the HRA.	Seven of 17 (41.2%) members calling in to request a car seat completed the HRA. After revising the intervention and expanding the targeted population, 24 of 42 members completed the HRA during outreach for a rate of 57.1% and 26 of 64 (40.6%) members receiving a postpartum outreach call completed the assessment for herself and the baby.	*Adopted after revising the intervention and expanding the targeted members. In addition, the care management staff places outbound calls to postpartum members and will start asking the member to complete the HRA for herself and the baby.*
Member-focused: Outreach conducted to targeted newly enrolled members via text messaging promoting the use of a direct link to the HRA and the available incentive for completion of the assessment.	Baseline rate for the intervention prior to testing was 18.23%. Intervention testing results showed that there were 2,272 newly enrolled members and, of those, 433 completed the HRA for a rate of 19.05%. The improvement with this intervention was minimal, and the MCO reported that it would continue to outreach newly enrolled members through targeted and scheduled texting campaigns for newly enrolled members, as well as telephonically by staff for promotion of HRA completion.	*Final status unknown. The MCO did not provide final intervention testing data with the submission of the final documents with Module 4.*
HPV Vaccine		
Member-focused: Early birthday cards with reminder to complete the HPV vaccine series for members turning 13 years of age.	Of the 163 targeted members sent an early HPV reminder birthday card, only 17 (10.4%) members completed the HPV vaccine series. The MCO reported that member outreach through mailings and telephone calls remains a challenge with some abrasion noted to the number of outreach calls and mailings members receive. Significant efforts were made utilizing personnel and time in an effort to gain impactful results; however, minimal positive results were obtained.	*Abandoned*

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Member-focused: Telephonic outreach by **ACNH** staff to targeted members to remind them of the need to complete the HPV vaccine series and the available incentive for completing the vaccine series.	No data reported.	*Final status unknown. Final PDSA worksheet was not submitted with the final Module 4.*
Provider-focused: Target providers who have members on the care gap report for the HPV vaccine series. Provide education about the HEDIS *IMA* measure, care gap report use, and there is no longer a requirement to wait a year plus one day to schedule well-child visits.	Of the seven participating providers, two (28.6%) providers had fewer members who were non-compliant with the completion of the HPV vaccine series on the care gap report after receiving the education. The MCO reported that there were positive results in data received, revealing an increase in the number of providers who met with **ACNH** and received the education who had a decrease in the number of members on the care gap report.	*Adopted*

HRA Completion

The MCO's final Module 4 submission did not meet all validation criteria. The MCO followed the accepted and validated PIP methodology for the re-measurement period, and achieved statistically significant improvement and surpassed the SMART Aim goal; however, **ACNH** did not provide complete intervention testing results, and the intervention testing results that were reported could not be reasonably linked to the demonstrated improvement. Based on these validation findings, HSAG assigned a *Low Confidence* rating to the PIP.

HSAG analyzed each **ACNH**'s PIP data to draw conclusions about the MCO's quality improvement (QI) efforts. Based on its review, HSAG determined the methodological validity of each 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	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HRA Completion					
By December 31, 2023, **ACNH** will use key driver diagram interventions to increase the percentage of completed HRAs among the eligible members from 14.53% to 15.0%.	14.5%	15.0%	34.6%	*Yes*	*Low Confidence*

ACNH achieved statistically significant improvement and surpassed the SMART Aim goal with a re-measurement rate of 34.6 percent for targeted members who completed the HRA. The increase over baseline was 20.1 percentage points.

HPV Vaccine

The MCO's final Module 4 submission met all validation criteria. The MCO followed the accepted and validated PIP methodology for the re-measurement period, and achieved statistically significant improvement and surpassed the SMART Aim goal. Based on the intervention testing data submitted, HSAG was able to reasonably link at least one intervention, provider outreach and education, to the improvement achieved, resulting in the *High Confidence* rating assigned to the PIP.

HSAG analyzed each **ACNH**'s PIP data to draw conclusions about the MCO's QI efforts. Based on its review, HSAG determined the methodological validity of each 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 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 3-11—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HPV Vaccine					
By December 31, 2023, **ACNH** will use key driver diagram interventions to increase the completed HPV vaccine series percentage, according to the HEDIS *Immunizations for Adolescents (IMA)* specifications, among eligible adolescent members who turn 13 years of age during the measurement period from 9.3% to 16.5%.	9.3%	16.5%	21.4%	*Yes*	*High Confidence*

ACNH achieved statistically significant improvement and surpassed the SMART Aim goal with a re-measurement rate of 21.4 percent for the targeted members who completed the HPV vaccine series. The increase over baseline was 12.1 percentage points.

New Hampshire Healthy Families

In SFY 2024, HSAG completed the final three scheduled intervention check-ins and received Module 4, PIP Conclusions, for each PIP topic.

Table 3-12 summarizes **NHHF**'s interventions 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
HRA Completion		
Member-focused: Revised email language. The MCO solicited feedback from members who received the original email on how they could improve the content in the email.	The MCO sent out 20,147 revised emails with 644 of them opened, and the HRA was completed online within two weeks of sending the email (3.2%). **NHHF** determined that outreach through email is an effective way to reach members, and it will adopt the intervention and continue to monitor the data.	*Adopted*
Member-focused: Quick response (QR) code postcard mailing. The MCO developed a postcard that included a QR code that took the member to the online version of the HRA for ease of completing.	In May 2023, a total of 18,448 postcards were sent, and 223 HRAs were completed within two weeks (1.2%). In June 2023, 15,861 postcards were sent, and 140 HRAs were completed (0.88%). Although the responses were low, the MCO determined that the QR code was a useful method for offering an uncomplicated way for members to complete the HRA. Due to the cost of the bulk mailings and a less than 10 percent response rate, **NHHF** decided not to repeat the mailing. The postcards themselves will be used as handouts when the MCO's outreach team does community events. The MCO reported it would do additional testing using the QR code in an updated letter that would be sent out each month.	*Adopted*
Member-focused: Spanish language HRA reminder text.	A total of 2,089 texts in Spanish were sent to members to complete the HRA, and 47 members completed the HRA (2.25%). Due to the low response rate and cost to translate the text into Spanish or other languages, the MCO plans to continue using email and regular mailings to get information to the members for completing the HRA.	*Abandoned*
Member-focused: Members receive a reminder call after hours and have an option to leave a message for assistance with completion of the HRA.	For the first testing cycle, 3,390 after-hours messages were left for members, and zero members left a message requesting assistance with completing the HRA. For the second cycle, the message was sent on a Saturday instead of during the week but had the same outcome of zero members requesting assistance with completing the HRA. Despite the testing results, the MCO reported that it adopted the intervention and there was no reason to not send the message as there may be members at some point who request assistance with completing the HRA.	*Adopted*

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
HPV Vaccine		
Provider-focused: Clinic outreach with delivery of HPV vaccine toolkit to targeted clinics.	Ten clinics outreached with six reporting using the toolkit within two weeks of receiving (60%). The HPV toolkit was found to be useful for most clinics that received it. Providing the information via fax or email, and on the MCO's provider website, was a non-abrasive method to share best practices for improving vaccine rates.	*Adopted*
Provider-focused: Clinics were provided a list of their members who were non-compliant for the second vaccine dose.	Following distribution of the non-compliant member lists, the data showed the following: A total of 86 members were outreached. Of those 86 members, 28 received the second HPV dose and completed the series (32.6%). Of those 28 members, 24 had the second vaccine before their birthday (27.9%).	*Adopted*
Member-focused: HPV vaccine email campaign. Member outreach conducted through email with information about HPV vaccine series.	Cycle 1: 7,534 members were sent the email with 3,971 reported as opened (52.7%). Cycle 2: 244 members needing a second dose of vaccine were sent the email with 122 reported as opened (50.0%). The MCO reported that this intervention resulted in programmatically significant improvement. The overall open rate of 52.6% was considered high per industry standards. The MCO's analysis showed that the number of members who had a vaccine service was higher for those whose parents received the email. **NHHF** also reported that there may be other factors contributing to these results; however, testing did show that the email campaign was successful.	*Adopted*
Provider-focused: Someone You Love (SYL) video event. The MCO held an event for providers and showed a video about HPV. Providers were surveyed following the event to see if they would change at least one thing with their practice after the event training.	Cycle 1: 10 out of 10 providers attending the event reported that they will do at least one thing different in their practice as a result of attending the event. Due to the low attendance (10 of 66 providers) and feedback from the SYL educational event, the MCO plans to revise this intervention to shorten the time and to focus the session on clinic staff versus providers. However, after numerous failed attempts to connect with the NH Medical Group Management Association, which would approve this event, **NHHF** abandoned this intervention and moved to a different intervention providing an HPV toolkit to clinics.	*Abandoned*

In SFY 2024, **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.

HRA Completion

The MCO's final Module 4 met all validation criteria. The MCO followed the accepted and validated PIP methodology for the re-measurement period, and achieved statistically significant improvement and surpassed the SMART Aim goal. Based on reported intervention testing data, the two interventions could reasonably be linked to the demonstrated improvement, resulting in the *High Confidence* rating assigned 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	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HRA Completion					
By Dec. 31, 2023, use key driver diagram interventions to increase the percentage of HRA completed among the NH Healthy Families Medicaid membership from 27.07% to 27.5%.	27.07%	27.5%	34.86%	*Yes*	*High Confidence*

NHHF achieved statistically significant improvement and surpassed the SMART Aim goal with a re-measurement rate of 34.86 percent for targeted members who completed the HRA. The increase over baseline was 7.79 percentage points.

HPV Vaccine

The MCO's final Module 4 met all validation criteria. The MCO followed the accepted and validated PIP methodology for the re-measurement period, and achieved statistically significant improvement and surpassed the SMART Aim goal. Based on reported intervention testing data, three of the four interventions could reasonably be linked to the demonstrated improvement, resulting in the High Confidence rating assigned 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 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 3-14—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HPV Vaccine					
By 12/31/2023, use key driver diagram interventions to increase the administrative data rate of eligible members meeting HEDIS measure for HPV vaccines during MY2023 from 26.26% to 28.9%.	26.26%	28.9%	29.41%	*Yes*	*High Confidence*

NHHF achieved statistically significant improvement and surpassed the SMART Aim goal with a re-measurement rate of 29.41 percent for the targeted members who completed the HPV vaccine series. The increase over baseline was 3.15 percentage points.

WellSense Health Plan

In SFY 2024, HSAG completed the final three scheduled intervention check-ins and received Module 4, PIP Conclusions, for each PIP topic.

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
HRA Completion		
Member-focused: The MCO sent a text message to members needing to complete the HRA. The text message included a link for the member to complete the HRA.	**WS** documented that the intervention was to be initiated in the winter 2023, but due to unforeseen complications, the intervention was not launched. The MCO reported it conducted all necessary research, contracting, and information technology	*Abandoned*

Intervention Description	Intervention Evaluation Results	Final Intervention Status
	(IT) security reviews to develop an integrated texting campaign that would allow for HRA completion without logging in. However, the MCO experienced negotiation issues with the intended vendor and was determining whether it will continue moving forward with the intended vendor or pivot to a new one.	
Member-focused: Care manager outreach calls conducted to members who had not completed the HRA.	• Cycle 1: 12.5% (36/287) of members completed the assessment when outreached. **WS** chose to abandon the intervention due to the low performance of the intervention and return on investment.	*Abandoned*
Member-focused: A digital option for completing the HRA was provided to members.	• Cycle 1: 0.0012% (88/66,636) of members completed the HRA through the digital option. **WS** reported there was no clinical outcome to report as there were no clinical outcomes measured directly to those members who completed the HRA. The digital option of completing HRAs demonstrated an increase in the overall completion rates.	*Adopted*
Member-focused: HRA completion incentive promotion.	• Cycle 1: 0.14% (141/98,625) of members completed the HRA and received the incentive. • Cycle 2: 3.15% (2,246/71,306) of members completed the HRA and received the incentive. • Cycle 3: 6.07% (4,668/76,784) of members completed the HRA and received the incentive. • Cycle 4: 18.28% (12,178/66,636) of members completed the HRA and received the incentive. Due to the continued increase in HRAs completed during testing, **WS** adopted this intervention.	*Adopted*

Intervention Description	Intervention Evaluation Results	Final Intervention Status
HPV Vaccine		
Provider-focused: The MCO sent targeted providers a quarterly newsletter that included imbedded links to HPV educational information and to the MCO's website that also included educational materials.	• Cycle 1: 22.2% (2/9) of providers completing the survey responded positively about the educational materials. • Cycle 2: 100% (5/5) of providers completing the survey responded positively about the educational materials. • Cycle 3: No data. Due to a lack of responses from providers to the initial survey, the intervention was adapted based on feedback the MCO received from providers. The MCO will offer concise educational materials to providers quarterly by providing links in its provider newsletter and provide educational materials and video links on its website. • Cycle 4: 0.17% (3/1,733) of providers sent educational materials used the materials provided on the MCO's website through a provided link. After four cycles of testing and two revisions, **WS** chose to adopt the intervention. Based on provider feedback, the MCO will use the provider newsletter for quarterly HPV education reminders with links embedded and will post HPV educational materials on the MCO's website.	*Adopted*
Member-focused: The MCO conducted an outreach campaign using an educational text message about the HPV vaccine.	• Cycle 1: 70% of texts sent successfully. • Cycle 2: 68% of texts sent successfully. • Cycle 3: 97% of texts sent successfully. At the time of this submission, **WS** did not have the data to indicate whether the vaccine series was completed because of the text message. **WS** documented that using a text campaign effectively reached more members than phone calls, was more convenient for members, and was more cost-effective than using internal team members to conduct telephonic outreach.	*Adopted*

HRA Completion

The MCO's final Module 4 met all validation criteria. The MCO met the SMART Aim goal and statistically significant improvement over the baseline. Additionally, **WS** reported that the digital outreach

intervention resulted in programmatic change, resulting in an increase of HRAs completed. Based on the validation findings, HSAG assigned a rating of *High Confidence* in 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 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 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 3-16—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HRA Completion					
By December 31st, 2023, use key driver diagram interventions to increase the percentage of annual Health Risk Assessments performed among the eligible Medicaid population, from 9.8% to 10.04% ($p < 0.05$).	9.8%	10.04%	21.24%	*Yes*	*High Confidence*

HPV Vaccine

The MCO's final Module 4 submission for the above PIP did not achieve all validation criteria. **WS** followed the accepted and validated PIP methodology for the re-measurement period but did not achieve the SMART Aim goal or statistically significant improvement over the baseline. However, the SMART Aim measure demonstrated non-statistically significant improvement, and there were supporting data that the parent-focused texting campaign resulted in clinically and programmatically significant improvement. Additionally, HSAG identified inaccuracies in the narrative summary of results. Based on the validation findings, a *Moderate Confidence* rating in the reported PIP results was assigned.

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 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 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 3-17—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Re-measurement Rate	Statistically Significant Improvement Achieved	Confidence Rating
HPV Vaccine					
By 12/31/2023, use key driver diagram interventions to increase the percentage of HPV vaccines among adolescents turning 13 years of age during the measurement year, from 27.63% to 30.16% ($p < 0.05$).	27.63%	30.16%	28.86%	*No*	*Moderate Confidence*

WS achieved non-statistically significant improvement over the baseline and was 1.3 percentage points away from meeting the SMART Aim goal with a re-measurement rate of 28.86 percent.

Conclusions and Recommendations for Improvement

ACNH

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

- When evaluating and reporting measure results over time, **ACNH** must report changes in rates accurately. The MCO should ensure quality checks are in place to facilitate accurate reporting of data. Accurate data reporting will provide more meaningful and actionable information to facilitate ongoing improvement.
- **ACNH** should develop a plan for sustaining and spreading the effective adopted interventions.
- **ACNH** must ensure that all intervention testing data are reported in PDSA worksheets, and that any improvement achieved can be reasonably linked to at least one intervention tested.
- **ACNH** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

NHHF

NHHF completed two methodologically sound PIPs and achieved the desired outcomes for both PIPs.

- **NHHF** should develop a plan for sustaining and spreading the effective adopted interventions.

- **NHHF** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

WS

WS completed two methodologically sound PIPs and achieved the desired outcomes for both PIPs.

- When evaluating and reporting measure results over time, **WS** must report accurate analysis of results. The MCO should ensure quality checks are in place to facilitate accurate reporting of data. Accurate data reporting will provide more meaningful and actionable information to facilitate ongoing improvement.
- **WS** should develop a plan for sustaining and spreading the effective adopted interventions.
- **WS** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

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

PMV

HSAG conducted the validation activities in New Hampshire as outlined in the CMS EQR *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023 (referred to as the CMS EQR Protocol 2 in this report).[12] The following section of the report describes the results of HSAG's SFY 2024 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 2024, each MCO submitted rates for 18 performance measures validated during PMV. HSAG offered recommendations to each MCO to facilitate continued QI in the New Hampshire MCM program.

Based on the validation activities, HSAG determined the results achieved by the MCOs for the performance measures.

HSAG identifies four possible validation finding designations for performance measures, which are defined in Table 3-18.

Table 3-18—Designation Categories for Performance Measures

Report (R)	Measure was compliant with state specifications.
Do Not Report (DNR)	MCO rate was materially biased and should not be reported.
Not 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.

The validation designation for the measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measures by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*.

The HSAG designation categories established an overall level of confidence for this year's validation review of each performance measure based on the MCO following state-specific measure guidelines as defined below:

> The measure was determined *Reportable*: High confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measure during the reporting period.
>
> The measure was determined *Do Not Report:* No confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measure during the reporting period.

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[12] 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: Jan 13, 2025.

Table 3-19 and Table 3-20 display the findings from the PMV activities conducted for each MCO in SFY 2024.

Table 3-19—Measure-Specific Review Findings and Designations for Each MCO

Performance Measure	Performance Measure Description	ACNH		NHHF		WS	
		Key Review Finding	Measure Designation	Key Review Finding	Measure Designation	Key Review Finding	Measure Designation
ACCESSREQ.06	*Requests for Assistance Accessing Physician/Advanced Practice Registered Nurse (APRN) Specialists (non-MCO Designated) by County*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
APPEALS.01	*Resolution of Standard Appeals Within 30 Calendar Days*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
APPEALS.02	*Resolution of Extended Standard Appeals Within 44 Calendar Days*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
CLAIM.21	*Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
CLAIM.26	*Claims Quality Assurance: Claims Financial Accuracy*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
CMS_A_CDF	*Screening for Clinical Depression and Follow-up Plan*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
CMS_CH_DEV	*Developmental Screening in the First Three Years of Life*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
CMS_A_INP_PQI01	*Diabetes Short-Term Complication Admissions*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
GRIEVANCE.05	*Timely Processing of All Grievances*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
MEMCOMM.06	*Member Communications: Reasons for Telephone Inquiries*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
PDN.04	*Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R

Performance Measure	Performance Measure Description	ACNH		NHHF		WS	
		Key Review Finding	Measure Designation	Key Review Finding	Measure Designation	Key Review Finding	Measure Designation
PHARM_PDC.01	*Proportion of Days Covered—Diabetes All Class Rate (PDC-DR)*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
PHARMUTLMGT.03	*Pharmacy Utilization Management: Generic Drug Substitution*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
PROVCOMM.07	*Provider Communications: Reasons for Telephone Inquiries*	No issues were identified.	R	No issues were identified.	R	**WS** was required to correct its PROVCOMM.07-G Exhibit O submission due to an error in how the calls were mapped.	R
SERVICEAUTH.01	*Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
SERVICEAUTH.03	*Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
SERVICEAUTH.04	*Pharmacy Service Authorization Timely Determination Rate*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R
SUD.42	*MCO Contacts and Contact Attempts Following Emergency Department (ED) Discharges for Substance Use Disorder (SUD)*	No issues were identified.	R	No issues were identified.	R	No issues were identified.	R

Appendix A contains the performance measure rates for each MCO.

Table 3-20—SFY 2024 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.

During primary source verification (PSV) of SERVICEAUTH.01, HSAG discovered discrepancies in the priority statuses of multiple service authorizations (i.e., standard authorizations documented as expedited/urgent), which HSAG determined to be due to **ACNH**'s manual data entry errors. HSAG therefore recommends that **ACNH** improve its internal monitoring of service authorization categories to reduce the risk of manual error. **ACNH** should take corrective action to add quality assurance (QA) steps to its existing internal auditing and oversight processes to readily identify prior authorization manual data entry errors. This may include creating additional daily reports, adjusting its supervisory team's oversight processes, enhancing internal audits to identify service authorization status errors, implementing system alerts when manual entries are being used, or other **ACNH**-identified improvements.

NHHF

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

While **NHHF** generally had adequate controls in place to ensure accurate and timely reporting of member grievances, HSAG recommends that **NHHF** continue to explore options to avoid duplicative data entry of appeals in TruCare and Microsoft SharePoint due to the increased risk of manual documentation errors. HSAG also recommends that **NHHF** continue to explore options to automate New Hampshire appeals reporting so that it does not rely on the customized Microsoft SharePoint site due to the increased risk of manual documentation errors.

During the virtual review, **NHHF** vendors generally did not demonstrate knowledge of the performance measures in scope of review and did not appear well-prepared to discuss their operations. Considering **NHHF** relies on its vendors to produce some of the Exhibit O reports for delegated services, HSAG recommends that **NHHF** enhance its vendor oversight to ensure vendors have assigned knowledgeable staff members to maintain and oversee Exhibit O reports.

WS

WS used a variety of methods for producing the measures under review and had staff members dedicated to quality reporting. **WS** produced the measures in accordance with the specifications, benchmarked appropriately based on its population/sub-populations, and had sufficient policies and procedures in place to ensure reporting accuracy. **WS** 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.

WS described adequate QA processes related to reviewing call center staff documentation for completeness and accuracy. However, the virtual review revealed a mismatch in the PROVCOMM.07 measure call category in comparison to the Customer Service Task Related Notes within Facets. HSAG therefore recommends that **WS** add a review of Facets customer service free text fields to its QA process. Additionally, during the virtual review, HSAG identified that **WS** had incorrectly mapped provider calls to the wrong submeasure. **WS** was able to identify the PROVCOMM.07 incorrectly mapped calls and provided a corrected, HSAG-validated Exhibit O report to DHHS. As a result of this issue, HSAG recommends that **WS** complete corrective action to maintain its call categorization crosswalk in alignment with the PROVCOMM.07 submeasures and implement improvements to reduce the risk of staff members selecting incorrect Facets drop-down reasons.

For additional information concerning the measures reviewed and HSAG's methodology for validating performance measures, see Appendix C. Methodologies for Conducting EQR Activities, page C-15.

NAV

For SFY 2024, HSAG conducted the following activities to assess the MCOs' network adequacy. HSAG performed the following three key tasks during the SFY 2024 NAV:

- **Information Systems Capabilities Assessment (ISCA):** In accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (referred to as the CMS EQR Protocol 4 in this report),[13] HSAG conducted a desk review of materials that the MCOs submitted, supplemented with live virtual review sessions demonstrating the information systems (IS), data processing procedures, and underlying methodology that the MCOs utilized to support their network adequacy indicator reporting.
- **Time and distance analysis:** DHHS requires MCOs to meet geographic access standards by providing access to a minimum number of network providers within a minimum driving distance or driving time from members' residences.[14] These standards apply to a broad range of provider categories, including but not limited to primary care providers (PCPs), mental health providers, SUD service providers, hospitals and other facilities, and several types of physician specialists. For each MCO, HSAG calculated the percentage of members able to access care within the time or distance requirements defined in the DHHS MCM Services Contract and the required reporting template.
- **Network capacity analysis**: DHHS requires MCOs to meet network capacity standards for five specific types of SUD service providers. DHHS limited the scope of this year's work to two of them: opioid treatment providers (OTPs) and residential SUD treatment programs. For each of these provider categories, DHHS requires the MCOs to contract with a minimum percentage of the total providers licensed and practicing in the State. HSAG assessed whether each MCO met these standards by comparing the MCOs' provider data to the list of licensed and practicing providers in the DHHS report template.

Appendix C contains further details on the methodology.

ISCA

HSAG completed an ISCA for each of the MCOs contracted to provide Medicaid services in New Hampshire and presented findings and an assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the MCOs assessed. Additionally, HSAG determined that each MCO's data collection procedures were acceptable. For the MCOs that used external delegated entities to complete network adequacy indicator reporting during the reporting period, no issues were identified within the last year that required correction.

[13] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 13, 2025.

[14] Such standards are generally referred to as "time and distance" standards, although for New Hampshire, an MCO need only meet either the time *or* distance element. As DHHS' template includes both time and distance calculations, HSAG calculated both time and distance and counted an indicator as met if time or distance (or both) were within the standard.

Statewide Results

All three MCOs participated fully with the ISCA process and provided HSAG with the requested access to their IS. Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether the MCOs' interpretation of data was accurate.

Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has *High Confidence* in the MCOs' data systems, methodologies, and the accuracy and reliability of their reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for any of the MCOs. Overall, HSAG recommends that the MCOs continue to monitor member access through network adequacy assessments based on DHHS' expectations.

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that the MCOs used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 3-21 summarizes HSAG's validation ratings for the MCOs, with all three MCOs receiving *High Confidence* for all three indicator types (access and availability, network capacity, and time and distance).

Table 3-21—Validation Ratings by MCO*

MCO	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
ACNH	100%	0%	0%	0%
NHHF	100%	0%	0%	0%
WS	100%	0%	0%	0%

* The percentages presented in the tables are based on the total number of indicators assessed and what percentage of the indicators scored *High*, *Moderate*, *Low*, or *No Confidence/Significant Bias* overall.

Time and Distance Analysis

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if an MCO meets either the time or distance requirement. HSAG's time and distance analysis produced results consistent with the results that the MCOs reported in their data submissions to DHHS. **ACNH** met the standards for 95.0 percent of the provider categories, **NHHF** met the standards for 98.4 percent of the provider categories, and **WS** met the standards for 73.8 percent of the provider categories.

Table 3-22 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 the minimum time and distance standards for a specific provider category.

Table 3-22—Percentage of Members With Required Access to Care by Provider Category and MCO

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	**Member Population**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**
Primary Care							
Primary Care, Adult	Adults	100.0%	99.9%	100.0%	99.9%	100.0%	>99.9%
Primary Care, Pediatric	Children and adolescents	100.0%	>99.9%	100.0%	99.9%	100.0%	97.7%
Physician Specialists							
Allergist, Adult	Adults	99.9%	98.1%	99.9%	97.6%	95.1%	93.4%
Allergist/Immuno-logist, Pediatric[1]	Children and adolescents	81.7%	79.0%	98.8%	87.3%	78.0%	71.8%
Audiologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Audiologist, Pediatric	Children and adolescents	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Cardiologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cardiologist, Pediatric[1]	Children and adolescents	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist, Pediatric[1]	Children and adolescents	100.0%	98.0%	>99.9%	97.2%	>99.9%	98.0%
Endocrinologist, Pediatric[1]	Children and adolescents	100.0%	99.5%	>99.9%	97.2%	>99.9%	99.3%
Gastroenterologist, Pediatric[1]	Children and adolescents	100.0%	99.5%	>99.9%	97.2%	>99.9%	98.2%
General Surgeon	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
Neurologist, Pediatric[1]	Children and adolescents	100.0%	99.4%	>99.9%	97.2%	>99.9%	99.3%
Obstetrician/Gynecologist or Other Maternity Provider	Females ages 13 years and older	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Oncologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	99.9%	99.6%
Ophthalmologist, Adult	Adults	97.6%	95.6%	99.9%	99.2%	99.9%	99.5%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Ophthalmologist, Pediatric[1]	Children and adolescents	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Optometrist	All members	99.9%	99.6%	100.0%	100.0%	100.0%	100.0%
Orthopedic Surgeon, Pediatric[1]	Children and adolescents	100.0%	98.0%	99.9%	70.1%	0.0%	0.0%
Orthopedist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist, Pediatric	Children and adolescents	100.0%	98.0%	100.0%	100.0%	0.0%	0.0%
Otolaryngologist, Adult	Adults	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Otolaryngologist, Pediatric[1]	Children and adolescents	100.0%	98.0%	>99.9%	97.2%	92.2%	81.6%
Pediatrician, Developmental-Behavioral[1]	Children and adolescents	74.2%	53.0%	91.6%	78.1%	71.3%	49.2%
Plastic Surgeon, Adult	Adults	93.4%	91.7%	99.6%	98.7%	93.0%	91.4%
Plastic Surgeon, Pediatric	Children and adolescents	100.0%	98.0%	100.0%	100.0%	0.0%	0.0%
Podiatry, Adult	Adults	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Psychiatrist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	99.8%	98.9%
Psychiatrist, Pediatric	Children and adolescents	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%
Psychologist	All members	100.0%	99.4%	100.0%	99.8%	99.8%	97.2%
Thoracic Surgeon, Adult	Adults	95.8%	93.7%	94.6%	94.1%	95.7%	94.8%
Urologist, Adult	Adults	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Urologist, Pediatric[1]	Children and adolescents	100.0%	98.6%	>99.9%	97.2%	>99.9%	98.0%
Hospital Services							
Hospital—General Acute Care	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	**Member Population**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**
Hospital—Maternity[2]	Females ages 13 years and older	100.0%	>99.9%	99.9%	99.2%	0.0%	0.0%
Hospital—Level 3/4 Neonatal Intensive Care[2]	All members	100.0%	98.1%	>99.9%	97.2%	0.0%	0.0%
Hospital—Level 1 Major Trauma Treatment[2]	All members	100.0%	98.1%	100.0%	100.0%	0.0%	0.0%
Hospital—Diagnostic Cardiac Catheterization[2]	All members	98.6%	97.3%	98.0%	95.0%	0.0%	0.0%
Hospital—Open-Heart Surgery Services[2]	All members	100.0%	98.0%	>99.9%	97.2%	0.0%	0.0%
Hospital—Therapeutic Radiation	All members	95.7%	93.7%	93.2%	91.7%	66.0%	59.4%
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	All members	100.0%	100.0%	100.0%	99.6%	94.7%	92.3%
Short Term Care Facility for Involuntary Psychiatric Admissions[2]	All members	95.1%	93.2%	93.4%	91.6%	0.0%	0.0%
General Inpatient Psychiatric	All members	99.2%	96.4%	98.8%	96.3%	99.9%	97.3%
Diagnostic Services							
CAT [Computed Tomography] Scan Provider[2]	All members	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100.0%	100.0%	100.0%	100.0%	39.3%	29.5%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Magnetic Resonance Imaging Center	All members	100.0%	100.0%	100.0%	100.0%	94.6%	93.2%
Laboratory	All members	100.0%	100.0%	100.0%	100.0%	84.6%	88.0%
Other Facilities and Services							
Pharmacy	All members	100.0%	99.6%	100.0%	99.4%	100.0%	99.6%
Durable Medical Equipment (DME)	All members	99.6%	97.9%	100.0%	>99.9%	>99.9%	99.8%
Adult Medical Daycare	Adults	99.5%	96.0%	98.6%	93.2%	99.2%	93.9%
Family Planning	All members ages 13 years and older	100.0%	100.0%	100.0%	100.0%	98.1%	95.9%
Licensed Renal Dialysis Provider	All members	98.8%	96.1%	100.0%	>99.9%	100.0%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Community Mental Health Center	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospice	Adults	99.9%	99.6%	100.0%	>99.9%	99.9%	99.5%
Hospice	All members	99.9%	99.6%	100.0%	>99.9%	>99.9%	99.6%
SUD Services							
SUD Master Licensed Alcohol & Drug Counselor	All members	100.0%	98.5%	99.3%	92.5%	99.9%	94.4%
Methadone Clinics	All members	95.2%	93.8%	98.8%	95.2%	95.2%	93.8%
SUD Comprehensive Program	All members	>99.9%	99.8%	99.9%	99.5%	95.1%	93.9%
SUD Outpatient Program	All members	100.0%	>99.9%	100.0%	99.9%	98.2%	97.5%

[1] DHHS identified these specialists using taxonomy codes, as did **ACNH** and **NHHF**. **WS** did not use taxonomy codes.
[2] Data that **WS** submitted to HSAG did not include providers of these services, but the report that **WS** submitted to DHHS did include them.

The MCOs' greatest challenge was contracting with sufficient pediatric specialists to meet access standards, with two of the three MCOs failing to meet standards for pediatric allergy/immunology specialists (**ACNH** and **WS**), pediatric ophthalmologists (**ACNH** and **NHHF**), and developmental-behavioral pediatricians (**ACNH** and **WS**). **WS** also did not meet the standards for access to pediatric specialists in audiology, orthopedics and orthopedic surgery, plastic surgery, imaging providers, or laboratory services. In addition, **WS** did not meet several standards because the provider data file the MCO submitted to HSAG lacked data identifying hospitals providing specific services covered by the DHHS standards (e.g., maternity hospitals, neonatal intensive care units [NICUs], open-heart surgery).

Network Capacity Analysis

HSAG conducted the network capacity analysis by comparing the number of providers associated with each MCO's provider network to lists provided by DHHS in its template identifying all licensed and practicing providers in the State for the two specific provider categories reported. HSAG encountered challenges with using the DHHS-provided lists for the residential SUD treatment programs, since the list of SUD programs in DHHS' Network.01 report template did not reflect changes in the provider landscape after November 7, 2022. Accordingly, these results are being considered as informational only and should be interpreted with caution.

Opioid Treatment Programs (OTPs)

Table 3-23 displays the statewide network capacity analysis results for OTPs (i.e., the percentage of providers licensed and practicing in New Hampshire).

Table 3-23—Statewide Network Capacity Analysis Results for OTPs by MCO

MCO	Standard	Number (%) of Listed Providers Contracted
ACNH	75% of 10 listed providers	10 (100.0%)
NHHF	75% of 10 listed providers	10 (100.0%)
WS	75% of 10 listed providers	10 (100.0%)

These results indicate that all three of the MCOs were able to meet the capacity standards for contracting with at least 75 percent of the OTP providers identified by DHHS.

Residential SUD Treatment Programs

Table 3-24 displays the statewide network capacity analysis results for residential SUD treatment programs (i.e., the percentage of providers or programs licensed and practicing in New Hampshire). These results should be considered informational only and interpreted with caution.

Table 3-24—Statewide Network Capacity Analysis Results for Residential SUD Treatment Programs by MCO

MCO	Standard	Number (%) of Listed Programs Contracted
ACNH	50% of 24 listed programs	7 (29.2%)
NHHF	50% of 24 listed programs	13 (54.2%)
WS	50% of 24 listed programs	13 (54.2%)

These results indicate that two of the three MCOs, **NHHF** and **WS**, were able to meet the capacity standards for contracting with at least 50 percent of the residential SUD treatment programs. **ACNH** was unable to meet the capacity standard for contracting with at least 50 percent of the residential SUD treatment programs.

Health Plan-Specific Conclusions and Recommendations

Drawing from the results of the SFY 2024 NAV, HSAG provides the following health plan-specific conclusions and recommendations for the MCOs to consider.

ACNH

HSAG recommends that **ACNH** maintain current levels of access to care and continue to address network gaps for the following provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists.

HSAG recommends that **ACNH** continue to monitor member access through network adequacy assessments based on the State's expectations.

NHHF

HSAG recommends that **NHHF** enhance its vendor oversight to ensure vendors are knowledgeable and can support network adequacy analyses. HSAG also recommends that **NHHF** consider cross-training its staff to increase internal knowledge and capabilities to support ongoing network adequacy data monitoring.

HSAG recommends that **NHHF** maintain the current level of access to care and continue to address network gaps for pediatric ophthalmologists.

HSAG recommends that **NHHF** continue to monitor member access through network adequacy assessments based on the State's expectations.

WS

HSAG recommends that **WS** maintain current levels of access to care and continue to address network gaps for the following pediatric provider categories: allergist/immunologist, audiologist, orthopedic

surgeon, orthopedist, and plastic surgeon as well as developmental-behavioral pediatricians. **WS** should also consider collecting and using taxonomy codes in accordance with DHHS' standards.

HSAG recommends that **WS** continue to monitor member access through network adequacy assessments based on the State's expectations.

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.[15]

The CAHPS 5.1H Surveys include a set of standardized items including four global ratings and four composite scores.[16] 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 3-25 and Table 3-26. An upward **green** arrow (↑) denotes if the lower limit of the confidence interval was higher than the national average. A downward **red** arrow (↓) denotes if the upper limit of the confidence interval was lower than the national average. The table displays a **dash** (—) if the national average was within the confidence interval indicating that there was no significant difference in the rates.

Table 3-25 contains the adult Medicaid CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to the NCQA national averages.

[15] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2023.

[16] For this report, the 2024 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 3-25—ACNH, NHHF, and WS Adult Medicaid CAHPS Results

CAHPS Measure	2024 Adult Medicaid Positive Rates	2023 National Average Comparison*	2024 Adult Medicaid Positive Rates	2023 National Average Comparison*	2024 Adult Medicaid Positive Rates	2023 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**72.5%**	↓	**75.2%**	—	**79.1%**	—
Rating of All Health Care	**70.9%**	—	**67.6%**	↓	**74.4%**	—
Rating of Personal Doctor	**78.2%**	—	**82.8%**	—	**79.6%**	—
Rating of Specialist Seen Most Often	**80.4%**	—	**79.1%**	—	**76.8%**	—
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**82.6%**	—	**80.5%**	—	**82.1%**	—
Getting Care Quickly	**84.3%**	—	**82.5%**	—	**82.4%**	—
How Well Doctors Communicate	**93.1%**	—	**92.4%**	—	**91.2%**	—
Customer Service	**86.8%**	—	**89.7%**	—	**91.3%**	—

* The 2023 NCQA national averages are the most current benchmarks available.
↑ Indicates the lower limit of the confidence interval is statistically significantly higher than the national average.
↓ Indicates the upper limit of the confidence interval is statistically significantly lower than the national average.
— Indicates the measure rate is neither statistically significantly higher nor lower than the national average.

Table 3-26 contains the general child CAHPS positive rates for **ACNH**, **NHHF**, and **WS** and comparisons to NCQA national averages.

Table 3-26—ACNH, NHHF, and WS Child Medicaid CAHPS Results

CAHPS Measure	2024 Child Medicaid Positive Rates	2023 National Average Comparison*	2024 Child Medicaid Positive Rates	2023 National Average Comparison*	2024 Child Medicaid Positive Rates	2023 National Average Comparison*
Global Ratings	**ACNH**		**NHHF**		**WS**	
Rating of Health Plan	**84.8%**	—	**85.2%**	—	**85.7%**	—
Rating of All Health Care	**88.3%**	—	**83.3%**	—	**87.5%**	—
Rating of Personal Doctor	**89.3%**	—	**87.6%**	—	**88.0%**	—
Rating of Specialist Seen Most Often	**81.4%+**	—	**85.9%+**	—	**83.5%**	—

CAHPS Measure	2024 Child Medicaid Positive Rates	2023 National Average Comparison*	2024 Child Medicaid Positive Rates	2023 National Average Comparison*	2024 Child Medicaid Positive Rates	2023 National Average Comparison*
Composite Measures	**ACNH**		**NHHF**		**WS**	
Getting Needed Care	**84.7%**	—	**85.5%**	—	**87.0%**	—
Getting Care Quickly	**91.3%**	↑	**92.1%**	↑	**93.1%**	↑
How Well Doctors Communicate	**94.5%**	—	**95.3%**	—	**95.7%**	↑
Customer Service	**91.5%+**	—	**91.4%+**	—	**90.5%+**	—

* The 2023 NCQA national averages are the most current benchmarks available.
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the lower limit of the confidence interval is statistically significantly higher than the national average.
↓ Indicates the upper limit of the confidence interval 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 2024, and members returned 314 completed surveys. After excluding ineligible members, the response rate was 15.65 percent. In 2024, the **ACNH** adult Medicaid response rate was higher than the 2023 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 12.9 percent. Figure 3-1 and Figure 3-2 show **ACNH**'s adult Medicaid 2024 positive rates, and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.

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

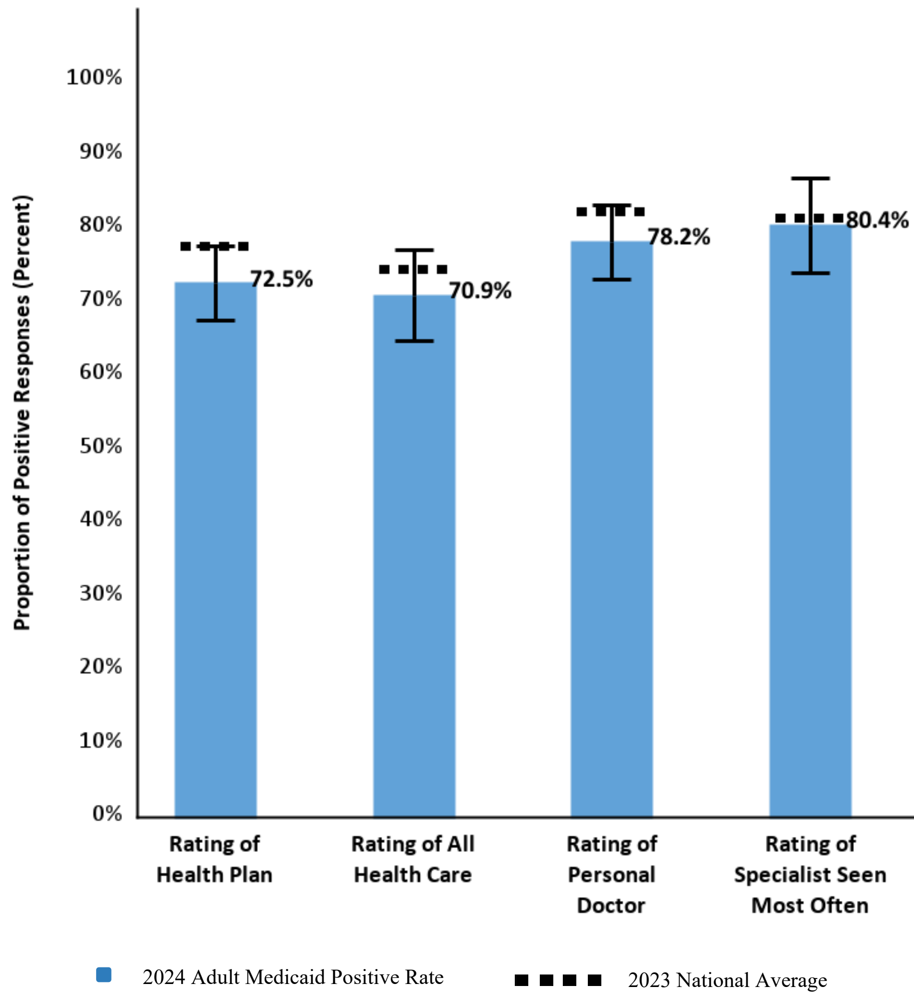
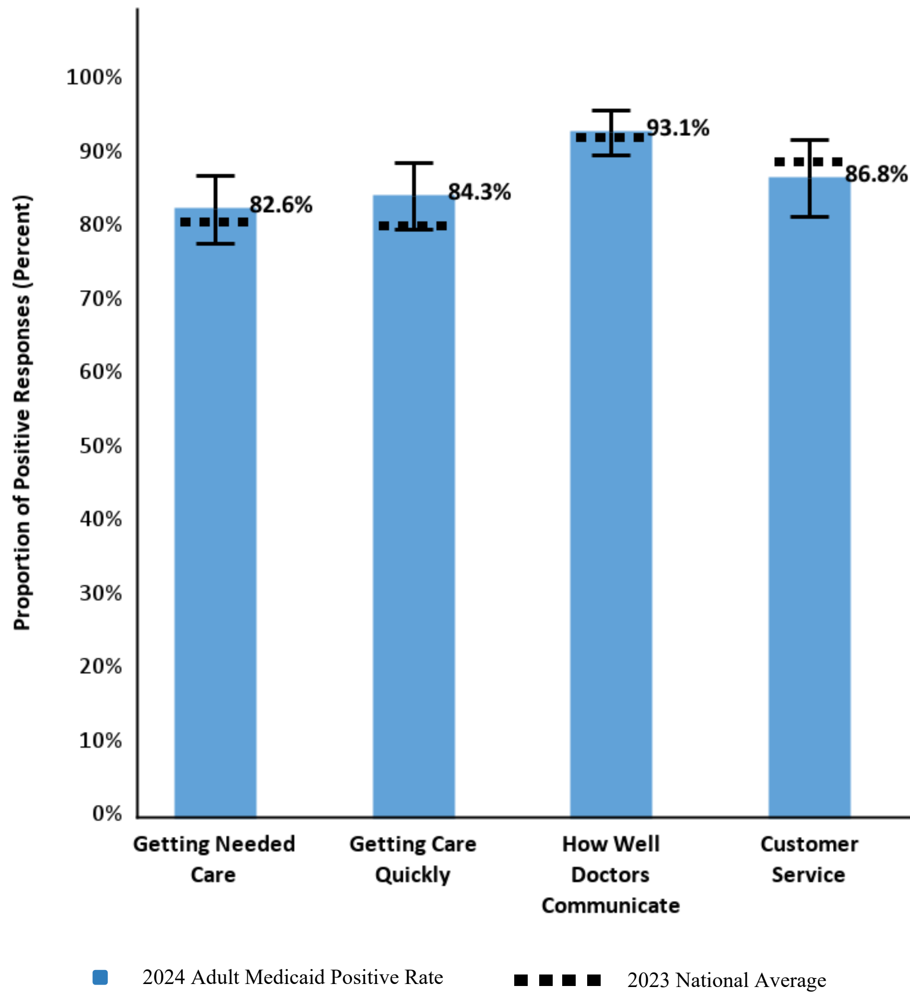


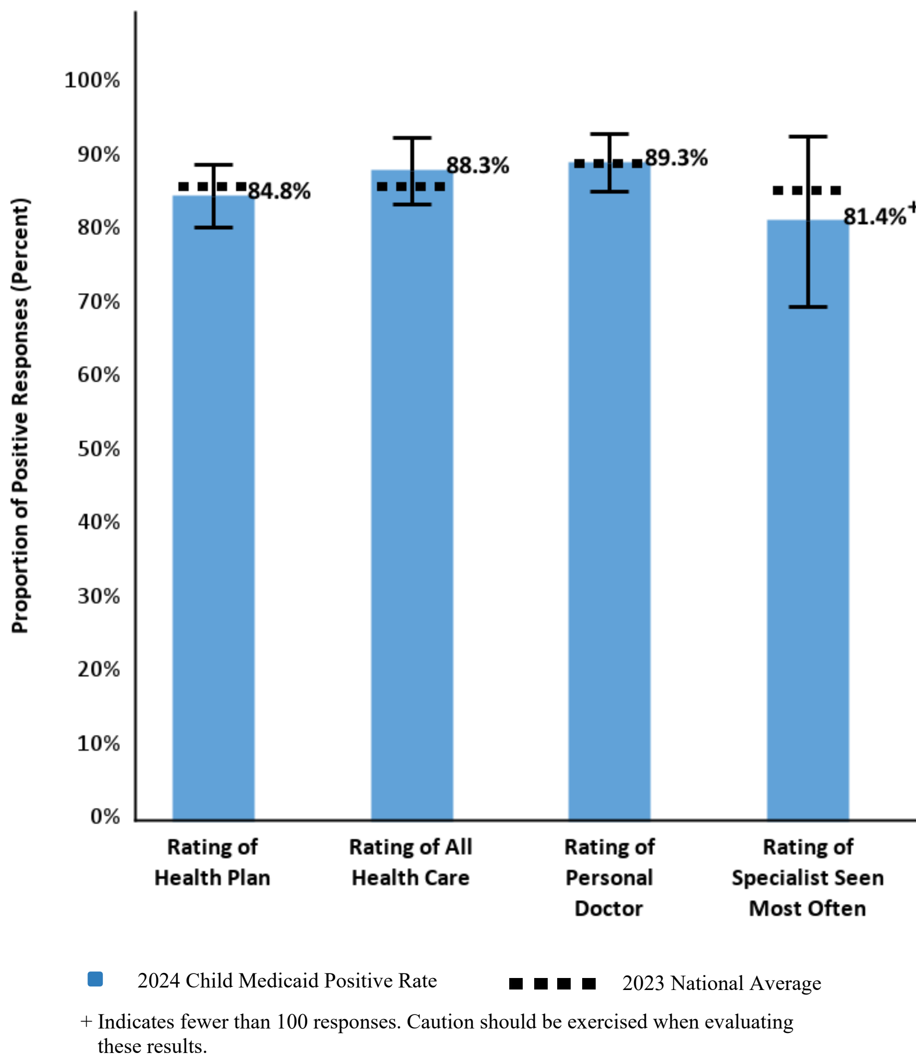
Figure 3-2—ACNH Adult Medicaid CAHPS Results: Composite Measures



For **ACNH**'s adult Medicaid population, three rates, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*, exceeded NCQA's 2023 national averages. The measure rate for *Rating of Health Plan* was statistically significantly lower than the national average.

ACNH surveyed 2,063 general child Medicaid members in 2024, and parents/caretakers of child members returned 377 completed surveys. After excluding ineligible members, the response rate was 13.49 percent. In 2024, the **ACNH** general child Medicaid response rate was higher than the 2023 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.[17] Figure 3-3 and Figure 3-4 show **ACNH**'s general child Medicaid 2024 positive rates, and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.[18]

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



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

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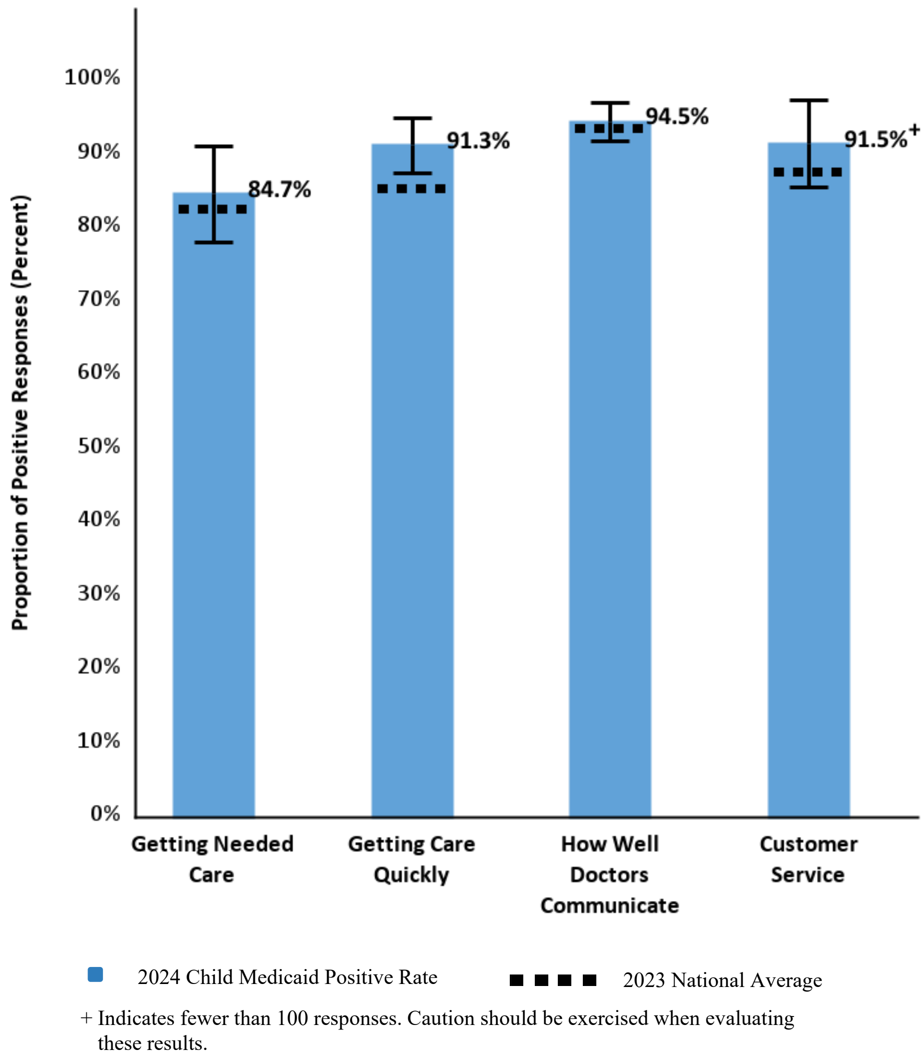
[17] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid members in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

[18] The 2024 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 All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* exceeded NCQA's 2023 national averages. The measure rate for *Getting Care Quickly* was statistically significantly higher than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and general child Medicaid populations' 2024 CAHPS survey results to the 2023 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. One of the 2024 measure rates for the adult Medicaid population was statistically significantly lower than the 2023 NCQA Medicaid national averages; therefore, HSAG recommends that **ACNH** focus ***quality of care*** improvement efforts on the *Rating of Health Plan* measure for the adult population. In addition, HSAG recommends that **ACNH** focus ***quality of care***

improvement efforts on the *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* measures for the general child population and the *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Customer Service* measures for the adult population, as these rates fell below the national averages.

The rates for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **ACNH** could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could positively impact 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. 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** also could consider obtaining feedback from patients on their recent office visits, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI to address these concerns.

ACNH could improve the *Customer Service* rate by evaluating current MCO call center hours and practices to determine if the hours and resources meet members' needs. **ACNH** could further promote the use of existing after-hours customer service to improve customer service results. Improving the *Customer Service* rate may positively affect ***quality of care.*** The MCO's Member Advisory Board could be used to better understand what constitutes high-quality services from the perspective of its members. **ACNH** could appoint workgroups that include call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

NHHF

NHHF surveyed 2,025 adult Medicaid members in 2024, and members returned 363 completed surveys. After excluding ineligible members, the response rate was 18.11 percent. In 2024, the **NHHF** adult Medicaid response rate was higher than the 2023 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 12.9 percent. Figure 3-5 and Figure 3-6 show **NHHF**'s adult Medicaid 2024 positive rates, and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.

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

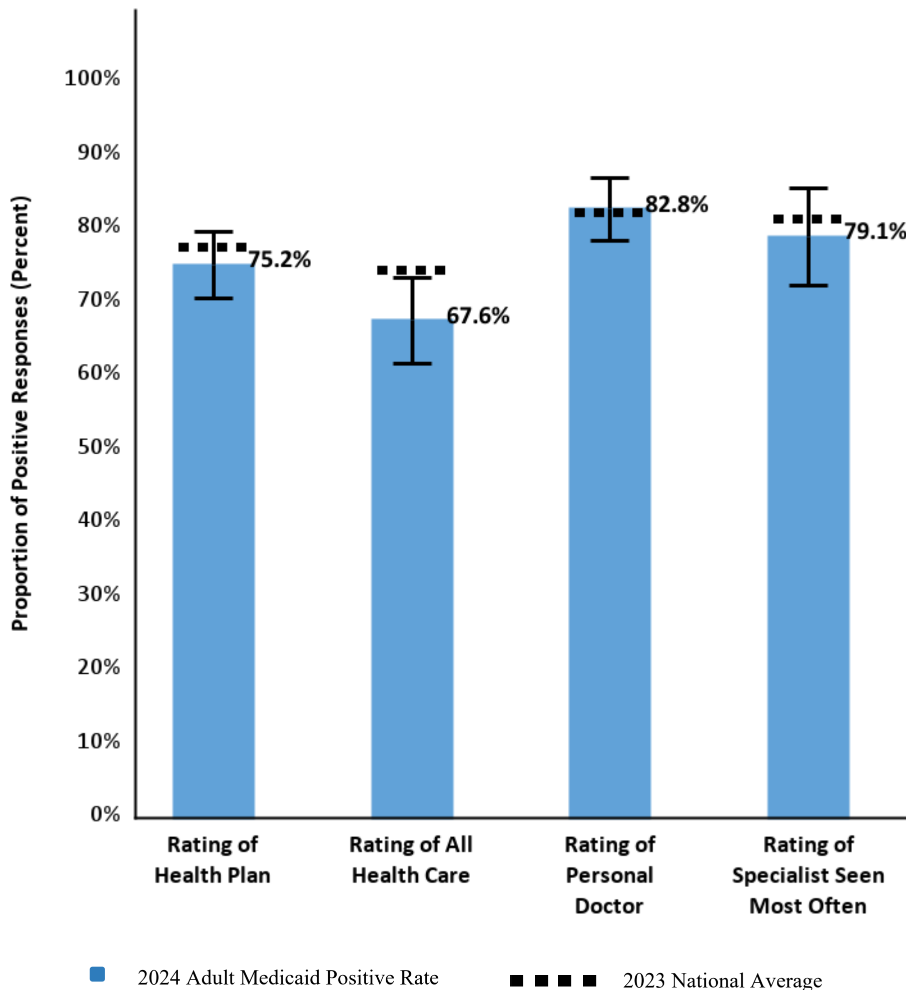
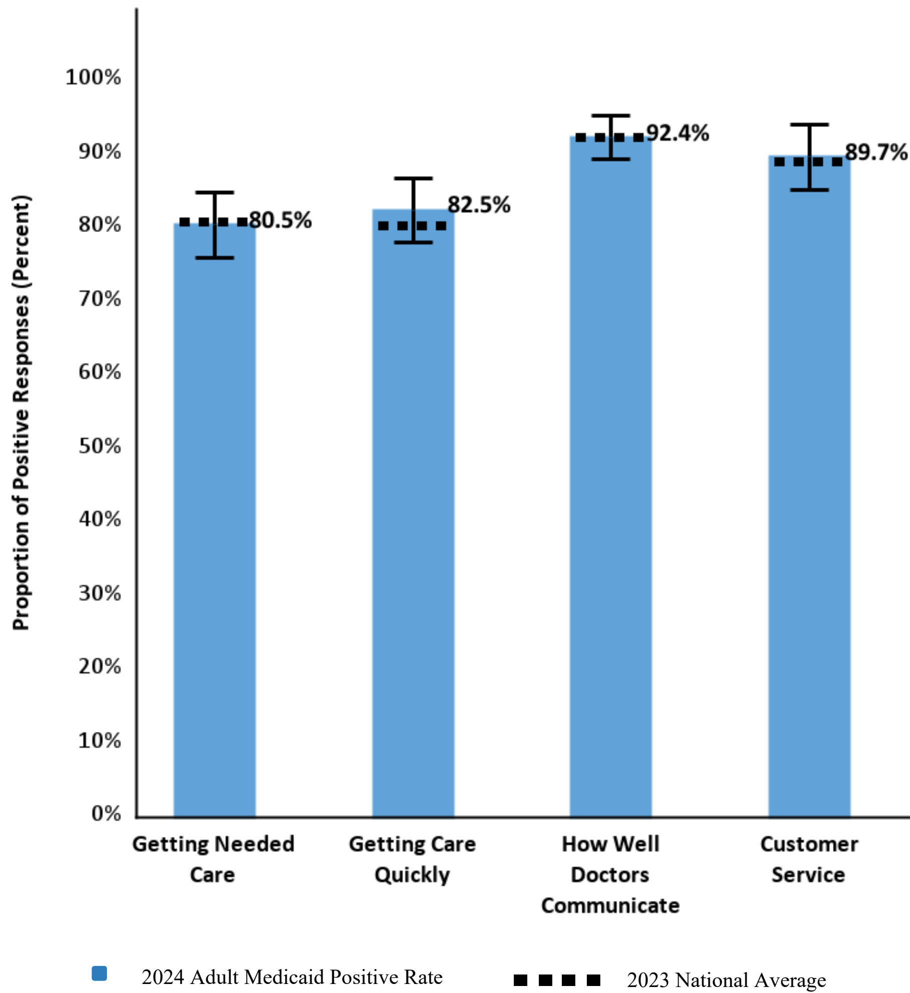


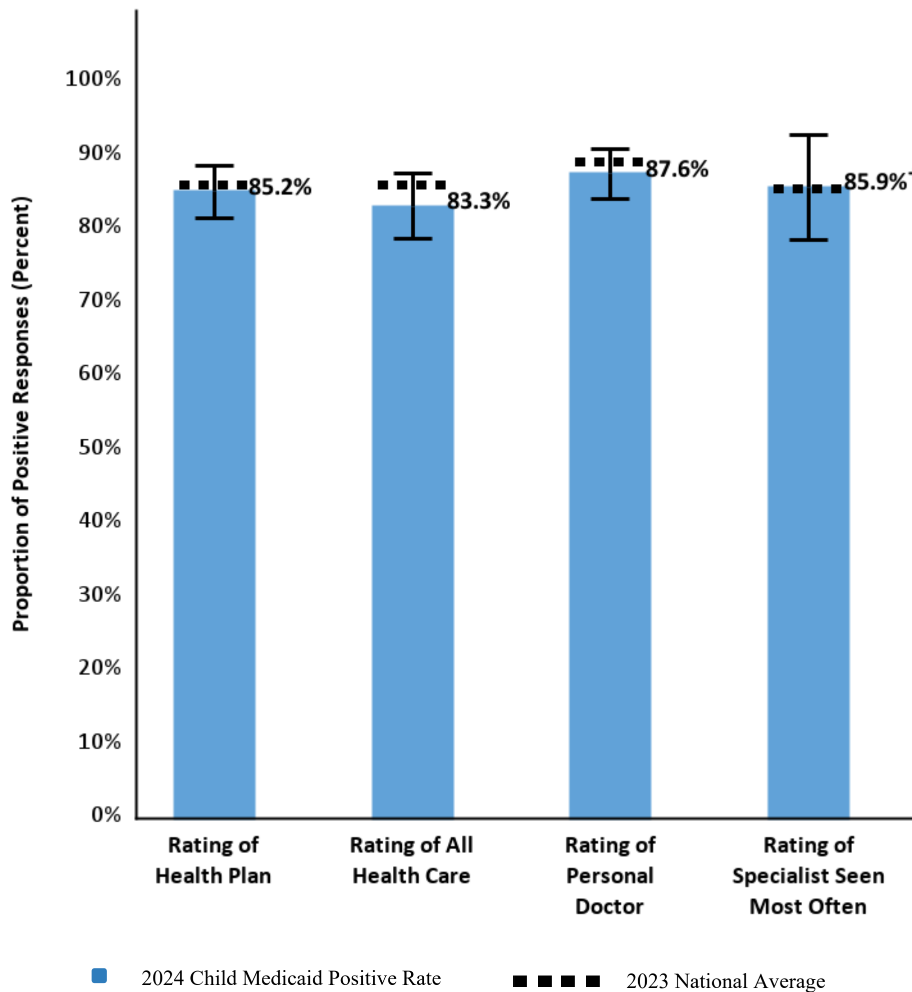
Figure 3-6—NHHF Adult Medicaid CAHPS Results: Composite Measures



For **NHHF**'s adult Medicaid population, three rates, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*, exceeded NCQA's 2023 national averages. The measure rate for *Rating of All Health Care* was statistically significantly lower than the national average.

NHHF surveyed 2,640 general child Medicaid members in 2024, and parents/caretakers of child members returned 397 completed surveys. After excluding ineligible members, the response rate was 15.12 percent. In 2024, the **NHHF** general child Medicaid response rate was higher than the 2023 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.[19] Figure 3-7 and Figure 3-8 show **NHHF**'s general child Medicaid 2024 positive rates, and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.[20]

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



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

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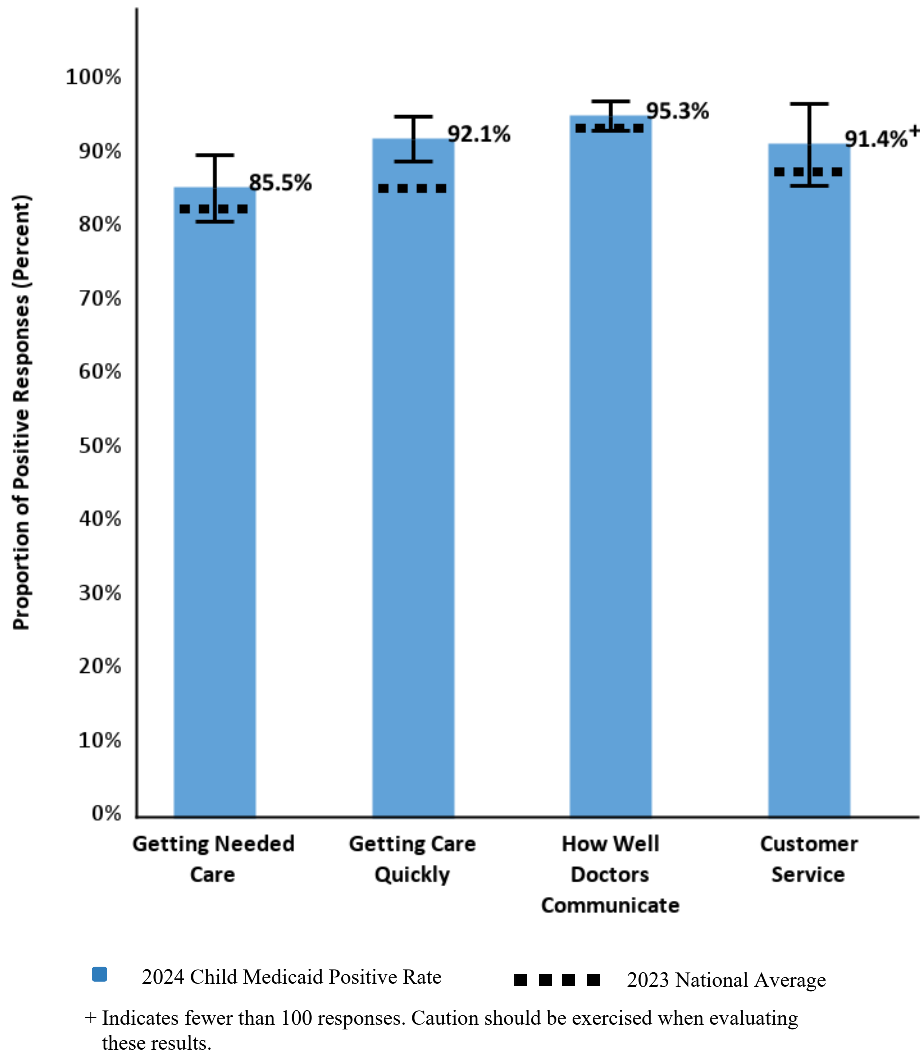
19 The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid members in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

20 The 2024 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, five rates, *Rating of Specialist Seen Most Often, Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2023 national averages. The measure rate for *Getting Care Quickly* was statistically significantly higher than the national average.

Conclusions and Recommendations for Improvement

HSAG compared the adult and general child Medicaid populations' 2024 CAHPS survey results to the 2023 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. One of the 2024 measure rates for the adult Medicaid population was statistically significantly lower than the 2023 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 adult population. In addition, HSAG recommends that **NHHF** focus ***quality of care*** and

access to care improvement efforts on the *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor* for the general child population and the *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *How Well Doctors Communicate* for the adult population as these rates fell below the national averages.

The rates for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **NHHF** could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient 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 visits, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of QI 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 *Getting Needed Care* could be improved by evaluating the care delivery process and identifying if there are any operational issues contributing to access to care barriers for members. **NHHF** could explore ways to direct members to useful and reliable sources of information on the Internet by expanding its website to include easily accessible health information and relevant tools, as well as links to related information. Benefits of Internet access to health information and advice may improve ***quality of care*** and ***access to care***. Furthermore, **NHHF** could consider implementing a variety of programs designed to provide immediate, on-demand access to information, advice, diagnoses, and treatment related to non-urgent health conditions and problems.

WS

WS surveyed 3,713 adult Medicaid members in 2024, and members returned 451 completed surveys. After excluding ineligible members, the response rate was 12.28 percent. In 2024, the **WS** adult Medicaid response rate was lower than the 2023 NCQA national average response rate for the CAHPS 5.1H Adult Medicaid Health Plan Survey, which was 12.9 percent. Figure 3-9 and Figure 3-10 show **WS**'s adult Medicaid 2024 positive rates, and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.

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

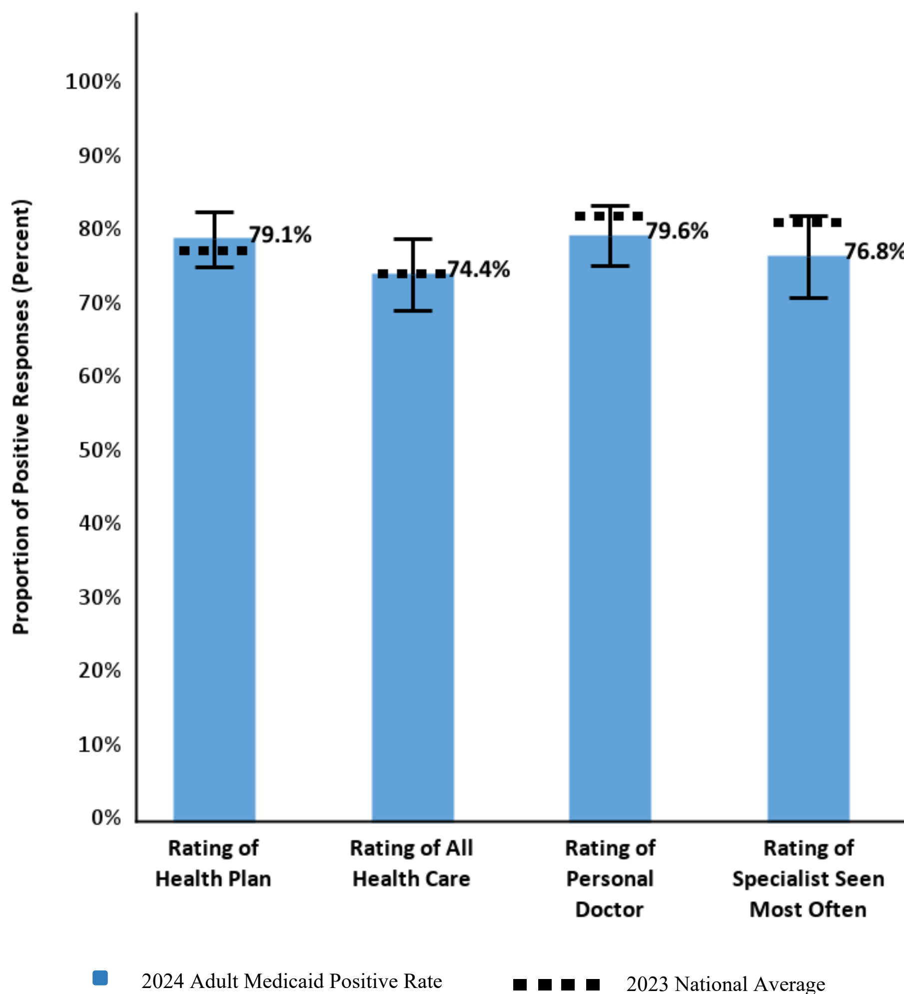
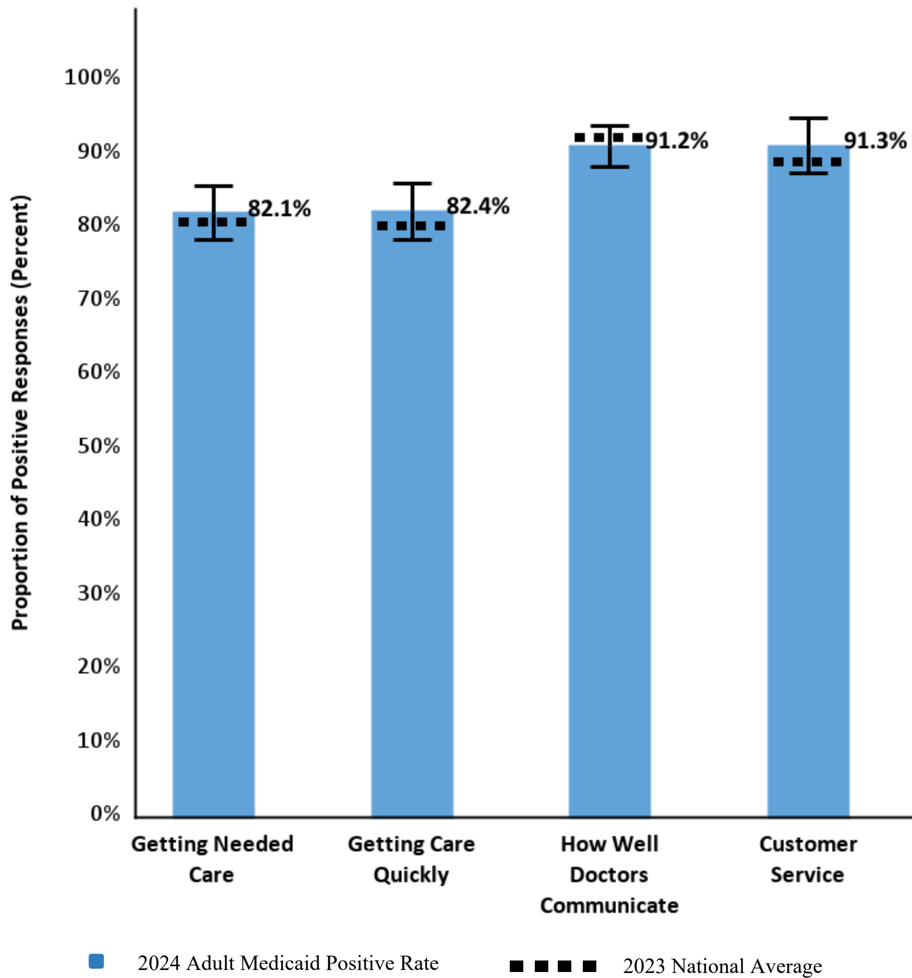


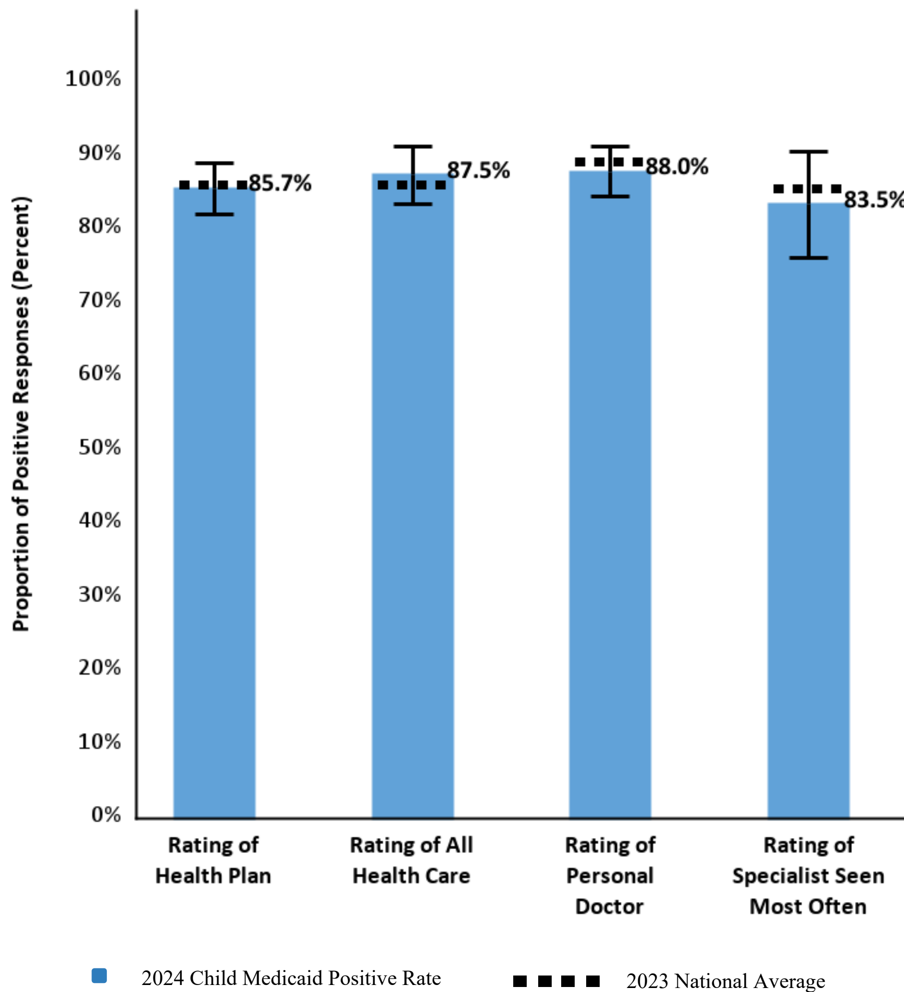
Figure 3-10—WS Adult Medicaid CAHPS Results: Composite Measures



For **WS**'s adult Medicaid population, four rates, *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service* exceeded NCQA's 2023 national average. However, no measure rates were statistically significantly higher or lower than the national averages.

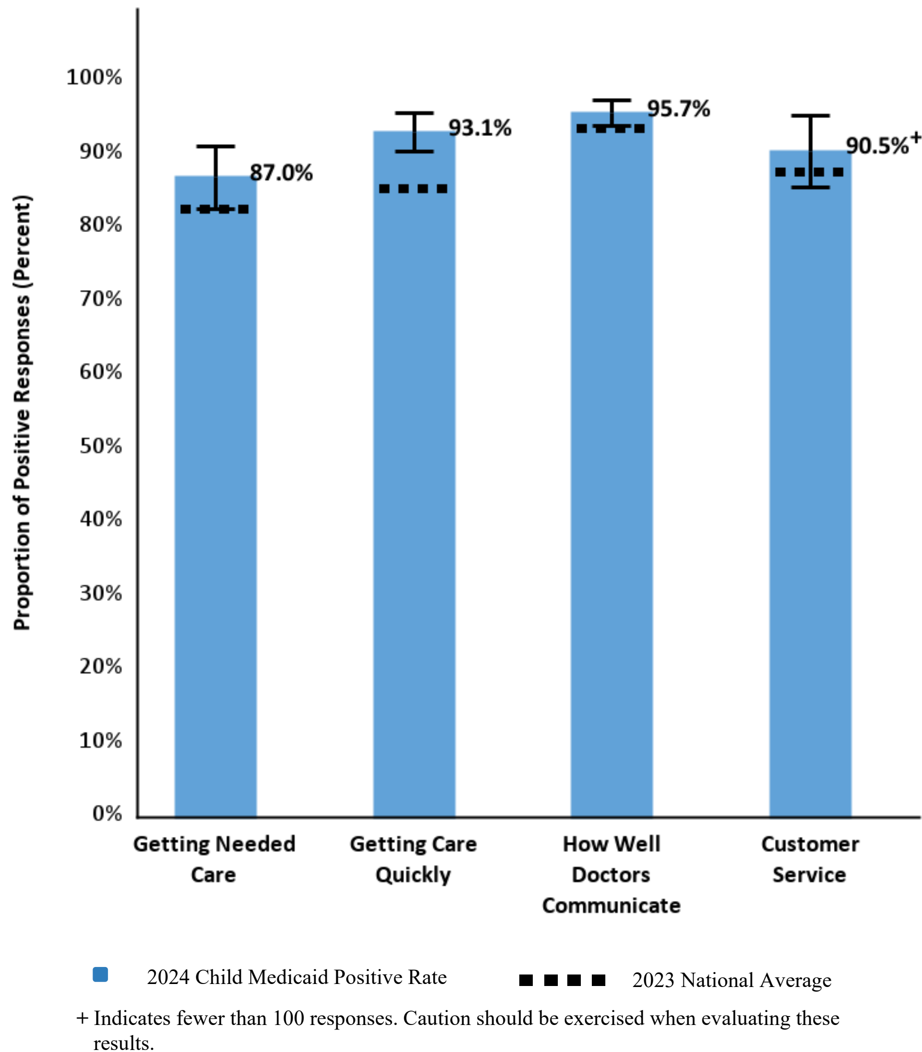
WS surveyed 4,538 general child Medicaid members in 2024, and parents/caretakers of child members returned 393 completed surveys. After excluding ineligible members, the response rate was 8.68 percent. In 2024, the **WS** general child Medicaid response rate was lower than the 2023 NCQA national average response rate for the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, which was 12.2 percent.[21] Figure 3-11 and Figure 3-12 show **WS**'s general child Medicaid 2024 positive rates and comparisons of the lower and upper confidence intervals to the 2023 NCQA national averages for the global ratings and composite measures, respectively.[22]

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



[21] 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).
[22] The 2024 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, five rates, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*, exceeded NCQA's 2023 national averages. The measure rates for *Getting Care Quickly* and *How Well Doctors Communicate* were statistically significantly higher than the national averages.

Conclusions and Recommendations for Improvement

HSAG performed a comparison of the adult and general child Medicaid populations' 2024 CAHPS survey results to the 2023 NCQA adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. None of the 2024 measure rates for the general child Medicaid population or the adult Medicaid population were statistically significantly lower than the 2023 NCQA Medicaid national averages. However, HSAG recommends that **WS** focus on ***quality of care*** improvement efforts on the *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of*

Specialist Seen Most Often measures for the general child population and the *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate* 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 Health Plan*, *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. Improvement in these areas will positively impact ***quality of care***. 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 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 them to provide the ***quality of care*** they 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 of its members related to how their doctor communicates with them.

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

HEDIS

HEDIS is a standardized set of nationally recognized indicators that are used to measure the performance of managed care plans. According to NCQA, HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. **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 R—Data Management and Reporting

This standard assesses whether:

- The organization's data management enables measurement.
- Data extraction and loads are complete and accurate.
- Data transformation and integration is accurate and valid.
- Data quality and governance are components of the organization's data management.
- Oversight and controls ensure correct implementation of measure reporting software.

IS C—Clinical and Care Delivery Data

This standard assesses whether:

- Data capture is complete.
- Data conform with industry standards.
- Transaction file data are accurate.
- Organization confirms ingested data meet expectations for data quality.

IS M—Medical Record Review Processes

This standard assesses whether:

- Forms capture all fields relevant to measure reporting. 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 is 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 A—Administrative Data

This standard assesses whether:

- Data conform with industry standards and measure requirements.
- Data are complete and accurate.
- Membership information system enables measurement.

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) 2023 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)—HbA1c Poor Control (>9.0%)*, *Plan All-Cause Readmissions (PCR)*, and *Ambulatory Care (AMB)—Emergency Department (ED) Visits—Total*, 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 2023 rates to national benchmarks that are based on NCQA's Quality Compass[23] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2022, the most recent benchmarks available for comparison.

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

Table 3-27 displays the HEDIS MY 2023 rates for the MCOs, the statewide average rate, and the HEDIS MY 2023 statewide average percentile ranking.

Table 3-27—HEDIS MY 2023 Health Plan Comparison Table

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Prevention					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total	77.43%	81.57%	82.10%	80.83%	75th–89th Percentile
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening	54.95%	57.34%	52.50%	54.99%	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	65.71%	61.05%	60.95%	62.21%	50th–74th Percentile
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	82.55%	79.07%	78.03%	79.57%	≥90th Percentile
Child and Adolescent Well-Care Visits (WCV)					
Ages 3 to 11 Years	72.03%	72.68%	71.57%	72.07%	≥90th Percentile
Ages 12 to 17 Years	58.96%	65.63%	64.26%	64.39%	≥90th Percentile
Ages 18 to 21 Years	36.72%	43.28%	41.75%	41.96%	≥90th Percentile
Total	64.74%	66.75%	65.93%	66.15%	≥90th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile—Total	57.32%	83.45%	77.93%	78.06%	25th–49th Percentile
Counseling for Nutrition—Total	62.28%	81.27%	73.94%	75.74%	50th–74th Percentile

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Counseling for Physical Activity—Total	57.82%	77.37%	68.62%	71.09%	50th–74th 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])	67.15%	67.64%	70.07%	68.40%	50th–74th Percentile
Combination 10 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	41.36%	35.52%	35.77%	37.29%	50th–74th Percentile
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	64.96%	75.43%	78.83%	76.18%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	24.22%	31.39%	33.33%	31.71%	25th–49th Percentile
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening	53.28%	59.37%	54.26%	55.94%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
*Non–Recommended Cervical Cancer Screening in Adolescent Females**	0.00%	0.11%	0.07%	0.08%	≥90th Percentile
Chlamydia Screening in Women (CHL)[1]					
Ages 16 to 20 Years	37.65%	44.50%	44.70%	44.08%	< 25th percentile
Ages 21 to 24 Years	55.37%	55.48%	55.33%	55.40%	< 25th percentile

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Total	47.47%	47.68%	47.64%	47.64%	< 25th percentile
***Prenatal and Postpartum Care (PPC)*[1]**					
Timeliness of Prenatal Care	76.34%	91.24%	88.33%	86.19%	50th–74th Percentile
Postpartum Care	79.93%	86.62%	85.00%	84.24%	75th–89th Percentile
Lead Screening in Children (LSC)					
Lead Screening in Children	75.67%	75.67%	76.89%	76.12%	75th–89th Percentile
Acute and Chronic Care					
Appropriate Testing for Pharyngitis (CWP)					
Total	84.84%	83.39%	84.85%	84.26%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)					
Total	93.26%	93.54%	93.40%	93.43%	50th–74th Percentile
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)					
Bronchodilator	88.06%	89.40%	88.57%	88.80%	75th–89th Percentile
Systemic Corticosteroid	83.58%	76.82%	88.00%	82.95%	≥90th Percentile
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
*HbA1c Poor Control (>9.0%)**	42.34%	33.82%	30.90%	34.43%	50th–74th Percentile
HbA1c Control (<8.0%)	50.12%	58.39%	58.88%	56.85%	50th–74th Percentile
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	62.53%	65.94%	69.27%	66.50%	50th–74th Percentile

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Use of Imaging Studies for Low Back Pain (LBP)					
Total	71.43%	65.45%	67.84%	67.84%	< 25th percentile
Plan All-Cause Readmissions (PCR)					
*Observed Readmissions—Total**	11.75%	10.47%	9.75%	10.48%	NC
Asthma Medication Ratio (AMR)					
Total	56.02%	62.64%	61.54%	61.31%	25th–49th Percentile
Ambulatory Care (AMB)*					
*ED Visits**	533.02	520.56	532.09	527.87	25th–49th Percentile
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	54.89%	59.20%	56.69%	57.30%	≥90th Percentile
30-Day Follow-Up—Total	71.43%	76.09%	72.07%	73.46%	≥90th Percentile
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.40%	81.48%	77.65%	79.72%	50th–74th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	71.11%	75.47%	72.32%	50th–74th Percentile

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.79%	72.22%	72.73%	73.03%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose Testing—Total	64.41%	57.92%	58.64%	58.65%	50th–74th Percentile
Cholesterol Testing—Total	38.98%	37.31%	36.50%	37.00%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	37.29%	36.66%	35.15%	35.94%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
Total	NA	69.62%	59.22%	64.48%	50th–74th Percentile
Antidepressant Medication Management (AMM)[1]					
Effective Acute Phase Treatment	65.21%	68.54%	65.73%	66.64%	75th–89th Percentile
Effective Continuation Phase Treatment	50.95%	52.81%	49.10%	50.86%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]					
Initiation Phase	46.15%	55.36%	36.69%	45.05%	50th–74th Percentile
Continuation and Maintenance Phase	46.15%	61.02%	39.44%	49.39%	25th–49th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)					
Initiation of SUD Treatment—Total	60.74%	47.19%	47.04%	50.92%	75th–89th Percentile

Performance Measure HEDIS MY 2023	ACNH	NHHF	WS	Statewide Average Rate	HEDIS MY 2023 Statewide Average Percentile
Engagement of SUD Treatment—Total	34.69%	25.46%	25.77%	28.16%	≥90th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	63.71%	69.89%	64.75%	66.60%	≥90th Percentile
30-Day Follow-Up—Total	72.18%	78.49%	74.10%	75.49%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)					
7-Day Follow-Up—Total	44.03%	43.57%	44.53%	44.11%	≥90th Percentile
30-Day Follow-Up—Total	55.11%	58.48%	57.23%	56.97%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)					
Total	23.93%	28.15%	23.20%	24.77%	25th–49th Percentile

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

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

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

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

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

Table 3-28 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 MY 2023.

Table 3-28—Summary of the NH MCM Program Statewide Scores for MY 2023 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	6	3	7	4	3	**23**
Acute and Chronic Care	2	1	4	2	1	**10**
Behavioral Health	8	3	7	2	0	**20**
All Domains	**16**	**7**	**18**	**8**	**4**	**53**
Percentage	**30.19%**	**13.21%**	**33.96%**	**15.09%**	**7.55%**	**100%**

The New Hampshire statewide Medicaid rates ranked at or above the 50th percentile for 41 measures (77.36 percent), with 16 of these measures (30.19 percent) meeting or exceeding the 90th percentile. A total of 12 measures (22.64 percent) fell below the 50th percentile, with four of the measures (7.55 percent) falling below the 25th percentile.

The following statewide average rates met or exceeded the HEDIS MY 2023 Statewide Average 90th percentile:

- Six Prevention measure indicator rates: *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total*; 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*
- Eight Behavioral Health measure indicator rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*; *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total*; *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; and *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

The following statewide average rates fell below the HEDIS MY 2023 Statewide Average 25th percentile:

- Three Prevention measure indicator rates: *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total*
- One Acute and Chronic Care measure indicator rate: *Use of Imaging Studies for Low Back Pain (LBP)—Total*

ACNH

Table 3-29 displays **ACNH**'s HEDIS MY 2021, HEDIS MY 2022, and HEDIS MY 2023 performance measure rates, and **ACNH**'s HEDIS MY 2023 percentile ranking. The HEDIS MY 2023 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022. 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 3-29—ACNH HEDIS MY 2021, MY 2022, MY 2023 Rates, and MY 2023 Percentile Rankings

ACNH HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	74.75%	72.01%	77.43%	50th–74th Percentile
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	52.69%	54.13%	54.95%	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	54.20%	62.42%	65.71%	75th–89th Percentile
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	70.21%	79.10%	82.55%	≥90th Percentile
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	65.66%	65.59%	72.03%	≥90th Percentile
Ages 12 to 17 Years	56.34%	54.19%	58.96%	75th–89th Percentile

ACNH HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Ages 18 to 21 Years	29.29%	27.36%	36.72%	75th–89th Percentile
Total	55.85%	55.22%	64.74%	≥90th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	69.34%	63.75%	57.32%	< 25th Percentile
Counseling for Nutrition—Total	69.59%	61.56%	62.28%	25th–49th Percentile
Counseling for Physical Activity—Total	66.91%	57.91%	57.82%	< 25th Percentile
Childhood Immunization Status (CIS)				
Combination 3 (diphtheria/tetanus/acellular pertussis [DTaP], polio [IPV], measles/mumps/rubella [MMR], haemophilus influenzae type B [Hib], hepatitis B [HepB], varicella [VZV], pneumococcal conjugate [PCV])	66.18%	66.42%	67.15%	50th–74th Percentile
Combination 10 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	41.12%	42.34%	41.36%	75th–89th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	61.69%	62.26%	64.96%	< 25th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	25.00%	22.04%	24.22%	< 25th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	46.23%	47.20%	53.28%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non–Recommended Cervical Cancer Screening in Adolescent Females**	0.00%	0.11%	0.00%	≥90th Percentile
Chlamydia Screening in Women (CHL)[1]				
Ages 16 to 20 Years	47.26%	46.55%	37.65%	< 25th Percentile
Ages 21 to 24 Years	60.60%	54.58%	55.37%	< 25th Percentile
Total	55.42%	51.53%	47.47%	< 25th Percentile

ACNH HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	82.73%	80.29%	76.34%	< 25th Percentile
Postpartum Care	80.78%	79.81%	79.93%	50th–74th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	79.08%	69.83%	75.67%	75th–89th Percentile
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	78.49%	79.37%	84.84%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	96.23%	95.25%	93.26%	50th–74th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	73.17%	87.50%	88.06%	75th–89th Percentile
Systemic Corticosteroid	78.05%	83.33%	83.58%	≥90th Percentile
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Poor Control (>9.0%)**	49.15%	53.77%	42.34%	25th–49th Percentile
HbA1c Control (<8.0%)	41.12%	40.39%	50.12%	25th–49th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	52.07%	57.42%	62.53%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	73.15%	71.43%	25th–49th Percentile
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	12.20%	8.89%	11.75%	—
Asthma Medication Ratio (AMR)				
Total	58.42%	52.61%	56.02%	< 25th Percentile
Ambulatory Care (AMB)*				
*ED Visits**	537.95	533.93	533.02	25th–49th Percentile

ACNH HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	59.31%	57.53%	54.89%	≥90th Percentile
30-Day Follow-Up—Total	73.70%	70.86%	71.43%	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	82.49%	77.97%	81.40%	50th–74th 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	66.67%	66.41%	75.79%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	44.74%	50.88%	64.41%	75th–89th Percentile
Cholesterol Testing—Total	21.05%	33.33%	38.98%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	21.05%	29.82%	37.29%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	NA	NA	NA	NC
Antidepressant Medication Management (AMM)[1]				
Effective Acute Phase Treatment	70.62%	69.99%	65.21%	50th–74th Percentile
Effective Continuation Phase Treatment	60.51%	57.89%	50.95%	75th–89th Percentile

ACNH HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	40.82%	45.78%	46.15%	50th–74th Percentile
Continuation and Maintenance Phase	NA	NA	46.15%	< 25th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	55.24%	60.74%	≥90th Percentile
Engagement of SUD Treatment—Total	—	27.01%	34.69%	≥90th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	71.51%	65.34%	63.71%	≥90th Percentile
30-Day Follow-Up—Total	79.23%	75.46%	72.18%	75th–89th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	46.19%	44.03%	≥90th Percentile
30-Day Follow-Up—Total	—	56.68%	55.11%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	34.25%	28.62%	23.93%	25th–49th Percentile

* For this indicator, a lower rate indicates better performance.
**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 is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Conclusions

ACNH was fully compliant with all NCQA-defined IS standards for HEDIS MY 2023.

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**:

- Four Prevention measure indicator rates: *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years* and *Total*; 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*
- Seven Behavioral Health measure indicator rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*; *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Initiation of SUD Treatment—Total* and *Engagement of SUD Treatment—Total*; *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total*; and *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Eight Prevention measure indicator rates: *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 1* and *Combination 2*; *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total*; and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- One Acute and Chronic Care measure indicator rate: *Asthma Medication Ratio (AMR)—Total*
- One Behavioral Health measure indicator rate: *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*

Recommendations

With 17 of 51 rates (33.33 percent) falling below the 50th percentile, **ACNH** should consider focusing efforts on weight assessment and counseling for BMI, nutrition, physical activity, and immunizations for adolescents. **ACNH** also should focus on ensuring young women are appropriately screened for cervical cancer screening and chlamydia. Additional areas of focus for **ACNH** include timely prenatal care, controlling HbA1c for diabetic patients, imaging studies for individuals with low back pain, asthma medication ratio, reducing ED visits, providing follow-up care and monitoring of children prescribed ADHD medication, and pharmacotherapy for opioid use disorder. 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 3-30 displays **NHHF**'s HEDIS MY 2021, HEDIS MY 2022, and HEDIS MY 2023 performance measure rates, and **NHHF**'s HEDIS MY 2023 percentile ranking. The HEDIS MY 2023 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022. 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 3-30—NHHF HEDIS MY 2021, MY 2022, MY 2023 Rates and MY 2023 Percentile Rankings

NHHF HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	78.34%	77.38%	81.57%	75th–89th Percentile
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	53.52%	57.06%	57.34%	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	55.87%	59.09%	61.05%	50th–74th Percentile
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	76.80%	77.51%	79.07%	≥90th Percentile
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	67.07%	70.17%	72.68%	≥90th Percentile
Ages 12 to 17 Years	58.16%	61.86%	65.63%	≥90th Percentile
Ages 18 to 21 Years	34.41%	35.76%	43.28%	≥90th Percentile
Total	58.38%	61.15%	66.75%	≥90th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	69.59%	72.99%	83.45%	50th–74th Percentile
Counseling for Nutrition—Total	67.40%	72.99%	81.27%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Counseling for Physical Activity—Total	62.04%	67.40%	77.37%	75th–89th 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])	69.34%	72.02%	67.64%	50th–74th Percentile
Combination 10 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	42.34%	38.93%	35.52%	50th–74th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	73.97%	78.83%	75.43%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	28.95%	33.33%	31.39%	25th–49th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	57.66%	54.99%	59.37%	50th–74th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non–Recommended Cervical Cancer Screening in Adolescent Females**	0.09%	0.12%	0.11%	75th–89th Percentile
Chlamydia Screening in Women (CHL)[1]				
Ages 16 to 20 Years	44.37%	46.58%	44.50%	25th–49th Percentile
Ages 21 to 24 Years	52.89%	56.57%	55.48%	< 25th Percentile
Total	47.15%	50.25%	47.68%	< 25th Percentile
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	80.78%	79.32%	91.24%	≥90th Percentile
Postpartum Care	76.89%	78.10%	86.62%	≥90th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	72.67%	68.13%	75.67%	75th–89th Percentile
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	78.81%	80.11%	83.39%	≥90th Percentile

NHHF HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	96.74%	95.80%	93.54%	50th–74th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	84.88%	85.57%	89.40%	75th–89th Percentile
Systemic Corticosteroid	78.49%	83.51%	76.82%	50th–74th Percentile
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Poor Control (>9.0%)**	39.90%	37.96%	33.82%	50th–74th Percentile
HbA1c Control (<8.0%)	47.45%	49.39%	58.39%	75th–89th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	59.37%	61.31%	65.94%	50th–74th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	71.53%	65.45%	< 25th Percentile
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	10.78%	9.60%	10.47%	NC
Asthma Medication Ratio (AMR)				
Total	60.09%	62.96%	62.64%	25th–49th Percentile
Ambulatory Care (AMB) *				
*ED Visits**	451.01	521.49	520.56	25th–49th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	61.07%	49.81%	59.20%	≥90th Percentile
30-Day Follow-Up—Total	76.41%	71.64%	76.09%	≥90th Percentile

NHHF HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 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	77.31%	75.00%	81.48%	50th–74th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.11%	62.75%	71.11%	50th–74th Percentile
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	72.01%	75.10%	72.22%	75th–89th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	58.58%	57.14%	57.92%	50th–74th Percentile
Cholesterol Testing—Total	39.23%	36.25%	37.31%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	38.32%	35.18%	36.66%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	74.18%	72.67%	69.62%	75th–89th Percentile
Antidepressant Medication Management (AMM)[1]				
Effective Acute Phase Treatment	65.66%	66.79%	68.54%	75th–89th Percentile
Effective Continuation Phase Treatment	48.72%	50.11%	52.81%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	52.04%	53.56%	55.36%	≥90th Percentile
Continuation and Maintenance Phase	56.68%	56.59%	61.02%	75th–89th Percentile

NHHF HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	44.32%	47.19%	50th–74th Percentile
Engagement of SUD Treatment—Total	—	24.05%	25.46%	≥90th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	70.16%	64.40%	69.89%	≥90th Percentile
30-Day Follow-Up—Total	79.48%	73.26%	78.49%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	41.94%	43.57%	≥90th Percentile
30-Day Follow-Up—Total	—	56.61%	58.48%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	29.30%	30.99%	28.15%	25th–49th Percentile

* For this indicator, a lower rate indicates better performance.
**This utilization rate is expressed as the rate per 1,000 members.
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Conclusions

NHHF was fully compliant with all NCQA-defined IS standards for HEDIS MY 2023.

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**:

- Seven Prevention measure indicator rates: *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*,

and *Total*; and *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care*

- One Acute and Chronic Care measure indicator rate: *Appropriate Testing for Pharyngitis (CWP)—Total*
- Eight Behavioral Health measure indicator rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase*; *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total*; *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; and *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Two Prevention measure indicator rates: *Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years* and *Total*
- One Acute and Chronic Care measure indicator rate: *Use of Imaging Studies for Low Back Pain (LBP)—Total*

Recommendations

With nine of 53 rates (16.98 percent) falling below the 50th percentile, **NHHF** should consider focusing efforts on immunizations for adolescents, chlamydia screening for women, and use of imaging studies for individuals with low back pain. **NHHF** also should focus on asthma medication ratio, reducing ED visits, and pharmacotherapy for opioid use disorder. Improving these rates will impact the ***timeliness of care*** and ***quality of care*** for **NHHF**'s members in the New Hampshire MCM program.

WS

Table 3-31 displays **WS**'s HEDIS MY 2021, HEDIS MY 2022, and HEDIS MY 2023 performance measure rates, and **WS**'s HEDIS MY 2023 percentile ranking. The HEDIS MY 2023 percentile ranking is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022. 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 3-31—WS HEDIS MY 2021, MY 2022, MY 2023 Rates and MY 2023 Percentile Rankings

WS HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Prevention				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Total	78.41%	74.48%	82.10%	75th–89th Percentile
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	47.88%	49.64%	52.50%	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	56.20%	57.16%	60.95%	50th–74th Percentile
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	75.02%	73.31%	78.03%	≥90th Percentile
Child and Adolescent Well-Care Visits (WCV)				
Ages 3 to 11 Years	65.93%	64.19%	71.57%	≥90th Percentile
Ages 12 to 17 Years	58.02%	54.77%	64.26%	≥90th Percentile
Ages 18 to 21 Years	32.88%	29.39%	41.75%	≥90th Percentile
Total	58.56%	55.25%	65.93%	≥90th Percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	71.74%	74.93%	77.93%	25th–49th Percentile
Counseling for Nutrition—Total	69.78%	71.43%	73.94%	50th–74th Percentile
Counseling for Physical Activity—Total	66.34%	65.50%	68.62%	50th–74th 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%	65.69%	70.07%	75th–89th Percentile

WS HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Combination 10 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV, hepatitis A [HepA], rotavirus [RV], Influenza)	44.28%	43.80%	35.77%	50th–74th Percentile
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	75.18%	73.24%	78.83%	25th–49th Percentile
Combination 2 (Meningococcal, Tdap, HPV)	30.90%	27.01%	33.33%	25th–49th Percentile
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening	61.71%	57.65%	54.26%	25th–49th Percentile
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
*Non–Recommended Cervical Cancer Screening in Adolescent Females**	0.22%	0.12%	0.07%	≥90th Percentile
Chlamydia Screening in Women (CHL)[1]				
Ages 16 to 20 Years	44.72%	42.23%	44.70%	25th–49th Percentile
Ages 21 to 24 Years	54.03%	53.71%	55.33%	< 25th Percentile
Total	47.63%	46.23%	47.64%	< 25th Percentile
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	83.04%	85.30%	88.33%	75th–89th Percentile
Postpartum Care	79.82%	83.51%	85.00%	≥90th Percentile
Lead Screening in Children (LSC)				
Lead Screening in Children	73.24%	65.69%	76.89%	75th–89th Percentile
Acute and Chronic Care				
Appropriate Testing for Pharyngitis (CWP)				
Total	80.87%	82.17%	84.85%	≥90th Percentile
Appropriate Treatment for Upper Respiratory Infection (URI)				
Total	96.83%	96.00%	93.40%	50th–74th Percentile
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Bronchodilator	93.49%	95.40%	88.57%	75th–89th Percentile
Systemic Corticosteroid	94.08%	88.51%	88.00%	≥90th Percentile

WS HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Poor Control (>9.0%)**	44.04%	34.55%	30.90%	75th–89th Percentile
HbA1c Control (<8.0%)	45.74%	56.20%	58.88%	75th–89th Percentile
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	56.45%	66.91%	69.27%	75th–89th Percentile
Use of Imaging Studies for Low Back Pain (LBP)				
Total	—	72.62%	67.84%	< 25th Percentile
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	11.35%	10.35%	9.75%	—
Asthma Medication Ratio (AMR)				
Total	62.55%	65.53%	61.54%	25th–49th Percentile
Ambulatory Care (AMB)*				
*ED Visits**	479.56	498.53	532.09	25th–49th Percentile
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	59.97%	53.70%	56.69%	≥90th Percentile
30-Day Follow-Up—Total	73.91%	71.45%	72.07%	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	74.68%	76.59%	77.65%	25th–49th Percentile
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.18%	61.29%	75.47%	75th–89th Percentile

WS HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	74.27%	72.64%	72.73%	≥90th Percentile
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing—Total	55.27%	54.32%	58.64%	50th–74th Percentile
Cholesterol Testing—Total	34.20%	30.77%	36.50%	50th–74th Percentile
Blood Glucose and Cholesterol Testing—Total	33.06%	29.98%	35.15%	50th–74th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
Total	60.33%	61.64%	59.22%	25th–49th Percentile
Antidepressant Medication Management (AMM)[1]				
Effective Acute Phase Treatment	62.48%	63.92%	65.73%	50th–74th Percentile
Effective Continuation Phase Treatment	46.73%	47.35%	49.10%	75th–89th Percentile
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	37.63%	41.46%	36.69%	< 25th Percentile
Continuation and Maintenance Phase	39.53%	42.28%	39.44%	< 25th Percentile
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total	—	47.17%	47.04%	50th–74th Percentile
Engagement of SUD Treatment—Total	—	24.37%	25.77%	≥90th Percentile
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	66.50%	61.68%	64.75%	≥90th Percentile
30-Day Follow-Up—Total	76.18%	72.97%	74.10%	≥90th Percentile
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7-Day Follow-Up—Total	—	46.57%	44.53%	≥90th Percentile

WS HEDIS Rates	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	HEDIS MY 2023 Percentile Rankings
30-Day Follow-Up—Total	—	60.53%	57.23%	≥90th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)				
Total	29.04%	26.35%	23.20%	25th–49th Percentile

* For this indicator, a lower rate indicates better performance.
**This utilization rate is expressed as the rate per 1,000 members.
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2023 and prior years be considered with caution.

Conclusions

WS was fully compliant with all NCQA-defined IS standards for HEDIS MY 2023.

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**:

- Seven Prevention measure indicator rates: *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total*; *Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)*; and *Prenatal and Postpartum Care—Postpartum Care*
- Two Acute and Chronic Care measure indicator rates: *Appropriate Testing for Pharyngitis (CWP)—Total* and *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*
- Seven Behavioral Health measure indicator rates: *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*; *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total*; *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; and *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

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

- Two Prevention measure indicator rates: *Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years* and *Total*
- One Acute and Chronic Care measure indicator rate: *Use of Imaging Studies for Low Back Pain (LBP)—Total*
- Two Behavioral Health measure indicator rates: *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

Recommendations

With 16 of 53 rates (30.19 percent) falling below the 50th percentile, **WS** should consider focusing efforts on ensuring young women are appropriately screened for breast cancer, cervical cancer, and chlamydia. **WS** also should focus on weight assessment and counseling for BMI and immunizations for adolescents. Additional areas of focus for **WS** include imaging studies for individuals with low back pain, asthma medication ratio, reducing ED visits, psychosocial care for children and adolescents on antipsychotics, providing follow-up care and monitoring of children prescribed ADHD medication, and pharmacotherapy for opioid use disorder. 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 C. Methodologies for Conducting EQR Activities, page C-27.

EDV

During SFY 2024, DHHS contracted HSAG to conduct an EDV study. HSAG conducted the following three core evaluation activities for the EDV activity in alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (referred to the CMS EQR Protocol 5 in this report):[24]

- 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 the changes made by the MCOs since April 2023.
- 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, 2023, and June 30, 2024, HSAG included encounter data with dates of service between July 1, 2022, and June 30, 2023, in the comparative analysis.

Information Systems Review

Health Plan Comparisons

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

- All MCOs had special software in place to receive data from providers/subcontractors, validate the data, generate encounters for DHHS, and perform compliance edits.
- Only **NHHF** and **WS** made changes since April 1, 2023. **NHHF** changed its pharmacy subcontractor from CVS to Express Scripts, and **WS** changed requirements for its DME subcontractor by removing coronavirus disease 2019 (COVID-19) processing rules.
- 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 gain a better understanding of the edits.

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[24] 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: Jan 13, 2025.

Health Plan-Specific Conclusions and Recommendations

Based on the IS review activity, HSAG has the following recommendations:

- **ACNH** should provide to DHHS its claim billing/payment documentation that explains/supports why **ACNH** used only WEDI SNIP levels 1 and 2 (i.e., not using level 3 or above).
- On the DME encounters that it submits to DHHS, **WS** should perform more quality checks such as the following:
  - Reconciliation with financial reports
  - Timeliness

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 the ongoing reports are produced on a monthly/quarterly basis, Table 3-32 displays aggregate compliance rates for each MCO in relation to the five standards within Exhibit A of the MCO contract. The aggregate results are for encounters submitted to DHHS between July 1, 2023, and June 30, 2024. Of note, if an MCO fails to meet a standard, it can work with DHHS to determine whether the MCO is responsible for the missed measure and/or if DHHS should adjust the measure result.

Table 3-32—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%	>99.9%	100%	100%	>99.9%	100%
		NHHF	100%	>99.9%	100%	100%	>99.9%	100%
		WS	100%	>99.9%	100%	99.9%	100%	>99.9%
Validity of Billing Provider Information	98.0%	**ACNH**	100%	>99.9%	100%	>99.9%	100%	>99.9%
		NHHF	100%	>99.9%	100%	100%	>99.9%	>99.9%
		WS	100%	>99.9%	100%	100%	100%	100%

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%	>99.9%	100%	>99.9%	NA	
		NHHF	100%	>99.9%	100%	>99.9%	NA	
		WS	100%	>99.9%	100%	>99.9%	NA	
Initial Submission Within 14 Days of Claim Payment	100%	**ACNH**	>99.9%		>99.9%		100%	
		NHHF	99.6%		>99.9%		98.0%	
		WS	99.7%		99.5%		99.8%	

¥ 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.
Green text indicates rates meeting the standards.

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 or nearly all submitted encounters with member identification numbers for all three encounter types. However, when these values were assessed, all MCOs either met the percent accurate standard of 100 percent or fell slightly below the standard by no more than 0.1 percentage points. Compared to the results in the SFY 2023 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 or nearly 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 2023 EDV Aggregate Report, all results were relatively 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 2023 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 encounters and **NHHF**'s institutional encounters. The remaining rates were all at least 98.0 percent (i.e., the lowest rate was for **NHHF**'s pharmacy encounters). Compared to the results in the SFY 2023 EDV Aggregate Report, the majority of results remained the same or improved slightly.

Health Plan-Specific Conclusions and Recommendations

ACNH

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

HSAG has no recommendations for **ACNH** to address related to the ongoing encounter data quality reports.

NHHF

NHHF's submitted encounters met the standards for the X12 EDI compliance 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 837P and pharmacy encounters.

WS

WS's submitted encounters met the standards for the X12 EDI compliance edits; the accuracy for member identification numbers in its 837P and 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 837I encounters, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all encounter types.

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 3-33 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 3-33—Record Omission and Surplus Rates by MCO and Encounter Type

MCO	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
ACNH	0.1%	0.1%	<0.1%	0.6%	0.1%	2.2%
NHHF	0.3%	0.1%	1.0%	0.7%	1.9%	0.2%
WS	0.7%	1.8%	1.6%	0.6%	<0.1%	0.1%
All MCOs	**0.4%**	**0.9%**	**1.0%**	**0.6%**	**0.8%**	**0.6%**

There were no rates that required the attention of the MCOs.

Element Omission and Surplus

Table 3-34 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 3-34—Data Element Omission, Surplus, and Missing by Data Element: Professional Encounters

Key Data Element	Element Omission			Element Surplus			Element Missing Values		
	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Beneficiary ID	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider Number/NPI	0.0%	<0.1%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
Rendering Provider Number/NPI	<0.1%	0.0%	<0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Referring Provider Number/NPI	<0.1%	1.0%	3.6%	0.0%	0.0%	0.0%	60.9%	63.2%	64.3%
Primary Diagnosis Code	<0.1%	<0.1%	<0.1%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
Secondary Diagnosis Codes	<0.1%	<0.1%	0.1%	0.0%	0.0%	1.2%	53.4%	53.7%	58.2%
Procedure Code	<0.1%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	<0.1%

Key Data Element	Element Omission			Element Surplus			Element Missing Values		
	ACNH	NHHF	WS	ACNH	NHHF	WS	ACNH	NHHF	WS
Procedure Code Modifiers	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	57.2%	54.9%	58.3%
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 3-35—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%	0.0%	<0.1%	0.0%	0.0%	0.0%
Attending Provider Number/NPI	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	<0.1%	<0.1%	0.1%
Referring Provider Number/NPI	<0.1%	<0.1%	0.0%	0.0%	<0.1%	0.0%	83.6%	82.8%	84.9%
Primary Diagnosis Code	0.0%	0.0%	0.0%	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%	21.3%	21.5%	21.0%
Procedure Code	<0.1%	0.5%	<0.1%	0.0%	0.1%	0.0%	14.7%	14.8%	16.1%
Procedure Code Modifiers	<0.1%	0.1%	0.0%	<0.1%	0.1%	0.0%	83.6%	83.6%	83.5%
Surgical Procedure Codes	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	94.3%	94.1%	94.5%
Revenue Code	<0.1%	<0.1%	0.0%	0.0%	<0.1%	0.0%	0.0%	<0.1%	0.0%
DRG	0.1%	0.3%	0.5%	0.0%	0.1%	0.0%	92.3%	90.9%	91.7%
Header Paid Amount	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Detail Paid Amount	0.0%	<0.1%	<0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCO Carrier ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

Table 3-36—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%
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 3-37 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 3-37—Data Element Percent of Accuracy by MCO: Professional Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	>99.9%
Detail Service From Date	>99.9%	>99.9%	>99.9%
Detail Service To Date	>99.9%	>99.9%	99.7%
Billing Provider Number/NPI	100%	>99.9%	98.9%
Rendering Provider Number/NPI	>99.9%	>99.9%	80.7%
Referring Provider Number/NPI	100%	100%	100%
Primary Diagnosis Code	>99.9%	>99.9%	99.8%

Key Data Element	ACNH	NHHF	WS
Secondary Diagnosis Codes	>99.9%	>99.9%	98.4%
Procedure Code	>99.9%	99.9%	99.9%
Procedure Code Modifiers	>99.9%	>99.9%	99.4%
Header Paid Amount	99.9%	99.3%	87.2%
Detail Paid Amount	>99.9%	98.8%	88.3%
MCO Carrier ID	100%	100%	100%

Red text indicates rates needing the MCOs' attention.
Red shaded cells indicate rates that decreased from the SFY 2023 EDV Aggregate Report rates by more than 10.0 percentage points.

WS needed to take action for three rates. There were no rates that required **ACNH**'s or **NHHF**'s attention.

Table 3-38—Data Element Percent of Accuracy by MCO: Institutional Encounters

Key Data Element	ACNH	NHHF	WS
Beneficiary ID	>99.9%	>99.9%	100%
Header Service From Date	>99.9%	>99.9%	>99.9%
Header Service To Date	>99.9%	>99.9%	>99.9%
Billing Provider Number/NPI	100%	>99.9%	99.7%
Attending Provider Number/NPI	100%	100%	97.2%
Referring Provider Number/NPI	100%	100%	100%
Primary Diagnosis Code	100%	100%	100%
Secondary Diagnosis Codes	>99.9%	99.9%	99.9%
Procedure Code	>99.9%	98.9%	100%
Procedure Code Modifiers	98.8%	99.8%	100%
Surgical Procedure Codes	100%	99.3%	100%
Revenue Code	>99.9%	99.0%	100%
DRG	99.7%	>99.9%	99.0%
Header Paid Amount	>99.9%	98.3%	90.1%
Detail Paid Amount	>99.9%	98.1%	99.2%
MCO Carrier ID	100%	100%	100%

Red text indicates rates needing the MCOs' attention.

WS needed to take action for one rate. There were no rates that required **ACNH**'s or **NHHF**'s attention.

Table 3-39—Data Element Percent of Accuracy by MCO: Pharmacy Encounters

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

There were no rates that required the MCOs' attention.

Health Plan-Specific Conclusions and Recommendations

ACNH

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

NHHF

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

WS

Among the rates listed in the comparative analysis section, **WS** needed to take action for 10 items. Of note, eight of these rates were based on the comparative analysis results and two resulted from HSAG's file review process. In addition, among the eight items from the comparative analysis results, four items were at the encounter type level (e.g., professional) and four items were related to the subcontractor(s) within an encounter type (e.g., vision encounters [a category within professional encounters] which reflect services from a vision subcontractor).

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 3-40—Results Needing Action From WS

Measure	Claim Type	Data Element	Reason	Rate
Record Omission	Professional (Vision)	Not applicable	Rate	13.4%
Record Surplus	Professional (Vision)	Not applicable	Rate	47.5%
Element Omission	Professional (DME)	Referring Provider Number/NPI	Rate	>99.9%
Element Missing	Professional (BH and Vision)	Referring Provider Number/NPI	File Review	NA
Element Missing	Institutional (BH)	Referring Provider Number/NPI	File Review	NA
Element Accuracy	Professional	Rendering Provider Number/NPI	Rate	80.7%
Element Accuracy	Professional	Header Paid Amount	Rate	87.2%
Element Accuracy	Professional	Detail Paid Amount	Rate	88.3%
Element Accuracy	Institutional	Header Paid Amount	Rate	90.1%
Element Accuracy	Institutional (BH)	Attending Provider Number/NPI	Rate	<0.1%

For additional information concerning HSAG's methodology for EDVs, see Appendix C. Methodologies for Conducting EQR Activities, page C-30.

Other EQR Activities

Semi-Structured Qualitative Interviews

Spring 2023 Semi-Structured Interviews

DHHS conducted an independent qualitative study of parents or guardians of children enrolled in the MCM program who were involved with the New Hampshire Division for Children, Youth and Families (DCYF) for at least 365 days. The study participants were prescribed two or more BH medications for at least nine months. Horn Research, HSAG's subcontractor, interviewed 28 parents or guardians between June 26, 2023, and August 2, 2023. The study explored seven points of inquiry: description of participants, experience with Medicaid managed care, quality of well-care, quality of BH care, access to information, experience with telehealth, and suggestions for improvement.

Overall, participants said they understood their child's health plan and could get answers to any of their questions. They appreciated the coverage for their child's healthcare, the ease of insurance use, and the customer service and case management support. The challenges associated with their child's MCO were related to provider options within the network (e.g., mental health, dental, and vision providers) and minor difficulties with prior authorization. Almost all participants reported receiving case management services either currently or in the past; however, only a few participants were currently receiving case management services through their child's MCO. Generally, participants reported positive experiences with those interactions.

Participants reported having a good relationship with their child's PCP and rated the care received very high. Although all participants reported their child had access to well care, over a third said their PCP had changed in the past year. Nearly all participants said the PCP discussed nutrition, exercise, and weight during their visits. About half said the discussion had a positive impact on their child. Most children had the required vaccinations. About two-thirds of participants said the PCP evaluated their child's mental and emotional health during the well visit. For the most part, participants noted an appropriate level of PCP engagement concerning their child's mental health.

All children in the study currently were prescribed medication. Less than half of participants said they had been advised to try alternative options before or while taking the drug. Less than two-thirds of participants said they received ongoing medication counseling for their children. Participants not receiving medication counseling expressed concern about having access to a psychiatrist to evaluate possible medication changes.

Over three-quarters of participants said their child received care from a BH care provider. Generally, participants reported positive appraisals of these providers; however, some reported limited effectiveness, varying levels of competency, and challenges with provider turnover. Over half of participants said their child's BH care provider had changed within the past year due to the provider not meeting the child's needs, turnover within the practice, retirement, or the child's return from residential treatment. Many participants reported long waitlists for care, a general lack of providers and services,

and a lack of providers who accepted the child's insurance. As a result of the lack of available care, nearly half of participants said their child had not received care as soon as needed.

Participants relied on their child's healthcare provider to answer questions about their child's health and usually did not encounter challenges getting their questions answered. Nearly all participants said they received information and reminders from their MCO; however, only a minority found the information useful—few said the information impacted their healthcare decisions. Most participants reported using telehealth for their child, but half said their experience was not positive. Participants said it was difficult for their child to focus during telehealth visits, which limited the success of the mental healthcare appointments. Other participants appreciated the convenience of telehealth, particularly for providers located far from their homes.

Recommendations

Participants offered four recommendations for the MCOs:

- Incentivize current mental healthcare providers to accept Medicaid.
- Participate in efforts to create a diverse pipeline of new mental healthcare providers.
- Provide respite care coverage and access to vetted respite care resources.
- Assess families' need for case management periodically and provide proactive support.

Participants offered two recommendations for DHHS:

- Provide information concerning the benefits of Medicaid to prospective foster parents.
- Participate in efforts to create a diverse pipeline of new mental healthcare providers.

Fall 2023 Semi-Structured Interviews

DHHS conducted an independent qualitative study of adults and parents or guardians of children enrolled in the MCM program who had a service authorization request between November 2022 and November 2023. Horn Research, HSAG's subcontractor, interviewed 30 individuals between December 27, 2023, and February 8, 2024. The study explored five points of inquiry: description of participants, experience with Medicaid managed care, quality of care, experience with the prior authorization and appeal process, and access to information.

Most of the participants reported having safe housing; however, the majority said they had experienced food insecurity over the past year. Several participants said they did not have access to regular food sources, and nearly half of the participants said they did not have reliable transportation. The bulk of participants did not routinely use the Medicaid transportation assistance program, and those who did were generally unhappy with the service provided.

The majority of participants had a sufficient understanding of the health insurance plan and reported that their or their child's health needs were met through the plan. Most participants called their MCO's customer service line when they had questions, and many reported dissatisfactory interactions with the

MCO's assistance. Other participants said they had good support through their healthcare provider. A few participants used their MCO's website to find answers to their questions but were generally unsuccessful.

Most participants said they had not experienced any limits to care. The limitations mentioned by others included access to out-of-state providers, specialist care, medications, vision care, and DME. The participants reported challenges that included incomplete coverage for specific needs, such as DME, the prior authorization process, insufficient provider network, formulary-limiting medication options, and constraints related to choosing a pharmacy. Very few participants were aware of their MCO's complaint process. Only six participants received case management support from the MCO, and only half of those felt the support was helpful.

Nearly all participants reported access to well care, and participants generally reported positive relationships with their or their child's PCP. The primary reasons reported by some participants for dissatisfaction with their provider were difficulty in scheduling appointments, poor communication, and inadequate care. The majority of participants, however, did not have any negative experiences with their or their child's PCP. Nearly all participants said they or their child could receive care as soon as needed. Participants often said their or their child's provider was a good listener and conscientious, and they appreciated that their provider was knowledgeable. Most participants said they or their child were current on vaccinations, but many said they refused the flu shot or the COVID-19 vaccine. Just over half of participants said the provider evaluated their or their child's mental health. Those who had not received an evaluation said this was due to the age or ability of the child, or that they were already receiving mental healthcare. Most participants said they could access specialist care. A small portion said that specialist care was unavailable locally and that there were delays in accessing specialist care.

Participants reported challenges with prior authorization for maintenance, long-term, and brand-name medications. The appeal process varied considerably among participants. Some participants said their provider and pharmacy handled the appeal process, while others had to coordinate communication or manage the process themselves. About a quarter of participants said they missed doses of their medication to the detriment of their health due to the prior authorization and appeal process. Slightly more participants said they did not experience any difficulties related to the process. Participants with prior authorization required for DME for either themselves or their child also had varying experiences with the process. Having an engaged healthcare provider proactively involved in the prior authorization process was helpful to some participants. Participants said the health insurance company did not seem to understand their or their child's needs. Nearly all participants with a DME prior authorization appealed the initial denial. Most said it took quite a while for the MCO to resolve the appeal. Parents said the process had delayed their child's progress and made the child less safe.

Participants reported a variety of information resources but most frequently used one-on-one conversations with providers. Nearly as many participants said they preferred to look online for information. A third of participants said they did not receive information and reminders from their MCO about well visits, screenings, or immunizations. Most participants who received messages from their MCO said they were easy to read and understand; however, only a minority of participants indicated

they appreciated getting the information. Two participants said the information impacted their decisions about accessing care.

Recommendations

Participants offered the MCOs seven recommendations:

- Review and improve transportation support rules and guidelines. In addition, the MCOs should monitor transportation subcontractors for compliance with requirements and their quality of service.
- Provide more flexibility in medication formularies to allow a greater range of dosage options.
- Review prior authorization denial, appeal, and reversal data to determine whether the triggering methodology is over-denying medications and DME.
- Review the prior authorization algorithm to reduce the redeterminations required for maintenance medications, medications critical for survival, and medications beneficiaries have been taking for many years.
- Review the prior authorization process for DME to ensure 1) clear information is available concerning coverage for DME to beneficiaries, healthcare providers, and DME suppliers; 2) decisions are timely and explained clearly; and 3) information provided by healthcare providers and beneficiaries is reviewed carefully in the authorization process.
- Improve communication to beneficiaries about medication prior authorization requirements and denials.
- Offer beneficiaries with complex needs access to a case manager to assist with DME and medication prior authorization processes.

Spring 2024 Semi-Structured Interviews

DHHS conducted an independent qualitative study of adults enrolled in the MCM Program who speak a primary language other than English, have a visual impairment, or have a hearing impairment. Horn Research, HSAG's subcontractor, interviewed 24 individuals between August 27, 2024, and October 18, 2024. The study explored five points of inquiry: Description of Participants, Communication, Experience with Medicaid Managed Care, Access to Information, and Quality of Care.

Most participants reported having safe housing. Several participants reported worrying about not having enough food and using food pantries. The bulk of participants said they had access to reliable transportation and did not routinely use the Medicaid transportation assistance program. Those who used the service reported several challenges with the program including missed appointments, disregard for physical disabilities, and confusing processes.

Overall, participants said communication with their MCO and PCP was easy and interpreters were available. Participants noted that in-person interpretation at medical appointments was far preferable to device-based interpretation. Participants also said interpretation services were less available for appointments with specialist providers. MCOs and healthcare providers typically did not furnish written documentation in a language or format accessible to participants. Access to and use of technology for

communication barriers was varied. Younger participants with limited English proficiency were more likely to use translation applications and interpreters, while older participants relied primarily on family members.

Participants reported sufficient understanding of their health plan and easy access to support from their MCO. Most participants had experienced no limits on care through their health plan. Restrictions mentioned included access to over-the-counter medications, prescription medications, desired medical providers, and medical equipment and supplies. Participants said they most liked the coverage provided by their MCO, the customer service, and reward program. The negative aspects of MCOs that participants most often reported included specific coverage gaps, including dental, vision care, medications, DME, and specific providers. Most participants did not have any knowledge of their MCO's complaint process but felt able to navigate any potential grievances. Case management services were available to just under half of participants. Most participants said the case management services were helpful. Nearly all participants said they communicate with a healthcare provider when they have questions about their health and prefer to speak with providers one-on-one.

Participants nearly universally reported access to well care and said they appreciated their PCP's kindness, communication skills, abilities, and quality of care. The most frequently noted challenge associated with primary care was appointment availability. Mental health evaluations were provided regularly for about half of participants. Caregivers noted challenges in evaluating the mental health of older adults with language barriers and beneficiaries with cognitive disability-based communication barriers. Specialist care was noted as a challenge for several participants who said wait times for appointments and the lack of specialists practicing locally were difficult for them. The primary challenges participants reported in getting their medications included language barriers at the pharmacy, transportation, and the prior authorization process. Participants also noted that remembering to take their medications and side effects were the biggest challenges related to taking their medications. Some caregivers said resistance to taking medications could be difficult to navigate.

Recommendations

Participants offered the MCOs the following recommendations:

- Ensure internal data on beneficiaries' language needs are correct.
- Ensure beneficiaries with communication barriers receive written information in the language or format needed by the beneficiary.
- Ensure specialists have equal access to interpretation services.
- Consider supporting pharmacies to provide interpretation services for people with limited English proficiency.
- Offer beneficiaries with limited English proficiency access to a case manager to help with coordination of care.
- Review and improve transportation support rules and guidelines based on the ongoing challenges Medicaid beneficiaries experience. In addition, the MCOs should provide greater oversight of transportation subcontractors for quality of service. The MCOs also should evaluate the complaint

process provided by the transportation subcontractors to determine whether the process is efficient and effective.

For additional information concerning HSAG's methodology for conducting semi-structured member interviews, see Appendix C. Methodologies for Conducting EQR Activities, page C-40.

Quality Study

Prevention Quality Indicators (PQIs) and Well Care Visits Quality Study

DHHS contracted with HSAG to calculate performance measures as part of the quality study activity for the three New Hampshire Medicaid health plans (i.e., **ACNH**, **NHHF**, and **WS**). The PQI and Well Care Visits Quality Study activity included two parts: (1) PQIs, and (2) Well-Care and Preventive Visits.

To support the Part One analysis, HSAG calculated the following the Agency for Healthcare Research and Quality (AHRQ) PQI measures for the SFY 2021 measurement period (i.e., July 1, 2020–June 30, 2021)[25] using administrative data provided by DHHS:

- *PQI-01: Diabetes Short-Term Complications Admission Rate*
- *PQI-05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*
- *PQI-08: Heart Failure Admission Rate*
- *PQI-15: Asthma in Younger Adults Admission Rate*

HSAG then collected health risk assessment (HRA) and care management enrollment information from the three MCOs for each member with numerator positive events for any of the PQI measures. Using the data provided by the MCOs, HSAG assessed whether members who had an inpatient event also had a completed HRA and/or were enrolled in care management.

To support the Part Two analysis, HSAG collected member PCP attribution information from the three MCOs for SFY 2021 and SFY 2022 (i.e., July 1, 2021–June 30, 2022). HSAG then used the information to assess whether members received primary care services from their attributed PCP. Additionally, HSAG also assessed ED utilization for those members attributed to a PCP.

This section presents the high-level findings for the PQI and Well-Care and Preventive Visits analyses.

PQI Results

Table 3-41 displays the SFY 2021 individual and total PQI measure results for each MCO and statewide. HSAG presented the rates per 100,000 member months. Please note that HSAG suppressed some measures due to a small numerator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for another small population was also suppressed, even if the value was 11 or more. For all rates in Table 3-41, a lower rate indicates better performance.

[25] HSAG completed the Part One analysis only for SFY 2021 to allow sufficient time for MCO follow-up after the admission to perform an HRA and enroll a member in care management.

Table 3-41—SFY 2021 PQI Results

Measure	ACNH			NHHF			WS			Statewide		
	Den	Num	Rate*	Den	Num	Rate*	Den	Num	Rate*	Den	Num	Rate*
PQI-01	288,106	*S*	*S*	528,083	*S*	*S*	561,876	*S*	*S*	1,378,065	180	13.06
PQI-05	124,552	27	21.68	240,484	74	30.77	244,279	79	32.34	609,315	180	29.54
PQI-08	288,106	89	30.89	528,083	160	30.30	561,876	199	35.42	1,378,065	448	32.51
PQI-15	163,554	*S*	*S*	287,599	*S*	*S*	317,597	*S*	*S*	768,750	20	2.60
Total^	288,106	139	48.25	528,083	304	57.57	561,876	385	68.52	1,378,065	828	60.08

*A lower rate indicates better performance.
^The denominator for the Total rate is the member months during the measurement year for all members 18 years of age or older. The numerator for the Total rate is the number of admissions for any of the PQIs (i.e., the numerator for the Total rate is the sum of the numerators for all PQIs).
S indicates that suppression was applied due to a small numerator (i.e., fewer than 11).

Table 3-41 shows that **ACNH** had the lowest rate of admissions for the PQI measures overall (48.25 per 100,000 member months), while **WS** had the highest rate of admissions overall (68.52 per 100,000 member months). The *PQI-15* measure rate was the lowest statewide, while the *PQI-08* measure rate was the highest rate for two of the three MCOs (**ACNH** and **WS**), which aligns with national trends in 2021.[26]

To understand the relationship between those members who were numerator-positive for a PQI event and the timing of an MCO completing an HRA and/or enrolling the member in care management, HSAG assessed whether numerator-positive members received an HRA and/or enrolled in care management prior to or after the admission. Table 3-42 presents the results of this analysis for each MCO and statewide.

[26] Agency for Healthcare Research and Quality (AHRQ). PQI Benchmark Data Tables, v2021. Available at: https://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2021/Version_2021_Benchmark_Tables_PQI.pdf. Accessed on: Jan 13, 2025.

Table 3-42—Percentage of Admissions Wherein Members Received an HRA or Enrolled in Care Management Within 12 Months of Admission

Measure Indicator	ACNH			NHHF			WS			Statewide		
	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate
Member received an HRA or enrolled in care management prior to the admission date	132	31	23.48%	303	128	42.24%	381	158	41.47%	816	317	38.85%
Member received an HRA or enrolled in care management after the admission date	132	23	17.42%	303	151	49.83%	381	163	42.78%	816	337	41.30%
Member received an HRA or enrolled in care management either prior to or after the admission date	132	49	37.12%	303	206	67.99%	381	286	75.07%	816	541	66.30%

Table 3-42 shows that **WS** had the highest rate of members who received an HRA or enrolled in care management either prior to or after the admission date (75.07 percent) compared to the other MCOs, while **ACNH** had the lowest rate (37.12 percent).

Well-Care and Preventive Visits Results

Table 3-43 and Table 3-44 display the overall utilization rates for well-care and preventive visits with a PCP or obstetrician/gynecologist (OB/GYN) stratified by time horizons from the PCP attribution start date (three, six, and 12 months) during SFY 2021 and SFY 2022, regardless of whether the visit was with the member's attributed PCP. Denominator sizes are noted in parentheses for each of the stratifications for reference.

Table 3-43—Overall Utilization of Well-Care and Preventive Visits During SFY 2021

Stratification (Denom)	Within 3 Months of PCP Attribution	Within 6 Months of PCP Attribution	Within 12 Months of PCP Attribution
Total (87,649)	40.95%	51.11%	56.63%
Age			
Pediatric (33,060)	43.09%	54.71%	62.42%
Adult (54,589)	39.66%	48.93%	53.13%
MCO (Pediatric and Adult)			
ACNH (35,532)	35.82%	43.82%	46.59%
NHHF (44,478)	43.63%	55.72%	63.51%
WS (7,639)	49.25%	58.21%	63.29%

Table 3-44—Overall Utilization of Well-Care and Preventive Visits During SFY 2022

Stratification (Denom)	Within 3 Months of PCP Attribution	Within 6 Months of PCP Attribution	Within 12 Months of PCP Attribution
Total (70,666)	40.73%	49.47%	53.16%
Age			
Pediatric (23,112)	47.35%	56.70%	60.80%
Adult (47,554)	37.52%	45.96%	49.45%
MCO (Pediatric and Adult)			
ACNH (27,149)	38.63%	46.96%	51.09%
NHHF (33,549)	42.62%	51.81%	55.27%
WS (9,968)	40.12%	48.47%	51.70%

Overall, a majority of MCO members with PCP attribution start dates that began in SFY 2021 and SFY 2022 (56.63 percent and 53.16 percent, respectively) had a well-care and preventive visit with any PCP or OB/GYN within 12 months of the PCP attribution start date. **ACNH** had an increase in the overall utilization rate of well-care and preventive visits with any PCP from SFY 2021 to SFY 2022 (4.5 percentage points). **NHHF** and **WS** both experienced a substantial decrease in the overall utilization rate from SFY 2021 to SFY 2022 (8.24 and 11.59 percentage points, respectively). However, the declines **NHHF** and **WS** experienced resulted in the three MCOs having similar well-child and preventive visit rates in SFY 2022.

Table 3-45 and Table 3-46 display the utilization rates for well-care and preventive visits with a member's attributed PCP stratified by time horizons from the PCP attribution start date (three, six, and

12 months) during SFY 2021 and SFY 2022. HSAG presents the rate of well-care and preventive visits with a non-attributed PCP in Table 3-45 and Table 3-46 for reference.

Table 3-45—Utilization of Well-Care and Preventive Visits With an Attributed PCP During SFY 2021

Stratification	Within 3 Months of PCP Attribution	Within 6 Months of PCP Attribution	Within 12 Months of PCP Attribution
Total Visits With an Attributed PCP	13.57%	17.29%	19.58%
Total Visits With a Non-Attributed PCP	26.92%	32.95%	35.96%
Total Visits With an Attributed PCP by Age			
Pediatric	15.51%	20.17%	23.65%
Adult	12.40%	15.55%	17.11%
Total Visits With an Attributed PCP by MCO (Pediatric and Adult)			
ACNH	11.46%	13.93%	14.87%
NHHF	14.30%	19.08%	22.49%
WS	19.11%	22.54%	24.51%

Table 3-46—Utilization of Well-Care and Preventive Visits With an Attributed PCP During SFY 2022

Stratification	Within 3 Months of PCP Attribution	Within 6 Months of PCP Attribution	Within 12 Months of PCP Attribution
Total Visits With an Attributed PCP	12.41%	15.29%	16.53%
Total Visits With a Non-Attributed PCP	26.81%	32.11%	34.20%
Total Visits With an Attributed PCP by Age			
Pediatric	15.55%	19.02%	20.69%
Adult	10.88%	13.48%	14.51%
Total Visits With an Attributed PCP by MCO (Pediatric and Adult)			
ACNH	12.85%	15.60%	16.97%
NHHF	11.88%	14.84%	16.09%
WS	12.96%	15.92%	16.84%

Members attributed to a PCP were more likely to have a well-care or preventive visit with a PCP who was not their attributed PCP across all MCOs for the total population. **NHHF** and **WS** had higher rates of visits with an attributed PCP than **ACNH** in SFY 2021; however, the rates for **NHHF** and **WS** from

SFY 2021 to SFY 2022 declined by 6.40 and 7.67 percentage points, respectively, making performance across all three MCOs similar in SFY 2022. Of note, members enrolled with **ACNH** or **NHHF** had higher rates of seeing a PCP who was part of the same practice as their attributed PCP compared to **WS.**

Table 3-47 and Table 3-48 display the ED utilization rates for members attributed to a PCP during SFY 2021 and SFY 2022.

Table 3-47—ED Utilization for Members Attributed to a PCP During SFY 2021

Measure	ACNH			NHHF			WS			Statewide		
	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate
Percentage of Members Attributed to a PCP Who Had an ED Visit												
Total	35,532	5,362	15.09%	44,478	8,492	19.09%	7,639	1,528	20.00%	87,649	15,382	17.55%
Percentage of Attributed Members Who Had an ED Visit and Had a Visit With an Attributed PCP Prior to the ED Visit*												
Total	5,362	758	14.14%	8,492	1,547	18.22%	1,528	318	20.81%	15,382	2,623	17.05%
Percentage of Attributed Members Who Had an ED Visit and Had a Visit With Any PCP Prior to the ED Visit*												
Total	5,362	2,254	42.04%	8,492	4,121	48.53%	1,528	828	54.19%	15,382	7,203	46.83%

*For this indicator, HSAG identified ED visits during each member's attribution span during the measurement year and then assessed whether the member had a visit with a PCP during their attribution span prior to their earliest ED visit during the measurement year.

Table 3-48—ED Utilization for Members Attributed to a PCP During SFY 2022

Measure	ACNH			NHHF			WS			Statewide		
	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate
Percentage of Members Attributed to a PCP Who Had an ED Visit												
Total	27,149	4,961	18.27%	33,549	6,366	18.98%	9,968	1,850	18.56%	70,666	13,177	18.65%
Percentage of Attributed Members Who Had an ED Visit and Had a Visit With an Attributed PCP Prior to the ED Visit*												
Total	4,961	791	15.94%	6,366	887	13.93%	1,850	310	16.76%	13,177	1,988	15.09%
Percentage of Attributed Members Who Had an ED Visit and Had a Visit With Any PCP Prior to the ED Visit*												
Total	4,961	2,236	45.07%	6,366	2,848	44.74%	1,850	868	46.92%	13,177	5,952	45.17%

*For this indicator, HSAG identified ED visits during each member's attribution span during the measurement year and then assessed whether the member had a visit with a PCP during their attribution span prior to their earliest ED visit during the measurement year.

ACNH had a slightly lower rate of ED utilization for members attributed to a PCP in SFY 2021 compared to the other MCOs; however, in SFY 2022, ED utilization for attributed members was similar

across MCOs. For all MCOs, members who had an ED visit were more likely to visit a non-attributed PCP than their attributed PCP prior to their ED visit during SFY 2021 and SFY 2022.

Recommendations

Based on the quality study results, HSAG has the following recommendations for the MCOs:

- **ACNH**, **NHHF**, and **WS** should investigate why rates of HRA completion and care management enrollment did not demonstrate a larger increase after an inpatient admission and determine if they need to implement mechanisms to automatically trigger an HRA and/or care management enrollment after an inpatient admission.
- **ACNH**, **NHHF**, and **WS** must ensure that they capture HRA refusal data to correctly determine whether lower rates of HRAs were due to HRAs being offered to but refused by the member, or simply not being offered to the member.

Service Authorization Quality Study

DHHS asked HSAG, New Hampshire's EQRO, to conduct a quality study to determine how each MCO in the New Hampshire MCM Program defined the reasons for denied service authorizations included in the quarterly SERVICEAUTH.05 Reports. Until DHHS received clarification concerning the specifications each MCO used to define the denials, the number of denials reported by the three MCOs could not be compared.

HSAG collected information for the study by sending questionnaires and scheduling meetings with the three Medicaid MCOs in New Hampshire: **ACNH**, **NHHF**, and **WS**.

Methodology

The process HSAG used to conduct the Service Authorization Quality Study is included in Appendix C. To begin the study, HSAG investigated the 32 service categories listed in the SERVICEAUTH.05 Report. HSAG assigned this task to employees familiar with the New Hampshire MCM Program who have worked on various external quality review (EQR) projects in the State.

DHHS also asked HSAG to identify the reasons why State Plan members had a service authorization denial for DME and/or pharmacy during the second quarter (Q2) and Q3 2023.

Findings

The study included a summary of information submitted in the SERVICEAUTH.05 Reports for Q2 and Q3 2023. The SERVICEAUTH.05 Report required submission of information for 32 services (DME, high-tech radiology/imaging studies, pharmacy, etc.). The summary completed by HSAG included the number of service authorization requests, approvals, and denials for each of the MCO's 1915b and State Plan members. Table 3-49 includes a summary of the information from those reports concerning the service authorizations that were requested and denied.

Table 3-49—SERVICEAUTH.05 MCO 1915b and State Plan: Q2 and Q3 2023

Population	Quarter Report	Service Authorization Requests	Service Authorization Denials	Percent Denied
1915b	2	8,043	1,100	13.7%
State Plan	2	45,122	8,880	19.7%
Total	**2**	**53,165**	**9,980**	**18.8%**
1915b	3	6,641	690	10.4%
State Plan	3	41,047	7,469	18.2%
Total	**3**	**47,688**	**8,159**	**17.1%**

The highest numbers of service authorization requests (45,122) and denials (8,880) occurred in Q2 for State Plan members. The lowest numbers of service authorization requests (6,641) and denials (690) occurred in Q3 for the 1915b population.

During Q2 2023, the MCOs processed a total of 53,165 requests for authorization for the 1915b and State Plan populations, and the statewide denial rate was 18.8 percent. In Q3 2023, the MCOs processed a total of 47,688 requests for authorization for the 1915b and State Plan populations, and the statewide denial rate was 17.1 percent, which was slightly lower than the Q2 percentage.

DHHS requested that HSAG limit the service authorization study to State Plan members and focus on service authorizations requested and denied for DME and pharmacy during Q2 and Q3 2023. The information in the SERVICEAUTH.05 Report contained two categories of information for DME and two categories of information for pharmacy as shown below:

- DME:
  - Adult excluding orthotics and prosthetics
  - Child (0–21 years) excluding orthotics and prosthetics
- Pharmacy:
  - Behavioral health (BH) drugs (mental health and SUD) includes office-based (including injections)
  - Non-BH drugs (including injections)

In Q2 2023, the rate of denial for State Plan members for the two DME services ranged from 1.8 percent to 22.4 percent. The rate of denial for the two pharmacy services in Q2 ranged from 30.2 percent to 47.3 percent. All three MCOs denied fewer than 10 percent of requested services for DME for adults and children in Q3 2023. Denials for pharmacy, however, ranged from 30.2 percent to 47.3 percent.

After reviewing the information concerning the State Plan denials by MCO in Q2 and Q3 2023, HSAG investigated how each MCO determined the number submitted in each column in the report. The process to obtain information from the MCOs included multiple questionnaires and individual meetings with

each MCO with the goal of defining the specifications used to compile the information submitted in the SERVICEAUTH.05 Report.

The MCOs submitted two questionnaires and participated in virtual meetings. After compiling the information, HSAG identified consistencies in the processes the MCOs used to submit information for the SERVICEAUTH.05 Report. All three MCOs indicated that they:

- Used detail-level information, not header information, to count the number of authorization requests.
- Counted an authorization as requested even if the file was awaiting additional documentation from the provider.
- Included both non-urgent and expedited authorizations in the Requested column.
- Completed the request for additional information for DME within 14 calendar days of receipt.
- Counted all denials, including partial denials, in the Total Denied column.
- Considered an authorization request as pending if the request had not yet been approved or denied.
- Contacted the provider at least once for missing information.

Conversely, the MCOs' processes for follow-up on requested documentation for standard authorizations varied, including the number of attempts made and the time allotted to obtain additional information. The processes also varied for the type of authorization prior to deciding to approve or deny the request. All MCOs initiated follow-up within 24–48 hours and utilized a variety of methods such as telephone, fax, and electronic outreach via a portal.

- **ACNH** made two attempts to contact providers for missing information for DME and pharmacy authorizations within 24–48 hours of receipt of the request.
- **NHHF** made one attempt to contact providers for missing information for DME and pharmacy authorizations and completed the pharmacy authorizations within 24 hours.
- **WS** made one attempt to contact providers for missing information for DME within the 14-day period and within 24 hours for pharmacy authorizations. In addition, **WS** required a subcontractor to complete the authorizations and noted that the time taken by the subcontractor to make a decision was generally half of the contract-required time period.

As a final step in the study, HSAG requested detailed reasons for Q2 and Q3 2023 DME and pharmacy authorizations that the MCOs submitted as denied in the SERVICEAUTH.05 Report. In addition to the qualitative responses from each MCO on the questionnaires and interviews, HSAG reviewed the MCO-reported quantitative information concerning the numbers of denied authorizations for the focused service categories of DME and pharmacy and the reasons for the denials. The MCOs furnished information concerning the following:

- The total number of requested authorizations
- The total number of denied authorizations
- Classifications for the denied authorizations:

- Incomplete/incorrect paperwork submitted
- Not a New Hampshire Medicaid covered service
- Request was not medically necessary
- Out-of-network denial
- Other

With one exception, the most prevalent reason for denial from all MCOs for all four categories of services was that the request was not medically necessary. The exception, **WS**'s Q3 rate for the adult DME excluding orthotics and prosthetics service type, had seven total denials for the quarter, three of which were due to incomplete/incorrect paperwork. In both pharmacy services studied, from 77.7 percent to 100 percent of the cases denied in both quarters were denied for not meeting the medical necessity requirement.

Conclusions, Limitations, and Recommendations

During the study, HSAG found that the three MCOs reported several similarities in the way they defined the numbers to submit for the quarterly SERVICEAUTH.05 Reports, including how each MCO calculated the requested and approved categories. The three MCOs reported different information in the Pending category of the SERVICEAUTH.05 Report and noted that some authorizations are not pended.

The study investigated more detailed reasons (i.e., not medically necessary, not a covered service, etc.) why the MCOs deny service authorization requests. Although the information obtained from the MCOs further defined the Total Denied column on the SERVICEAUTH.05 Report, future quality studies to determine what is included in the Request Determined Not Medically Necessary category may be necessary. Further study could investigate the reasons why the MCOs find the overwhelming majority of DME and pharmacy authorizations to be denied due to not meeting medical necessity. The high rate of pharmacy denials could be due to generic medications being available for requested brand-name medications or the medication not being on the formulary.

Limitations

In addition, the study found some limitations in understanding the MCOs' processes for a cancelled request. **WS** reported that a request could be cancelled or nullified related to duplication or retraction of the request. Those requests which the MCO cancelled were not included in the Total Requested category, nor was it clear whether all MCOs removed the cancelled requests prior to counting them as approved or denied.

HSAG could not determine the case mix of the members assigned to each MCO to determine if a higher number of service authorizations was appropriate for one of the MCOs due to having members with more chronic conditions.

The SERVICEAUTH.05 Report is a snapshot of activity during a given moment in time. Authorizations could move from pended to denied or approved within a day, causing data mismatches in a retrospective review.

Recommendations

HSAG provides the following recommendations from the information obtained as a result of this study for DHHS to consider:

- DHHS needs to develop specifications for each MCO to follow when submitting information for the SERVICEAUTH.05 Report.
- DHHS could consider including a Cancelled column on the SERVICEAUTH.05 Report to assist the MCOs in submitting this information on the report.
- HSAG confirmed that the MCOs could break down the Total Denied column into additional subcategories. Further refinement may be needed to identify specific reasons why the MCOs consider a service request not medically necessary. Reviewing this information could improve ***timeliness*** and ***access to care***.
- Further study could investigate the reasons that the MCOs find the overwhelming majority of DME and pharmacy authorizations to be denied due to not meeting medical necessity. Reviewing this information could improve ***quality***, ***timeliness***, and ***access to care***.
- Further study could determine if the high rate of pharmacy denials is due to generic medications being available for requested brand-name medications. Reviewing this information could improve ***timeliness*** and ***access to care***.
- DHHS could consider exploring the denials included in the Not a Covered Service category to determine if the same services are being requested by members enrolled in different MCOs. Determining if a re-occurring reason for a denied service should be evaluated to be included in a Medicaid-approved service could improve ***quality of care***.
- A future study could involve researching the denial decisions that were appealed by the member or provider to determine if the appeal overturned the original decision to deny.

Revealed Caller Provider Survey

SFY 2023 Revealed Caller Provider Survey

DHHS is responsible for the ongoing monitoring and oversight of its contracted Medicaid MCOs that deliver services to members under the MCM Program. As part of its provider network adequacy monitoring activities, DHHS contracted with HSAG to validate the accuracy of the managed care network information supplied to New Hampshire Medicaid members.

In SFY 2022, HSAG conducted a NAV survey among PCPs, select physical health specialists, and BH providers contracted with one or more of New Hampshire's Medicaid MCOs. Findings from the provider directory validation found high match rates. HSAG found over 96 percent of the providers in the directory and matched 78 percent of the provider data submitted by the three MCOs to the online provider directory across seven indicators.[27]

However, the findings from the SFY 2022 NAV pointed to a disconnect between the MCOs' provider databases, which were made available through the online provider directories, and the information obtained by contacting provider offices to confirm the information. While the provider data submitted by the MCOs generally agreed with the online provider directories, the matching rate of information when survey callers contacted provider offices was less than 50 percent.

Based on these findings, DHHS provided the MCOs a list of records with discrepancies and required the MCOs to correct their provider data within six months. In SFY 2023, HSAG recontacted these providers after the six-month correction window to determine if the information in the provider data was accurate. In addition, HSAG selected a sample of new cases for validation. Table 3-50 outlines the sample sizes by case type.

Table 3-50—Sample Sizes

MCO	SFY 2022 Discrepancy Cases	New SFY 2023 Cases	Total
ACNH	211	189	400
NHHF	124	276	400
WS	211	189	400

To address the study objectives described above, HSAG used a DHHS-approved methodology (Appendix C) to conduct the SFY 2023 Provider Network Survey among the following MCOs:

- ACNH
- NHHF
- WS

[27] The seven indicators included provider name, address, city, state, ZIP Code, telephone number, and type/specialty.

HSAG conducted the revealed calls among a sample of PCPs, eight different physical health specialists (i.e., allergists & immunologists, gastroenterologists, OB/GYNs, ophthalmologists, orthopedists, otolaryngologists [ears, nose, and throat (ENT) specialists], pulmonologists, and urologists) and BH providers.

Comparative Survey Outcomes—All Cases

HSAG attempted to contact 1,200 provider locations, with a 56.3 percent response rate. Table 3-51, Table 3-52, and Figure 3-13 present the summary results for all sampled providers by MCO, provider category, and number of matched indicators, respectively. The provider-specific indicators included providers practicing at the location, provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities. HSAG only assessed provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities for those providers at the location.

Table 3-51—Summary Results for All Sampled Providers by MCO

MCO	Able to Contact*	Accepted MCO**	Accepted New Hampshire Medicaid**	Accepted New Patients**	Matched on All 7 Provider Indicators***
ACNH	57.8%	57.6%	56.3%	47.2%	10.8%
NHHF	60.8%	51.9%	51.4%	38.7%	16.8%
WS	50.5%	58.4%	54.0%	45.5%	15.6%
Overall	**56.3%**	**55.8%**	**53.8%**	**43.6%**	**14.3%**

* The denominator includes all sampled providers.
** The denominator includes all respondents.
*** The denominator includes all respondents accepting New Hampshire Medicaid.

Table 3-52—Summary Results for All Sampled Providers by Provider Category (Overall)

Provider Category	Able to Contact*	Accepted MCO**	Accepted New Hampshire Medicaid**	Accepted New Patients**	Matched on All 7 Provider Indicators***
Behavioral Health Providers	33.5%	45.2%	38.9%	33.8%	9.8%
PCPs	71.5%	69.3%	68.9%	49.2%	4.3%
Physical Health Specialists	70.6%	50.2%	49.5%	44.5%	28.1%

* The denominator includes all sampled providers.
** The denominator includes all respondents.
*** The denominator includes all respondents accepting New Hampshire Medicaid.

Figure 3-13—Summary Results for All Sampled Providers by Number of Matched Indicators (Overall)

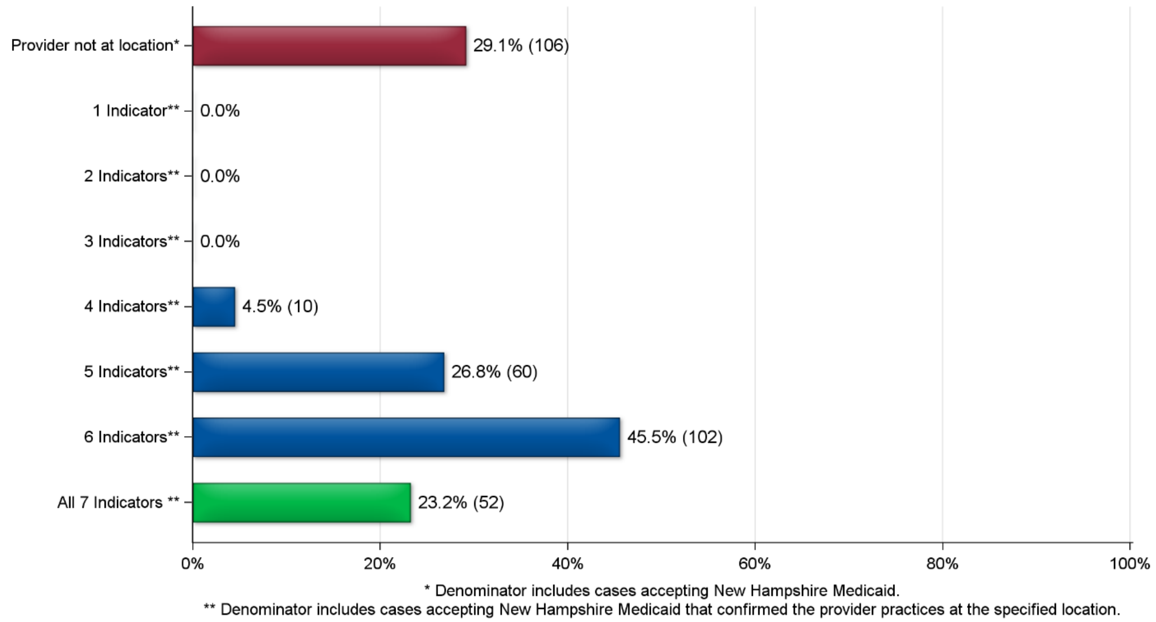
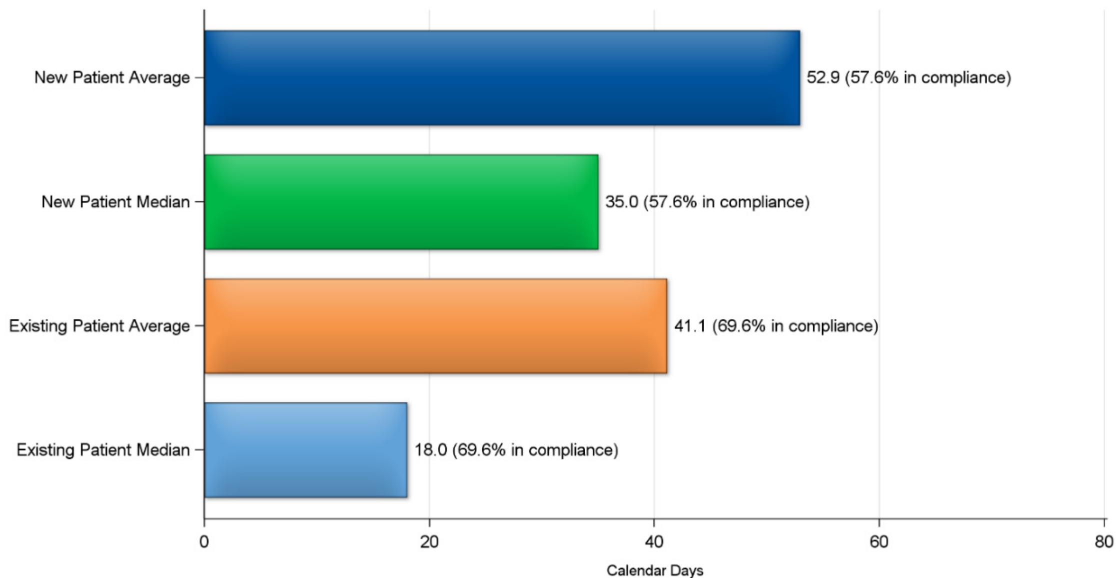


Figure 3-14 presents the summary wait times for new and existing patients for all sampled providers.

Figure 3-14—Summary Wait Times for All Sampled Providers (Overall)



Comparative Survey Outcomes—SFY 2022 Discrepancy Cases

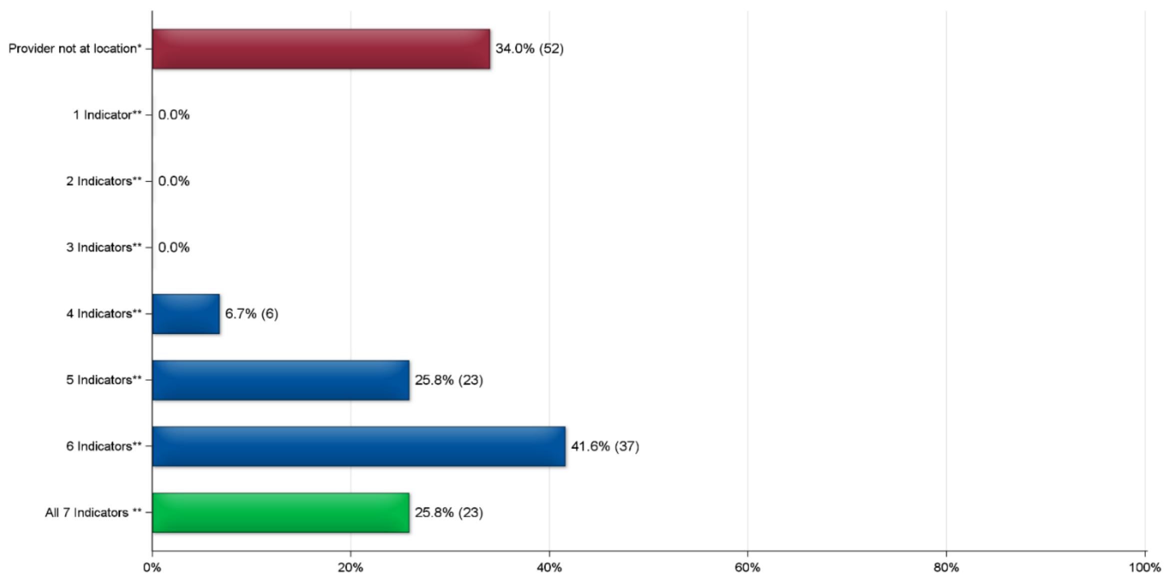
As described above, HSAG recontacted providers that were included in the SFY 2022 study to determine if the information in the provider data was now accurate (i.e., SFY 2022 discrepancy cases). Table 3-53 and Figure 3-15 present the summary results for all SFY 2022 discrepancy cases by MCO and number of matched indicators, respectively.

Table 3-53—Summary Results for SFY 2022 Discrepancy Cases by MCO

MCO	Able to Contact*	Accepted MCO**	Accepted New Hampshire Medicaid**	Accepted New Patients**	Matched on All 7 Provider Indicators***
ACNH	57.8%	54.9%	54.1%	41.0%	7.6%
NHHF	52.4%	55.4%	53.8%	36.9%	20.0%
WS	49.3%	58.7%	50.0%	40.4%	21.2%
Overall	**53.3%**	**56.4%**	**52.6%**	**39.9%**	**15.0%**

* The denominator includes all sampled providers.
** The denominator includes all respondents.
*** The denominator includes all respondents accepting New Hampshire Medicaid.

Figure 3-15—Summary Results for SFY 2022 Discrepancy Cases by Number of Matched Indicators (Overall)



* Denominator includes SFY 2022 discrepancy cases accepting New Hampshire Medicaid.
** Denominator includes SFY 2022 discrepancy cases accepting New Hampshire Medicaid that confirmed the provider practices at the specified location.

Health Plan-Specific Results—All Cases

Table 3-54 illustrates the survey dispositions and response rates by MCO and provider category.

Table 3-54—Survey Dispositions and Response Rates

MCO	Sampled Cases	Respondents	Refusals	Bad Phone Number*	Unable to Reach**	Response Rate
Overall	**1,200**	**676**	**79**	**76**	**318**	**56.3%**
ACNH	**400**	**231**	**34**	**24**	**100**	**57.8%**
PCPs	127	98	16	7	9	77.2%
Physical Health Specialists	132	90	11	12	18	68.2%
BH Providers	141	43	7	5	73	30.5%
NHHF	**400**	**243**	**22**	**28**	**95**	**60.8%**
PCPs	120	81	2	4	24	67.5%
Physical Health Specialists	125	94	9	8	11	75.2%
BH Providers	155	68	11	16	60	43.9%
WS	**400**	**202**	**23**	**24**	**123**	**50.5%**
PCPs	86	59	5	6	12	68.6%
Physical Health Specialists	141	97	11	9	18	68.8%
BH Providers	173	46	7	9	93	26.6%

* Includes reaching a disconnected number, fax number, or personal number that did not reach the sampled case number (e.g., reached a personal number or nonmedical facility).
** Includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after two attempts.

Table 3-55 summarizes the survey results by MCO and specialty category.

Table 3-55—Summary of Survey Results*

MCO	Correct Location	Offered Requested Services	Accepted MCO	Accepted New Hampshire Medicaid	Accepted New Patients
Behavioral Health Providers					
ACNH	95.3%	58.1%	46.5%	44.2%	37.2%
NHHF	77.9%	57.4%	38.2%	36.8%	32.4%
WS	84.8%	56.5%	54.3%	37.0%	32.6%
PCPs					
ACNH	91.8%	72.4%	69.4%	68.4%	53.1%
NHHF	88.9%	77.8%	71.6%	71.6%	40.7%
WS	79.7%	67.8%	66.1%	66.1%	54.2%
Physical Health Specialists					
ACNH	85.6%	68.9%	50.0%	48.9%	45.6%
NHHF	89.4%	59.6%	44.7%	44.7%	41.5%
WS	86.6%	63.9%	55.7%	54.6%	46.4%
Overall	**86.8%**	**65.7%**	**55.8%**	**53.8%**	**43.6%**

*The denominators include the count of respondents within each plan and specialty group.

Table 3-56 displays the mean and median routine visit wait times for new and existing patients by MCO, and the percentage of appointments meeting the compliance standard. In accordance with their contracts with DHHS, MCOs were required to maintain provider network capacity to ensure non-urgent appointment wait times for non-symptomatic office visits (i.e., preventive care) were available within 45 calendar days.

Table 3-56—Routine Visit Wait Times and Appointments Meeting Compliance Standard

MCO	New Patients			Existing Patients		
	Median (Calendar Days)	Average (Calendar Days)	Percent Within Compliance	Median (Calendar Days)	Average (Calendar Days)	Percent Within Compliance
ACNH	28.0	44.7	61.9%	18.0	36.6	72.3%
NHHF	43.0	62.6	50.6%	18.0	46.3	67.0%
WS	31.0	49.1	61.9%	18.0	38.7	70.5%
Overall	**35.0**	**52.9**	**57.6%**	**18.0**	**41.1**	**69.6%**

Provider-Specific Indicator Findings

Figure 3-16 and Table 3-57 display the results when the survey validated provider-specific information provided by the MCO. This included providers practicing at the location, provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities.

Figure 3-16—Number of Matched Indicators

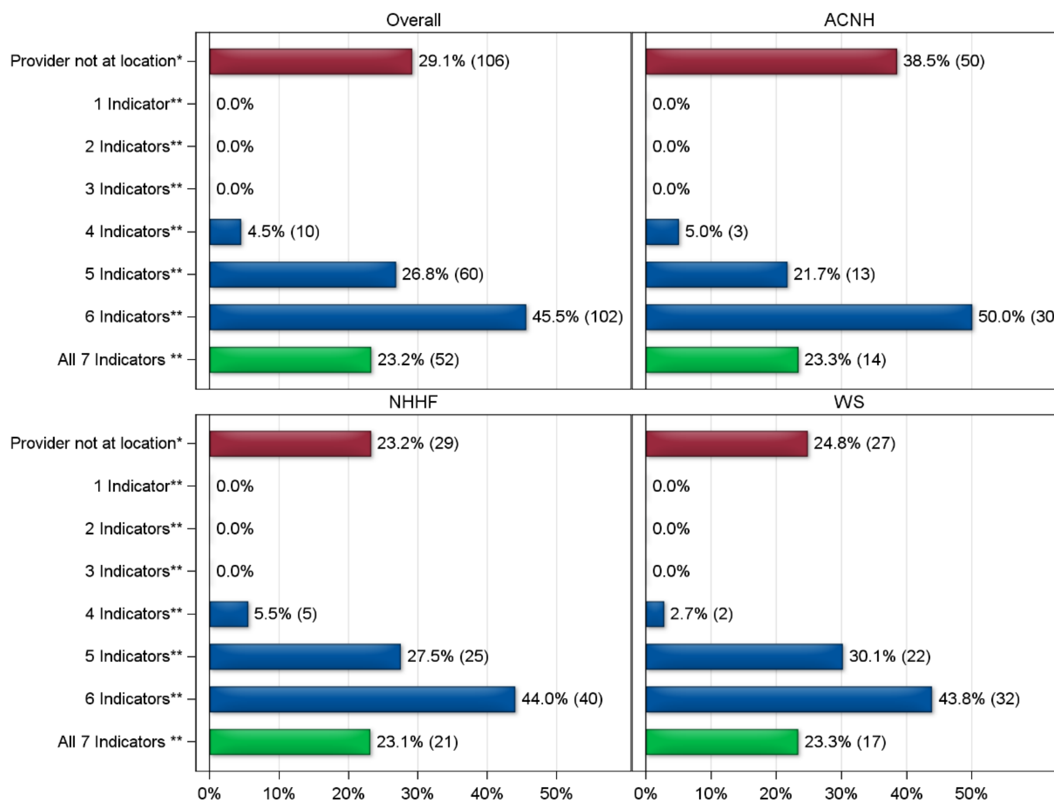


Table 3-57—Match Rate by Indicator

Indicator*	Overall	ACNH	NHHF	WS
Provider at Location	**61.5%**	46.2%	72.8%	67.0%
Provider Type/Specialty	**97.3%**	100%	96.7%	95.9%
Gender	**98.7%**	100%	98.9%	97.3%
Acceptance of New Patients	**75.9%**	81.7%	68.1%	80.8%
Non-English Speaking Language	**28.6%**	26.7%	29.7%	28.8%
Primary Language	**96.0%**	93.3%	96.7%	97.3%
Accommodation for Physical Disabilities	**91.1%**	90.0%	94.5%	87.7%

* Provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities were only assessed for those providers at the location.

Health Plan-Specific Results—SFY 2022 Discrepancy Cases

This section presents the results from the telephone survey of the resampled SFY 2022 discrepancy cases. Table 3-58 illustrates the survey dispositions and response rates by MCO.

Table 3-58—Survey Dispositions and Response Rates

MCO	Sampled Cases	Respondents	Refusals	Bad Phone Number*	Unable to Reach**	Response Rate
Overall	**546**	**291**	**34**	**31**	**154**	**53.3%**
ACNH	211	122	17	16	47	57.8%
NHHF	124	65	3	8	43	52.4%
WS	211	104	14	7	64	49.3%

* Includes reaching a disconnected number, fax number, or number that did not reach the sampled case number (e.g., reached a personal number of nonmedical facility).

** Includes reaching a voicemail, busy signal, continuous ringing, and/or extended hold time after two attempts.

Table 3-59 summarizes the discrepancy case survey results by MCO and specialty category.

Table 3-59—Summary of Survey Results

MCO	Correct Location	Offered Requested Services	Accepted MCO	Accepted New Hampshire Medicaid	Accepted New Patients
ACNH	89.3%	65.6%	54.9%	54.1%	41.0%
NHHF	89.2%	70.8%	55.4%	53.8%	36.9%
WS	85.6%	65.4%	58.7%	50.0%	40.4%
Overall	**88.0%**	**66.7%**	**56.4%**	**52.6%**	**39.9%**

Provider-Specific Indicator Findings

Figure 3-17 and Table 3-60 display the results when the survey validated provider-specific information related to the provider practicing at location, provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities.

Figure 3-17—Number of Matched Indicators

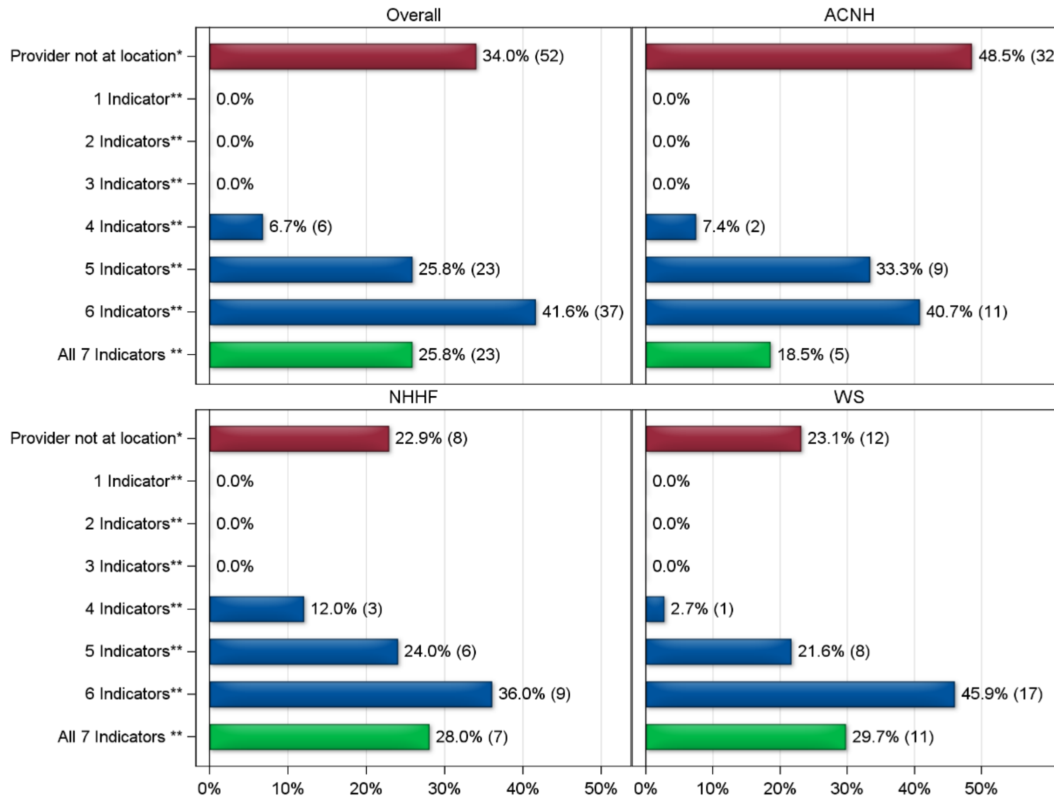


Table 3-60—Match Rate by Indicator

Indicator*	Overall	ACNH	NHHF	WS
Provider at Location	**58.2%**	40.9%	71.4%	71.2%
Provider Type/Specialty	**97.8%**	100%	96.0%	97.3%
Gender	**97.8%**	100%	96.0%	97.3%
Acceptance of New Patients	**73.0%**	66.7%	64.0%	83.8%
Non-English Speaking Language	**34.8%**	25.9%	40.0%	37.8%
Primary Language	**96.6%**	96.3%	96.0%	97.3%
Accommodation for Physical Disabilities	**86.5%**	81.5%	88.0%	89.2%

* Provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities were only assessed for those providers at the location.

Results—All Surveyed Cases

- Of the 1,200 provider locations sampled, only 56 percent could be reached. Response rates varied drastically by provider category, with BH providers exhibiting the lowest response rates among all MCOs. Over 6 percent of the sampled cases reached an incorrect phone number (i.e., disconnected, fax number, personal phone number, or nonmedical facility), indicating incorrect contact information provided by the MCOs.
- Of the locations contacted, 87 percent had the correct address, and 66 percent offered the PCP or specialty service indicated in the MCOs' files. Rates were relatively consistent across the MCOs. However, the study highlighted a variation across specialty type with only 57 percent of BH provider locations confirming the location offered the requested services.
- Overall, approximately 56 percent of the respondent locations confirmed acceptance of the MCO. Most respondents that accepted the MCO also accepted New Hampshire Medicaid.
- New patient acceptance varied among MCOs with 47 percent of the contacted locations accepting **ACNH**, 46 percent accepting **WS**, and 39 percent accepting **NHHF**.
- Performance across the specialties varied; however, the BH provider cases had the lowest rates across all indicators.
- For the physical health specialists, allergy and immunology (52 percent, n=11) and gastroenterology (54 percent, n=22) provider locations experienced the lowest percentage of respondents indicating the sampled location offered the requested services.[28]
- DHHS required that a Medicaid patient was able to make an appointment for a non-urgent reason within 45 calendar days. Overall, the average wait time for a new patient appointment was

[28] The low number of locations reached and responding to the specific specialty categories should be considered when evaluating this finding.

52.9 calendar days, while the average wait time for an existing patient appointment was 41.1 calendar days. Seventy percent of new and 58 percent of existing patient appointments met this standard.

  - Average new patient appointment wait times varied among the MCOs. **ACNH**'s average wait time (44.7 calendar days) was just below the 45-calendar day appointment wait time standard. **WS**'s (49.1 calendar days) and **NHHF**'s (62.6 calendar days) average wait times exceeded DHHS' appointment wait time standards.
    - Overall, 29 percent of sampled providers were not affiliated with the sampled location. Of the remaining 71 percent of cases that confirmed provider affiliation with the location, the accuracy of provider-specific information related to the provider type/specialty, gender, acceptance of new patients, non-English speaking language, primary language, and accommodation for physical disabilities was similar across MCOs. Overall, 23 percent of cases reached confirmed all seven provider-specific indicators matched the MCOs' data files, when the provider was affiliated with the location.
    - Two indicators had match rates below 90 percent: new patient acceptance (76 percent) and non-English speaking language (29 percent).

Results—SFY 2022 Discrepancy Cases

The accuracy of the SFY 2022 discrepancy cases continues to be low as outlined by the findings below:

- Of the 546 SFY 2022 discrepancy provider locations sampled, only 53 percent could be reached. Just under 6 percent of the sampled cases reached an incorrect phone number (i.e., disconnected, fax number, personal phone number, or nonmedical facility), indicating incorrect contact information provided by the MCOs.
- Of the locations contacted, 88 percent had the correct address, and 67 percent offered the PCP or specialty service indicated in the MCOs' files. Rates were relatively consistent across MCOs.
- Overall, approximately 56 percent of the respondent locations confirmed acceptance of the MCO, however, acceptance rates varied slightly among MCOs. Most respondents that accepted the MCO also accepted New Hampshire Medicaid.
- No more than 41 percent of contacted locations confirmed accepting new patients.
- Overall, 34 percent of sampled providers were not affiliated with the sampled location.
  - Overall, 26 percent of cases reached confirmed all seven provider-specific indicators matched the MCOs' data files, when the provider was affiliated with the location.
  - Three indicators had match rates below 90 percent: accommodation for physical disabilities (87 percent), new patient acceptance (73 percent), and non-English speaking language (35 percent).

Study Limitations

Various factors associated with the SFY 2023 Revealed Caller Provider Survey may affect the validity or interpretation of the results presented in this report when generalizing telephone survey findings to the MCOs' provider data, including, but not limited to, the following analytic considerations:

- HSAG received the provider data from the MCOs in February and March 2023 and conducted survey calls between April 17, 2023, and May 23, 2023. In this time period, it is possible that the provider data submitted by the MCOs could have changed. This limitation would most likely affect the match rates for indicators with the potential for short-term changes (e.g., the provider's address, telephone number, or new patient acceptance status). For example, it is possible that a provider was accepting new patients when the MCO submitted the provider data to HSAG but was no longer accepting new patients when HSAG called for the telephone survey. This would result in a lower match rate for this indicator.
- HSAG compiled survey findings from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., compared to the MCO's online provider directory or speaking to a different representative at the provider's office).
  - The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Since this survey required callers to indicate that they were conducting a survey on behalf of DHHS, responses may not accurately reflect members' experiences when seeking an appointment. Of note, 8.5 percent, 5.5 percent, and 5.8 percent of **ACNH**'s, **NHHF**'s, and **WS**'s locations declined to participate in the survey, respectively.
- The MCOs must ensure that members have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the MCOs' processes for aiding members who require timely appointments.
- HSAG only accepted appointments at the sampled location and counted cases as being unable to offer an appointment if the survey respondent offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Medicaid members are willing travel to an alternate location.

Recommendations

Based on the findings in this report and the accompanying case-level data files, HSAG offers the MCOs the following recommendations to evaluate and address potential ***data quality*** and/or ***access to care*** concerns.

ACNH

- **ACNH** had an overall response rate of 58 percent. **ACNH** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner.
- Among **ACNH**'s contacted locations, only 58 percent of the BH respondents indicated the location offered the requested services. **ACNH** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.
- Overall, only 58 percent of **ACNH**'s contacted locations indicated acceptance of **ACNH**. **ACNH** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **ACNH** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location.
- Only 47 percent of **ACNH**'s respondent locations indicated acceptance of new patients. **ACNH** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **ACNH** membership to determine whether additional provider contracts should be executed.
- Among **ACNH**'s respondent cases accepting New Hampshire Medicaid, 39 percent indicated the sampled provider was no longer affiliated with the location. **ACNH** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

NHHF

- **NHHF** had an overall response rate of 61 percent. **NHHF** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner.
- Among **NHHF**'s contacted locations, only 57 percent of the BH respondents indicated the location offered the requested services. **NHHF** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.
- Overall, only 52 percent of **NHHF**'s contacted locations indicated acceptance of **NHHF**. **NHHF** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **NHHF** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location.
- Only 39 percent of **NHHF**'s respondent locations indicated acceptance of new patients. **NHHF** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **NHHF** membership to determine whether additional provider contracts should be executed.
- The average appointment wait time for new **NHHF** members was 63 calendar days, while existing patients had a wait time of 46 calendar days. Both new and existing patients experienced wait times that exceeded DHHS' contract standard of 45 calendar days. **NHHF** should consider reviewing the

appointment wait time standards with its contracted providers and identifying whether additional provider capacity is necessary to reduce overall wait times.

- Among **NHHF**'s respondent cases accepting New Hampshire Medicaid, 23 percent indicated the sampled provider was no longer affiliated with the location. **NHHF** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

WS

- **WS** had an overall response rate of 51 percent. **WS** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner.
- Among **WS**'s contacted locations, only 57 percent of the BH respondents indicated the location offered the requested services. **WS** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.
- Overall, only 58 percent of **WS**'s contacted locations indicated acceptance of **WS**. **WS** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **WS** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location.
- Only 46 percent of **WS**'s respondent locations indicated acceptance of new patients. **WS** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **WS** membership to determine whether additional provider contracts should be executed.
- The average appointment wait time for new **WS** members was 49 calendar days, which exceeded DHHS' contract standard of 45 calendar days. **WS** should consider reviewing the appointment wait time standards with its contracted providers and identifying whether additional provider capacity is necessary to reduce overall wait times.
- Among **WS**'s respondent cases accepting New Hampshire Medicaid, 25 percent indicated the sampled provider was no longer affiliated with the location. **WS** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

SFY 2024 Revealed Caller Provider Survey

As part of its provider network adequacy monitoring activities, DHHS requested that its EQRO, HSAG, conduct a Revealed Caller Provider Survey among BH (mental health [MH] and SUD) providers contracted with one or more of New Hampshire's Medicaid MCOs to ensure that members have appropriate access to provider information.

The goal of the survey was to evaluate New Hampshire's Medicaid managed care network of BH locations for Community Mental Health Center (CMHC) providers, non-CMHC providers, and methadone clinics. Specific survey objectives included the following:

- Determine whether the contact information (i.e., phone number, address) was accurate for the contracted BH providers reported by the MCOs.
- Determine whether the BH locations accepted patients enrolled with a Medicaid MCO.
- Determine whether the BH locations accepted new patients.
- Determine appointment availability with the sampled BH locations for non-urgent/routine services.

To address the study objectives described above, HSAG used a DHHS-approved methodology (Appendix C) to conduct the SFY 2024 MCO Revealed Caller Provider Survey for **ACNH**, **NHHF**, and **WS**.

Comparative Survey Outcomes—Non-CMHC Providers

HSAG attempted to contact 972 provider locations, with a 36.0 percent response rate. Table 3-61 and Table 3-62 present the summary results for all sampled providers by MCO. The provider-specific indicators included providers practicing at the location, provider type/specialty, and acceptance of new patients. HSAG only assessed provider type/specialty and acceptance of new patients for those providers at the location.

Table 3-61—Summary Results for Non-CMHC Providers by MCO

MCO	Able to Contact[1]	Correct Address[2]	Offered Services[2]	Accepted MCO[2]	Accepted New Hampshire Medicaid[2]	Accepted New Patients[2, 3]	Offered Appointment[2]	Matched on All 3 Provider Indicators[4]
ACNH	43.8%	83.1%	63.4%	56.3%	54.9%	45.1%	48.6%	57.8%
NHHF	33.0%	84.1%	66.4%	55.1%	54.2%	43.9%	43.0%	57.1%
WS	31.2%	90.1%	49.5%	46.5%	42.6%	33.7%	36.6%	46.2%
Overall	**36.0%**	**85.4%**	**60.3%**	**53.1%**	**51.1%**	**41.4%**	**43.4%**	**54.5%**

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.
[3] Sample cases were not limited to locations accepting new patients; therefore, caution should be used when evaluating new patient acceptance data.
[4] The denominator includes all cases reached indicating the sampled provider practices at the location.

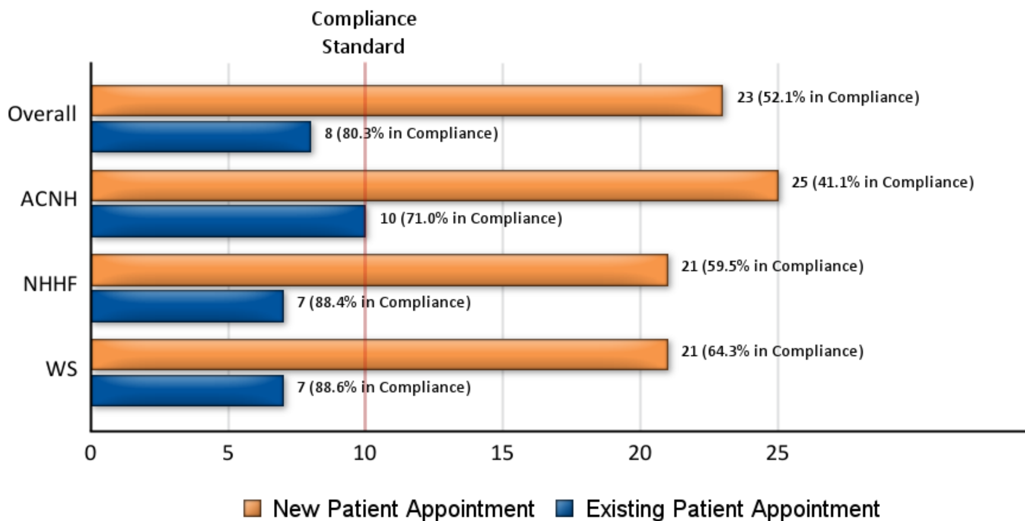
Table 3-62—Summary Results for Non-CMHC Providers by BH Category

BH Category	Able to Contact[1]	Correct Address[2]	Offered Services[2]	Accepted MCO[2]	Accepted New Hampshire Medicaid[2]	Accepted New Patients[2, 3]	Offered Appointment[2]	Matched on All 3 Provider Indicators[4]
MH	35.4%	89.6%	67.7%	60.7%	58.2%	45.3%	50.2%	48.5%
SUD	36.8%	79.9%	50.3%	43.0%	41.6%	36.2%	34.2%	66.7%
Overall	**36.0%**	**85.4%**	**60.3%**	**53.1%**	**51.1%**	**41.4%**	**43.4%**	**54.5%**

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.
[3] Sample cases were not limited to locations accepting new patients; therefore, caution should be used when evaluating new patient acceptance data.
[4] The denominator includes all cases reached indicating the sampled provider practices at the location.

Figure 3-18 presents the average wait times for new and existing patient appointments with non-CMHC providers and the percentage of cases in compliance with the wait time standard of 10 business days.

Figure 3-18—Summary Wait Times for Non-Urgent/Routine Services (Business Days)



Note: The percentage in compliance is out of the non-CMHC cases offered an appointment.

Survey Outcomes—CMHCs and Methadone Clinics

Since the CMHCs and methadone clinics were confirmed to accept all three MCOs, MCO-specific questions were not asked of these locations. Table 3-63 illustrates the survey outcomes and response rates for the CMHCs and methadone clinics.

Table 3-63—Survey Outcomes and Response Rates for CMHCs and Methadone Clinics

Provider Type	Sampled Cases	Respondents	Refusals	Bad Phone Number[1]	Unable to Reach[2]	Response Rate
CMHCs	24	22	0	1	1	91.7%
Methadone Clinics	10	10	0	0	0	100%

[1] Includes reaching a disconnected number, fax number, or number that connected to a personal line or non-medical facility.
[2] This includes reaching voicemail, receiving a busy signal, continuous ringing, and/or waiting for an extended hold time after four attempts.

Table 3-64 illustrates the new patient, non-urgent/routine appointment availability results for the CMHCs and methadone clinics.

Table 3-64—New Patient, Non-Urgent/Routine Appointment Availability Results for CMHCs and Methadone Clinics

Appointment Location	Number of Cases Offered an Appointment	Appointment Wait Time (Business Days)			
		Min	Max	Average	Median
CMHCs	13	1	132	40.8	17
Methadone Clinics	9	1	13	3.0	1

Table 3-65 illustrates the existing patient, non-urgent/routine appointment availability results for the CMHCs and methadone clinics.

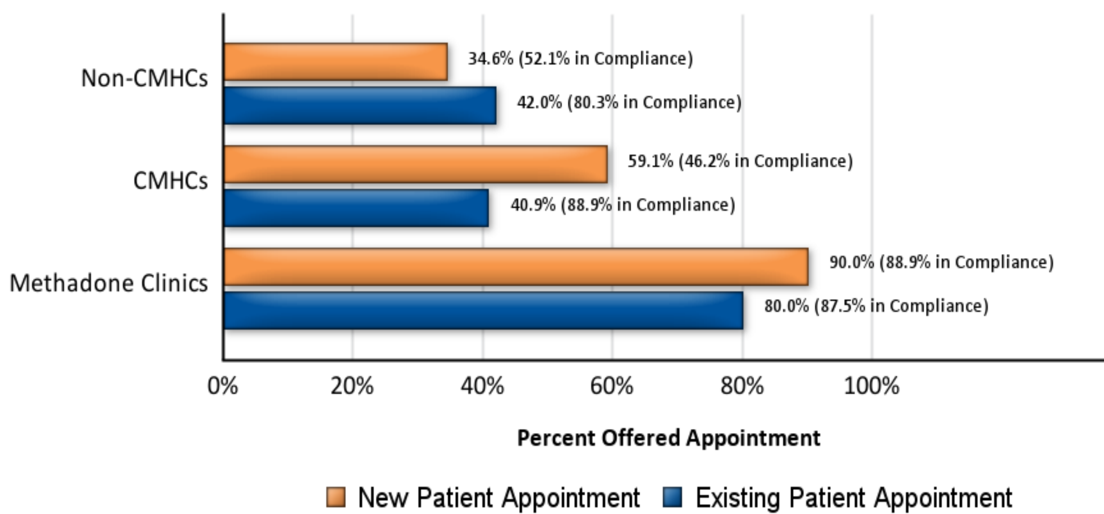
Table 3-65—Existing Patient, Non-Urgent/Routine Appointment Availability Results for CMHCs and Methadone Clinics

Appointment Location	Number of Cases Offered an Appointment	Appointment Wait Time (Business Days)			
		Min	Max	Average	Median
CMHCs	9	1	12	4.4	4
Methadone Clinics	8	1	13	2.8	1

Appointment Availability Comparison—Non-CMHCs, CMHCs, and Methadone Clinics

Figure 3-19 presents the percentage of cases offering an appointment and the percentage of appointments in compliance with the 10-business-day wait time standard for all sampled non-CMHC providers, CMHCs, and methadone clinics.

Figure 3-19—Appointment Availability Comparison for Non-Urgent/Routine Services for Non-CMHCs, CMHCs, and Methadone Clinics



Health Plan-Specific Results

Table 3-66 illustrates the survey outcomes and response rates by MCO and BH category.

Table 3-66—Survey Outcomes and Response Rates

MCO	Sampled Cases	Respondents	Refusals	Bad Phone Number[1]	Unable to Reach[2]	Response Rate
ACNH	**324**	**142**	**4**	**26**	**152**	**43.8%**
MH Providers	135	69	1	8	57	51.1%
SUD Providers	189	73	3	18	95	38.6%
NHHF	**324**	**107**	**2**	**47**	**168**	**33.0%**
MH Providers	270	84	1	37	148	31.1%
SUD Providers	54	23	1	10	20	42.6%
WS	**324**	**101**	**1**	**42**	**180**	**31.2%**
MH Providers	162	48	1	24	89	29.6%

MCO	Sampled Cases	Respondents	Refusals	Bad Phone Number[1]	Unable to Reach[2]	Response Rate
SUD Providers	162	53	0	18	91	32.7%
Non-CMHC Overall	**972**	**350**	**7**	**115**	**500**	**36.0%**

[1] Includes reaching a disconnected number, fax number, or number that connected to a personal line or non-medical facility.
[2] Includes reaching voicemail, receiving a busy signal, continuous ringing, and/or waiting for an extended hold time after four attempts.

Table 3-67 summarizes the survey results by MCO and BH category.

Table 3-67—Summary of Survey Results

MCO	Correct Location	Offered Requested Services	Accepted MCO	Accepted New Hampshire Medicaid	Accepted New Patients[1]
MH Providers					
ACNH	89.9%	69.6%	63.8%	60.9%	47.8%
NHHF	86.9%	70.2%	59.5%	58.3%	45.2%
WS	93.8%	60.4%	58.3%	54.2%	41.7%
SUD Providers					
ACNH	76.7%	57.5%	49.3%	49.3%	42.5%
NHHF	73.9%	52.2%	39.1%	39.1%	39.1%
WS	86.8%	39.6%	35.8%	32.1%	26.4%
Non-CMHC Overall	**85.4%**	**60.3%**	**53.1%**	**51.1%**	**41.4%**

[1] Sampled cases were not limited to locations accepting new patients; therefore, caution should be used when evaluating new patient acceptance rates.

Note: The denominators include the cases reached within each plan and BH category.

Table 3-68 and Table 3-69 display the number of cases in which the survey respondent offered appointments for non-urgent/routine services, as well as a summary of wait time statistics for all MCOs for new and existing patients, respectively. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Sample cases were not limited to locations accepting new patients; therefore, caution should be used when evaluating new patient appointment data.

Table 3-68—New Patient, Non-Urgent/Routine Appointment Availability Results

BH Category	Number of Respondents	Cases Offered an Appointment		New Appointment Wait Time (Business Days)			
		N	Rate	Min	Max	Average	Median
MH Providers							
ACNH	69	31	44.9%	1	175	34.9	21
NHHF	84	28	33.3%	0	179	25.4	8
WS	48	17	35.4%	2	261	27.5	10
SUD Providers							
ACNH	73	25	34.2%	0	43	12.7	10
NHHF	23	9	39.1%	1	24	8.8	5
WS	53	11	20.8%	0	43	10.8	5
Non-CMHC Overall Total	**350**	**121**	**34.6%**	**0**	**261**	**22.9**	**10**

Table 3-69—Existing Patient, Non-Urgent/Routine Appointment Availability Results

BH Category	Number of Respondents	Cases Offered an Appointment		Existing Appointment Wait Time (Business Days)			
		N	Rate	Min	Max	Average	Median
MH Providers							
ACNH	69	39	56.5%	0	48	9.4	5
NHHF	84	35	41.7%	0	39	7.5	5
WS	48	24	50.0%	0	24	5.3	5
SUD Providers							
ACNH	73	30	41.1%	0	109	11.3	5
NHHF	23	8	34.8%	1	5	3.0	3
WS	53	11	20.8%	0	43	10.0	5
Non-CMHC Overall Total	**350**	**147**	**42.0%**	**0**	**109**	**8.4**	**5**

Provider-Specific Indicator Findings

Figure 3-20 and Table 3-70 display the results when the survey validated provider-specific information provided by the MCO. This included providers practicing at the location, provider type/specialty, and acceptance of new patients.

Figure 3-20—Number of Matched Indicators

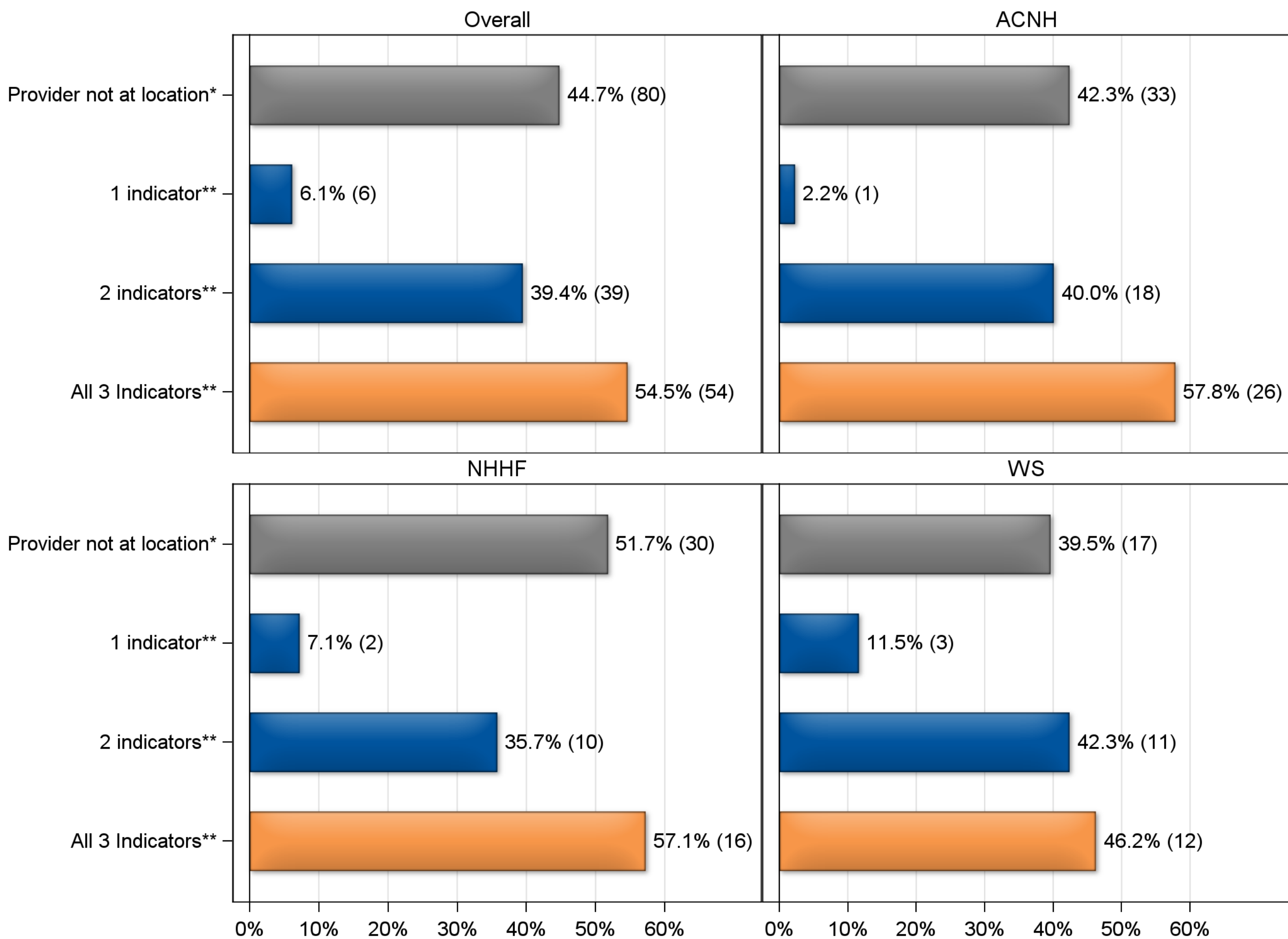


Table 3-70—Match Rate by Indicator

Indicator	Overall	ACNH	NHHF	WS
Provider at Location[1]	**55.3%**	57.7%	48.3%	60.5%
Provider Type/Specialty[2]	**93.9%**	97.8%	92.9%	88.5%
Acceptance of New Patients[2]	**54.5%**	57.8%	57.1%	46.2%

[1] Rate is calculated out of cases accepting New Hampshire Medicaid.
[2] Rate is calculated out of cases accepting New Hampshire Medicaid that confirmed the provider practices at the specified location.

Results

- Of the 972 non-CMHC locations sampled, only 36.0 percent could be reached. Response rates varied by BH category and MCO. Overall, 11.8 percent of the sampled cases reached an incorrect phone number (i.e., disconnected, fax number, personal phone number, or non-medical facility), indicating incorrect contact information provided by the MCOs.
- Of the locations contacted, 85.4 percent had the correct address, and 60.3 percent offered the services indicated in the MCOs' files. Accuracy of the location's specialty varied by MCO, with 66.4 percent of locations confirming accuracy of the specialty noted in **NHHF**'s data, 63.4 percent of locations confirming accuracy of the specialty noted in **ACNH**'s data, and 49.5 percent of locations confirming accuracy of the specialty noted in **WS**'s data.
- Overall, 53.1 percent of the respondent locations confirmed acceptance of the MCO. **ACNH** had the highest MCO acceptance rate at 56.3 percent, and **WS** had the lowest MCO acceptance rate at 46.5 percent. Most respondents that accepted the MCO also accepted New Hampshire Medicaid.
- New patient acceptance varied among MCOs with 45.1 percent of the contacted locations accepting **ACNH**, 43.9 percent accepting **NHHF**, and 33.7 percent accepting **WS**.
- Performance across the BH categories varied, with SUD provider cases exhibiting the lowest rates across all location-specific indicators. However, 66.7 percent of SUD locations matched on all three provider indicators, while 48.5 percent of MH locations matched on all provider indicators.
- Overall, 44.7 percent of sampled providers were not affiliated with the sampled non-CMHC location. Provider non-affiliation varied by MCO, with 51.7 percent of **NHHF** providers, 42.3 percent of **ACNH** providers, and 39.5 percent of **WS** providers not affiliated with the sampled location.
- DHHS requires that a Medicaid patient is able to make an MH or SUD appointment within 10 business days for non-urgent/routine services.
  - The average wait time for a non-CMHC new patient appointment was 23 business days, while the average wait time for a non-CMHC existing patient appointment was eight business days. Overall, 52.1 percent of new and 80.3 percent of existing non-CMHC patient appointments met this standard.

  - Overall, 59.1 percent of new patients and 40.9 percent of existing patients were offered a CMHC appointment, with 46.2 percent of new appointments and 88.9 percent of existing appointments meeting the wait time standard.
  - Methadone clinics offered new patients an appointment in 90.0 percent of cases, and existing patients were offered an appointment in 80.0 percent of cases. Overall, 88.9 percent of new patient appointments and 87.5 percent of existing patient appointments were within the wait time standard.

Study Limitations

Various factors associated with the SFY 2024 MCO Revealed Caller Provider Survey may affect the validity or interpretation of the results presented in this report when generalizing telephone survey findings to the MCOs' provider data, including, but not limited to, the following analytic considerations:

- HSAG received the provider data from the MCOs in January 2024 and conducted survey calls between March 4, 2024, and April 5, 2024. In this time period, it is possible that the provider data submitted by the MCOs could have changed. This limitation would most likely affect the match rates for indicators with the potential for short-term changes (e.g., the provider's address, telephone number, or new patient acceptance status). For example, it is possible that a provider was accepting new patients when the MCO submitted the provider data to HSAG but was no longer accepting new patients when HSAG called for the telephone survey. This would result in a lower match rate for this indicator.
- HSAG compiled survey findings from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., compared to the MCO's online provider directory or speaking to a different representative at the provider's office).
  - The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Since this survey required callers to indicate that they were conducting a survey on behalf of DHHS, responses may not accurately reflect members' experiences when seeking an appointment.
- The MCOs must ensure that members have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the MCOs' processes for aiding members who require timely appointments.
- HSAG only accepted appointments at the sampled location and counted cases as being unable to offer an appointment if the survey respondent offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Medicaid members are willing travel to an alternate location.

Recommendations

Based on the findings in this report and the accompanying case-level data files, HSAG offers the MCOs the following recommendations to evaluate and address potential ***data quality*** and/or ***access to care*** concerns.

ACNH

- **ACNH** had an overall non-CMHC response rate of 43.8 percent; however, rates varied drastically by BH category with 51.1 percent of MH providers and 38.6 percent of SUD providers responding to the survey. Overall, 8.0 percent of **ACNH**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **ACNH** should consider reviewing its processes for updating provider data in an accurate and timely manner.
- Among **ACNH**'s non-CMHC contacted locations, only 63.4 percent of the respondents indicated the location offered the requested services. **ACNH** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.
- Overall, only 56.3 percent of **ACNH**'s contacted non-CMHC locations indicated acceptance of **ACNH**. MCO acceptance varied greatly by BH category with 63.8 percent of MH locations and 49.3 percent of SUD locations confirming acceptance of **ACNH**. Additionally, only 54.9 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **ACNH** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally, **ACNH** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information.
- Only 45.1 percent of **ACNH**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied slightly by BH category with 47.8 percent for MH providers and 42.5 percent for SUD providers. **ACNH** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **ACNH** membership to determine whether additional provider contracts should be executed.
- Among **ACNH**'s non-CMHC respondent cases accepting New Hampshire Medicaid, 42.3 percent indicated the sampled provider was not currently affiliated with the location. **ACNH** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

NHHF

- **NHHF** had an overall non-CMHC response rate of 33.0 percent; however, rates varied by BH category with 31.1 percent of MH providers and 42.6 percent of SUD providers responding to the survey. Overall, 14.5 percent of **NHHF**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **NHHF** should consider reviewing its processes for updating provider data in an accurate and timely manner.
- Among **NHHF**'s non-CMHC contacted locations, only 66.4 percent of the respondents indicated the location offered the requested services. **NHHF** should consider reviewing its methods for acquiring

and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.

- Overall, only 55.1 percent of **NHHF**'s contacted non-CMHC locations indicated acceptance of **NHHF**. MCO acceptance varied greatly by BH category with 59.5 percent of MH locations and 39.1 percent of SUD locations confirming acceptance of **NHHF**. Additionally, only 54.2 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **NHHF** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally, **NHHF** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information.
- Only 43.9 percent of **NHHF**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied by BH category with 45.2 percent for MH providers and 39.1 percent for SUD providers. **NHHF** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **NHHF** membership to determine whether additional provider contracts should be executed.
- Among **NHHF**'s non-CMHC respondent cases accepting New Hampshire Medicaid, 51.7 percent indicated the sampled provider was not currently affiliated with the location. **NHHF** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

WS

- **WS** had an overall non-CMHC response rate of 31.2 percent; however, rates varied by BH category with 29.6 percent of MH providers and 32.7 percent of SUD providers responding to the survey. Overall, 13.0 percent of **WS**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **WS** should consider reviewing its processes for updating provider data in an accurate and timely manner.
- Among **WS**'s non-CMHC contacted locations, only 49.5 percent of the respondents indicated the location offered the requested services. **WS** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides needed services.
- Overall, only 46.5 percent of **WS**'s contacted non-CMHC locations indicated acceptance of **WS**. MCO acceptance varied greatly by BH category with 58.3 percent of MH locations and 35.8 percent of SUD locations confirming acceptance of **WS**. Additionally, only 42.6 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **WS** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally, **WS** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information.
- Only 33.7 percent of **WS**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied by BH category with 41.7 percent for MH providers and 26.4 percent for SUD providers. **WS** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **WS** membership to determine whether additional provider contracts should be executed.

Among **WS**’s non-CMHC respondent cases accepting New Hampshire Medicaid, 39.5 percent indicated the sampled provider was not currently affiliated with the location. **WS** should consider reviewing its methods for acquiring and maintaining provider information to ensure members have access to accurate provider information.

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, or PAHP 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.[29]
- ***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."[30] 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).[31]

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***, ***timeliness***, and ***access*** to care furnished by the MCO, PIHP, or PAHP entity in

[29] U. S. Government Publishing Office. (2024). *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: Jan 13, 2025.

[30] NCQA. *2023 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2023: UM5.

[31] U. S. Government Publishing Office. (2024). *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: Jan 13, 2025.

§438.364(a)(1).[32] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the ***quality***, ***timeliness***, 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 draws conclusions about the overall ***quality***, ***timeliness***, 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***, ***timeliness***, 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***, ***timeliness***, and ***access*** to care for each MCO by activity. 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***, ***timeliness***, and ***access*** to care for the New Hampshire MCM Program members.

[32] U. S. Government Publishing Office. (2024). *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: Jan 13, 2025.

AmeriHealth Caritas New Hampshire

MCO Contractual Compliance

This was the fifth year that **ACNH** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 100 percent on the review. Of the six standards reviewed that included 193 applicable elements, **ACNH** achieved a 100 percent score in all 193 elements. 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 beneficiaries.

ACNH demonstrated strength in Care Management/Care Coordination by using the Johns Hopkins University Adjusted Clinical Group scores to generate a risk stratification to identify members with high needs/high risks and ensuring that staff members contacted those members to determine if they would benefit from care management services. **ACNH** convened an integrated care team to discuss barriers to care and strategies to address those barriers. Team members included a care manager, nurses, BH specialists, and social workers; and representatives from UM, pharmacy, and the senior clinical leadership staff. Having members receive care management services from multidisciplinary team members will assist in ensuring that the New Hampshire MCM Program members improve their ***access to care*** and ***quality of care***.

ACNH demonstrated strength in Member Enrollment and Disenrollment by ensuring that its eligibility files were incorporated and updated within one business day of receipt. **ACNH** notified DHHS within five business days of any member's circumstances that would affect his/her eligibility. **ACNH** assisted members with maintaining eligibility by outreaching to members 60 days prior to their eligibility expiration date to provide education and assist with paperwork. Additionally, **ACNH** assigned a PCP to all members who did not choose a PCP within 14 calendar days to ensure access to appropriate care. Ensuring that effective enrollment and disenrollment procedures were implemented contributed to improved ***timeliness of care*** and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in the Member Services standard by ensuring that it sent a welcome letter to new members within seven calendar days of enrollment explaining how to access the provider directory. **ACNH** ensured members were informed of their rights and that it provided all member materials in easily understood language and format. Additionally, **ACNH** ensured the availability of written translation of materials in other languages, large print materials, oral interpretation, and auxiliary aids and services. These activities may result in improved ***quality of care*** and ***access to care*** for **ACNH**'s members.

ACNH demonstrated strength in the Utilization Management standard by ensuring that appropriately licensed clinicians made all determinations to deny services and that **ACNH** made all decisions within 14 calendar days for standard requests for authorization of services and 72 hours for expedited requests. **ACNH** ensured that it furnished all services sufficient in an amount, duration, and scope to reasonably achieve their purpose. Additionally, **ACNH** ensured that it notified members of denial decisions and their rights to appeal those decisions. Ensuring that **ACNH** makes timely and appropriate authorization

decisions may result in enhanced ***quality of care***, ***timeliness of care***, and ***access to care*** for Medicaid members.

ACNH demonstrated strength in Quality Management by ensuring that the quality committee adopted clinical practice guidelines (CPGs) from the American Society of Addiction Medicine (ASAM), the U.S. Preventive Services Task Force, the American Academy of Pediatrics (AAP) Bright Futures program, and the Zero Suicide Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.[33] **ACNH**'s member handbook and provider manual addressed the dissemination of CPGs to providers, and the CPGs were available on request to members and potential members. The MCO also conducted a comprehensive medication review and offered counseling to any member available on request. Additionally, **ACNH** also developed a comprehensive QAPI program that included re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions. Ensuring that the MCO develops a QAPI program and that practitioners follow nationally recognized CPGs will assist the New Hampshire MCM Program members in improving their ***quality of care***.

ACNH also demonstrated strength by complying with requirements in the Third Party Liability standard. Plan documents and staff interviews confirmed the implementation of third-party liability (TPL) claims processing and handling of the recovery of applicable funds. The NH TPL Overpayments Resulting in Member Refunds process flowchart correctly illustrated the process used to ensure that **ACNH** returned appropriate overpayments to the member.

ACNH correctly implemented all the requirements of the standards HSAG reviewed during SFY 2024. Therefore, **ACNH** was not required to implement a CAP.

PIPs

For the *Improving HPV Vaccinations* PIP and *Improving Health Risk Assessments* PIP, there was an opportunity to improve ***quality of care*** and ***access to care*** for the eligible members.

During SFY 2024, **ACNH** demonstrated the following strengths that positively impacted these identified domains of care:

- Successfully conducted methodologically sound PIPs.
- Used QI tools and processes effectively to determine barriers and develop interventions.
- Achieved statistically significant improvement over the baseline and surpassed the SMART Aim goals for both PIPs.

[33] Zero Suicide. Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments. Available at: [Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments | Zero Suicide](). Accessed on: Jan 13, 2025.

Based on information obtained through the validation of **ACNH**'s PIPs, HSAG offers the following suggestions to enhance the PIP activities:

- When evaluating and reporting measure results over time, **ACNH** must report changes in rates accurately. The MCO should ensure quality checks are in place to facilitate accurate reporting of data. Accurate data reporting will provide more meaningful and actionable information to facilitate ongoing improvement.
- **ACNH** should develop a plan for sustaining and spreading the effective adopted interventions.
- **ACNH** must ensure that all intervention testing data are reported in PDSA worksheets, and that any improvement achieved can be reasonably linked to at least one intervention tested.
- **ACNH** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

PMV

HSAG's PMV activities found all 18 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and the auditors recommended that **ACNH**:

- Improve its internal monitoring of service authorization categories to reduce the risk of manual data entry errors in National Imaging Associates' source data for all UM measures in New Hampshire. **ACNH** should take corrective action to add QA steps to its existing internal auditing and oversight processes to readily identify prior authorization manual data entry errors. This may include creating additional daily reports, adjusting its supervisory team's oversight processes, enhancing internal audits to identify service authorization status errors, implementing system alerts when manual entries are being used, or other **ACNH**-identified improvements. Improving this requirement will facilitate ***quality of care***.

NAV

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

Strengths

- **ACNH** had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform calculation of network adequacy standards and indicators. HSAG had no concerns with **ACNH**'s data collection procedures, network adequacy methods, or network adequacy results.
- **ACNH** had sufficient policies and procedures in place to ensure that it uses sound methods to assess the adequacy of its managed care networks as required by the State and accurately reported results to the State in the required format. HSAG has *High Confidence* in **ACNH**'s ability to produce and report accurate results to support the MCO's and the State's network adequacy monitoring efforts.

- DHHS requires its contracted MCOs to provide ***access to care*** to 90 percent of members within DHHS' time and distance standards. **ACNH** met the State's time and distance standards for 58 of 61 provider categories. Based on these findings, members' ***access to care*** is robust for primary care, hospital services, diagnostic services, other facilities and services, and SUD services.
- For the network capacity analysis, **ACNH** met the network capacity standard for contracting with at least 75 percent of OTPs. Based on these findings, members' ***access to care*** is robust for this provider type.

Opportunities for Improvement

- HSAG did not identify any specific opportunities related to the data collection and management processes **ACNH** had in place to inform calculation of network adequacy standards and indicators for the SFY 2024 ISCA.
- **ACNH** did not meet the 90 percent time and distance standards for three provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists.

CAHPS

One of the 2024 measure rates representing the ***quality of care*** domain (i.e., *Rating of Health Plan*) for **ACNH**'s general adult Medicaid population was statistically significantly lower than the 2023 NCQA general adult Medicaid national average, while one measure rate representing the ***quality of care*** and ***timeliness of care*** domains (i.e., *Getting Care Quickly*) for **ACNH**'s general child Medicaid population was statistically significantly higher than the national average. The 2024 measure rates representing the ***timeliness of care*** and ***access to care*** domains for **ACNH**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2023 NCQA adult Medicaid national averages. The 2024 measure rates representing the ***access to care*** domain for **ACNH**'s general child Medicaid population were neither statistically significantly higher nor lower than the 2023 NCQA general child 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 the patient reported. To properly handle customer complaints, **ACNH** could implement the following protocols: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate

staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

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 2023.

Table 4-1—Summary of ACNH's Scores for MY 2023 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	4	5	4	2	8	**23**
Acute and Chronic Care	2	1	2	4	1	**10**
Behavioral Health	7	4	5	1	1	**18**
All Domains	**13**	**10**	**11**	**7**	**10**	**51**
Percentage	**25.49%**	**19.61%**	**21.57%**	**13.73%**	**19.61%**	**100%**

[1] Please note that the total percentage may not be equal to 100 percent due to rounding of total percentages for each percentile ranking.

ACNH's rates ranked at or above the 50th percentile for 34 measures (66.67 percent), with 13 of these measures (25.49 percent) meeting or exceeding the 90th percentile. The rates for 17 measures (33.33 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 33 of the 52 (63.46 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)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3–11 Years*, Ages 12 to 17 Years, Ages 18 to 21 Years,* and *Total**

- *Childhood Immunization Status (CIS)—Combination 10 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV, HepA, RV, Influenza)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Lead Screening in Children (LSC)*
- *Appropriate Testing for Pharyngitis (CWP)—Total**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and *Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing (Total)*
- *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Initiation of SUD Treatment—Total** and *Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total†, Counseling for 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)—Ages 16–20 Years†*, *Ages 21–24 Years†,* and *Total†*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care†*
- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*
- *Use of Imaging Studies for Low Back Pain (LBP)—Total*
- *Asthma Medication Ratio (AMR)—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***, **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 care; chlamydia screening; hemoglobin A1C control for patients with diabetes; immunizations for adolescents; and weight assessment, counseling for nutrition, and physical activity for children and adolescents. **ACNH** should also focus efforts on improving use of imaging studies for individuals with low back pain, asthma medication ratio, follow-up care and monitoring of children prescribed ADHD medication, and pharmacotherapy for opioid use disorder.

ACNH demonstrated strength in measures related to ***timeliness of care***, meeting or exceeding the 50th percentile for 15 of the 19 (78.95 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)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator* and *Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Initiation of SUD Treatment—Total** and *Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*†
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*†
- *Pharmacotherapy for Opioid Use Disorder (POD)—Total*

To improve ***timeliness of care***, **ACNH** should continuously inform members through member communications about the importance of timely prenatal care and the benefits of those visits for moms and

their babies. Additionally, **ACNH** also could inform members of the importance of follow-up care for children prescribed ADHD medications and pharmacotherapy for opioid use disorder.

ACNH demonstrated strength in measures related to ***access to care***, meeting or exceeding the 50th percentile for 16 of the 19 (84.21 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)—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3 to 11 Years*, Ages 12 to 17 Years, Ages 18 to 21 Years,* and *Total**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Initiation of SUD Treatment—Total** and *Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*†
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase*†

To improve ***access to care***, **ACNH** could consider encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits to 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 follow-up care for children prescribed ADHD medication during the continuation and maintenance phase.

EDV

For the IS review activity, **ACNH** did not make any changes since July 1, 2023. **ACNH** should provide DHHS its claim billing/payment documentation that explains/supports why **ACNH** used only WEDI SNIP levels 1 and 2 (i.e., not using level 3 or above).

ACNH demonstrated strength by meeting the standards for the X12 EDI compliance edits; the accuracy for member identification numbers, billing providers, and servicing providers for all applicable encounter types; and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all applicable encounter types.

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 were 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***.

PQI and Well Care Visits Quality Study

PQI Results

- **ACNH** had a total rate of 48.25 per 100,000 member months for the *PQI* measures overall. The *PQI-05* measure rate was the lowest for ACNH (21.68 per 100,000 member months), while the *PQI-08* measure rate was the highest (30.89 per 100,000 member months), which is expected given that heart failure is the second most frequent primary diagnosis for an inpatient admission in the United States.[34]
- The rate for the *PQI-05* measure for **ACNH** was better than the median statewide performance rate (i.e., the 50th percentile) from the CMS federal fiscal year (FFY) 2020 Child and Adult Health Care Quality Measures data set,[35] indicating a strength for **ACNH**. This rate represented better ***access to care*** for **ACNH** members with COPD and asthma. However, these results should be interpreted with caution due to the potential impacts that the COVID-19 pandemic may have had on inpatient admissions during SFY 2021.[36]
- Approximately 37 percent of **ACNH** members completed an HRA and/or enrolled in care management either prior to or after the admission date, which was below the statewide rate by approximately 29 percentage points. The percentage of **ACNH** members who completed an HRA was lower than the percentage of members who completed an HRA from the other two MCOs. Increasing the number of members receiving care management services could improve ***quality of care*** and ***access to care*** for **ACNH** members.
- The difference in rates between members who completed an HRA and/or enrolled in care management prior to and after the admission date was small for **ACNH** (i.e., within approximately 6

[34] McDermott KW and Roemer M. Most Frequent Principal Diagnoses for Inpatient Stays in U.S. Hospitals, 2018. HCUP Statistical Brief #277. July 2021. Agency for Healthcare Research and Quality, Rockville, MD. Available at: https://hcup-us.ahrq.gov/reports/statbriefs/sb277-Top-Reasons-Hospital-Stays-2018.pdf. Accessed on: Jan 13, 2025.

[35] CMS. 2020 Child and Adult Health Care Quality Measures. Available at: 2020 Child and Adult Health Care Quality Measures. Accessed on: Jan 13, 2025.

[36] Blecker S, Jones SA, Petrilli CM, et al. Hospitalizations for Chronic Disease and Acute Conditions in the Time of COVID-19. Oct 2020. *JAMA Internal Medicine*. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2772351. Accessed on: Jan 13, 2025.

percentage points); therefore, the results may indicate that a member being admitted to the hospital may not be a large contributing factor for triggering an HRA or enrollment in care management.

- The majority of **ACNH** members did not complete an HRA and/or enroll in care management after an admission. These results suggest that **ACNH** may not have used an inpatient admission to trigger conducting an HRA and/or enrolling a member in care management.

Well-Care and Preventive Visits

- **ACNH** had an increase in the rate of overall utilization of well-care and preventive visits with any PCP within 12 months of attribution from SFY 2021 to SFY 2022 (4.5 percentage points). This increase contributed to improved ***quality of care*** and ***access to care*** for **ACNH** members.
- **ACNH** had an increase in the rate of utilization of well-care and preventive visits with an attributed PCP within 12 months of attribution from SFY 2021 to SFY 2022 (2.1 percentage points). An increased rate of utilization of well-care and preventive visits contributed to improved ***quality of care*** and ***access to care*** for **ACNH** members.
- **ACNH** members attributed to a PCP had a slightly lower rate of ED utilization compared to the statewide rate in SFY 2021 and SFY 2022. This decrease in ED utilization may have contributed to improved ***quality of care*** and ***access to care*** for **ACNH** members. Additionally, **ACNH** members who had an ED visit were more likely to visit a non-attributed PCP than their attributed PCP prior to their ED visit during SFY 2021 and SFY 2022.

  Based on the results of the quality study, **ACNH** should investigate why rates of HRA completion and care management enrollment did not demonstrate a larger increase after an inpatient admission and determine if **ACNH** needs to implement mechanisms to automatically trigger an HRA and/or care management enrollment after an inpatient admission. Additionally, **ACNH** must ensure that HRA refusal data are captured to correctly determine if lower rates of HRAs were due to HRAs being offered to but refused by the member, or simply not being offered to the member.

SFY 2023 Revealed Caller Provider Survey

The following sections provide information concerning **ACNH**'s opportunities for improvement identified during the SFY 2023 Revealed Caller Provider Survey.

- **ACNH** had an overall response rate of 58 percent; however, rates varied drastically by provider type/specialty, with 77 percent of PCPs, 68 percent of physical health specialists, and 31 percent of BH providers responding to the survey. **ACNH** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner to increase members' ***access to care***.
- Among **ACNH**'s contacted locations, only 58 percent of the BH respondents indicated the location offered the requested services. **ACNH** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.

- Overall, only 58 percent of **ACNH**'s contacted locations indicated acceptance of **ACNH**. **ACNH** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **ACNH** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.
- Only 47 percent of **ACNH**'s respondent locations indicated acceptance of new patients. New patient acceptance varied greatly by provider type/specialty: 37 percent for BH providers, 46 percent for physical health specialists, and 53 percent for PCPs. **ACNH** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **ACNH** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- Among **ACNH**'s respondent cases accepting New Hampshire Medicaid, 39 percent indicated the sampled provider was no longer affiliated with the location. **ACNH** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

SFY 2024 Revealed Caller Provider Survey

The following sections provide information concerning **ACNH**'s strengths identified during the Revealed Caller Provider Survey and opportunities for improvement.

Strengths

- Based on the survey findings, HSAG did not identify any strengths for **ACNH**.

Opportunities for Improvement

- **ACNH** had an overall non-CMHC response rate of 43.8 percent; however, rates varied drastically by BH category, with 51.1 percent of MH providers and 38.6 percent of SUD providers responding to the survey. Overall, 8.0 percent of **ACNH**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **ACNH** should consider reviewing its processes for updating provider data in an accurate and timely manner to increase data ***quality*** and members' ***access to care***.
- Among **ACNH**'s non-CMHC contacted locations, only 63.4 percent of the respondents indicated the location offered the requested services. **ACNH** should consider reviewing its methods for acquiring and maintaining this specialty information to increase data ***quality*** and allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.
- Overall, only 56.3 percent of **ACNH**'s contacted non-CMHC locations indicated acceptance of **ACNH**. MCO acceptance varied greatly by BH category, with 63.8 percent of MH locations and 49.3 percent of SUD locations confirming acceptance of **ACNH**. Additionally, only 54.9 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **ACNH** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally,

ACNH should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.

- Only 45.1 percent of **ACNH**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied slightly by BH category, with 47.8 percent for MH providers and 42.5 percent for SUD providers. **ACNH** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **ACNH** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- Among **ACNH**'s non-CMHC respondent cases accepting New Hampshire Medicaid, 42.3 percent indicated the sampled provider was not currently affiliated with the location. **ACNH** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

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

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

Quality	Access	Timeliness	Strengths
✓		✓	**ACNH** improved the Child Medicaid CAHPS results for *Getting Care Quickly* from a measure rate that was neither statistically significantly higher nor lower than the national average in SFY 2023 to a rate that is statistically significantly higher than the national average in SFY 2024. Improvements in this CAHPS measure positively affected members' perception of their ***quality of care*** and ***timeliness of care***.
✓			**ACNH** reported efforts in its Follow-Up on Prior Recommendations section of this report to improve the HEDIS measure rates for *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* for MY 2023. The MY 2023 HEDIS rates improved from below the 25th percentile to the 25th–49th percentile range. **ACNH** reported that it implemented a provider incentive program for the submission of Current Procedural Terminology Category II (CPT II) codes, reached out to providers to educate them regarding data exchange options and the use of CPT II codes, and included the *Hemoglobin A1c Control for Patients With Diabetes (HBD)* measure in its provider value-based payment program. These efforts may have contributed to the increase in the rates and percentiles, and improvements in these measures positively affect members' ***quality of care***.

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

Quality	Access	Timeliness	Weaknesses
✓			In MY 2023, the adult Medicaid CAHPS results for *Rating of Health Plan* scored neither statistically significantly lower nor higher than the national average; however, in MY 2024, the adult Medicaid CAHPS results for *Rating of Health Plan* scored statistically significantly lower than the national average. **ACNH** should implement efforts and activities to improve this rate. Improving the rate for *Rating of Health Plan* will affect members' perception of the ***quality of care*** received at **ACNH**.
✓	✓	✓	**ACNH**'s rate for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* decreased from 80.29 percent in MY 2022 to 76.34 percent in MY 2023, despite the MCO's reported efforts to improve the rate. The rate also remained below the 25th percentile. **ACNH** reported its efforts to improve this HEDIS measure rate in its Follow-Up on Prior Recommendations section of this report, which included incentive programs and outreach to members to provide education and awareness (i.e., the Bright Start program, wellness center events for prenatal and postpartum mothers, women's health value-based program). The *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* measure is also a focus area of DHHS' Quality Strategy. **ACNH** should implement additional efforts and activities and/or review its current programs for potential enhancements to improve the rate. Improving this rate will affect members' ***quality of care***, ***access to care***, and ***timeliness of care***.

New Hampshire Healthy Families

MCO Contractual Compliance

This was the 11th year that **NHHF** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 99.7 percent on the review. Of the six standards reviewed that included 193 applicable elements, **NHHF** achieved a 100 percent score in Care Management/Care Coordination, Member Enrollment and Disenrollment, Member Services, Quality Management, and Third Party Liability. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM program beneficiaries.

NHHF demonstrated strength in Care Management/Care Coordination by using results of the High Risk Assessment Screening (HRAS); claims history; encounter data; pharmacy; immunization; admission, discharge, transfer (ADT) reports; and ED visits to generate a risk stratification to identify members with high needs/high risks and ensuring that staff members contacted those members to determine if they would benefit from care management services. **NHHF** convened an integrated care team to discuss barriers to care and strategies to address those barriers. Team members included the member, caretaker(s), PCP, BH providers, specialists, home- and community-based services (HCBS) case managers, school personnel, nutritionists, pharmacists, care managers, program specialists, program coordinators, and community health services representatives. Having members receive care management services from multidisciplinary team members will assist in ensuring that the New Hampshire MCM Program members improve their ***access to care*** and ***quality of care***.

NHHF demonstrated strength in Member Enrollment and Disenrollment by ensuring that its eligibility files were incorporated and updated within one business day of receipt. **NHHF** notified DHHS within five business days of any member's circumstances that would affect his/her eligibility. **NHHF** assisted members with maintaining eligibility by outreaching to members 30 days prior to their eligibility expiration date to provide education and assist with paperwork. Additionally, **NHHF** assigned a PCP to all members who did not choose a PCP to ensure access to appropriate care. Ensuring that effective enrollment and disenrollment procedures were implemented contributed to improved ***timeliness of care*** and ***access to care*** for **NHHF**'s members.

NHHF demonstrated strength in the Member Services standard by ensuring that it sent a welcome letter to new members within seven calendar days of enrollment explaining how to access the provider directory. **NHHF** ensured members were informed of their rights and that it provided all member materials in easily understood language and format. Additionally, **NHHF** ensured the availability of written translation of materials in other languages, large print materials, oral interpretation, and auxiliary aids and services. These activities may result in improved ***quality of care*** and ***access to care*** for **NHHF**'s members.

NHHF demonstrated strength in Quality Management by ensuring that the quality committee adopted CPGs from ASAM, the U.S. Preventive Services Task Force, AAP's Bright Futures program, and Zero

Suicide Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.[37] The member handbook and the provider manual addressed the dissemination of CPGs to providers, and the CPGs were available on request to members and potential members. The MCO also conducted a comprehensive medication review and provided counseling to any member upon request. Additionally, **NHHF** also developed a comprehensive QAPI program that included re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions. Ensuring that the MCO develops a QAPI program and that practitioners follow nationally recognized CPGs will assist the New Hampshire MCM Program members in improving their ***quality of care***.

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

NHHF demonstrated strength in the Utilization Management standard by ensuring that appropriately licensed clinicians made all determinations to deny services and that **NHHF** made all decisions within 14 calendar days for standard requests for authorization of services and 72 hours for expedited requests. **NHHF** ensured that it furnished all services sufficient in an amount, duration, and scope to reasonably achieve their purpose. Additionally, **NHHF** ensured it notified members of denial decisions and their rights to appeal those decisions. Ensuring that **NHHF** makes timely and appropriate authorization decisions may result in enhanced ***quality of care***, ***timeliness of care***, and ***access to care*** for Medicaid members.

However, **NHHF** scored *Not Met* in one element from the Utilization Management standard. This element represents an opportunity for improvement to ensure compliance with federal and State requirements in ***timeliness of care*** and ***access to care*** for New Hampshire Medicaid beneficiaries. To improve the Utilization Management requirements, **NHHF** must ensure that it and its delegates have only one level of appeal and notify members of their State fair hearing rights if it upholds a denial decision upon appeal.

After finalization of the SFY 2024 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 *Not Met* during the compliance review. **NHHF** successfully submitted CAPs for all the recommendations and created documents to rectify the deficiencies identified during the SFY 2024 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2024 Compliance Review CAP items during the SFY 2025 compliance audit.

[37] Zero Suicide. Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments. Available at: [Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments | Zero Suicide](). Accessed on: Jan 13, 2025.

PIPs

For the *Improving HPV Vaccinations* PIP and *Improving Health Risk Assessments* PIP, there was an opportunity to improve ***quality of care*** and ***access to care*** for the eligible members.

During SFY 2024, **NHHF** demonstrated the following strengths that positively impacted these identified domains of care:

- Successfully conducted methodologically sound PIPs.
- Used QI tools and processes effectively to determine barriers and develop interventions.
- Achieved statistically significant improvement over the baseline for both PIPs, and at least one of the interventions could be reasonably linked to the demonstrated improvement.

Based on information obtained through the validation of **NHHF**'s PIPs, HSAG offers the following suggestions to enhance the PIP activities:

- **NHHF** should develop a plan for sustaining and spreading the effective adopted interventions.
- **NHHF** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

PMV

HSAG's PMV activities found all 18 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and auditors recommended that **NHHF**:

- Continue to explore options to automate New Hampshire appeals reporting so that it does not rely on the customized Microsoft SharePoint site due to the increased risk of manual documentation errors. Improving this requirement will facilitate ***quality of care***.
- Enhance its vendor oversight to ensure vendors have assigned knowledgeable staff members to maintain and oversee Exhibit O reports. Improving this requirement will facilitate ***quality of care***.

NAV

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

Strengths

- **NHHF** had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform calculation of network adequacy standards and indicators. HSAG had no concerns with **NHHF**'s data collection procedures, network adequacy methods, or network adequacy results.

- **NHHF** had sufficient policies and procedures in place to ensure that it uses sound methods to assess the adequacy of its managed care networks as required by the State and accurately reported results to the State in the required format. HSAG has *High Confidence* in **NHHF**'s ability to produce and report accurate results to support the MCO's and the State's network adequacy monitoring efforts.
- DHHS requires its contracted MCOs to provide access to 90 percent of members within DHHS' time and distance standards. **NHHF** met the State's time and distance standards for 60 of 61 provider categories. Based on these findings, members' ***access to care*** is robust for primary care, hospital services, diagnostic services, other facilities and services, and SUD services.
- For network capacity analysis, **NHHF** met the network capacity standard for contracting with at least 75 percent of OTPs and at least 50 percent of residential SUD treatment programs. Based on these findings, members' ***access to care*** is robust for these provider types.

Opportunities for Improvement

- HSAG observed that **NHHF** had minimal programmer staff trained and capable of supporting network adequacy data analysis and oversight of contracted vendors performing network adequacy calculations.
- **NHHF** did not meet the 90 percent time and distance standard for one provider category: pediatric ophthalmologist.

CAHPS

One of the 2024 measure rates representing the ***quality of care*** domain (i.e., *Rating of All Health Care*) for **NHHF**'s adult Medicaid population was statistically significantly lower than the 2023 NCQA adult Medicaid national average. One of the 2024 measure rates representing the ***quality of care*** and ***timeliness of care*** domains (i.e., *Getting Care Quickly*) for **NHHF**'s general child Medicaid population was statistically significantly higher than the 2023 NCQA general child Medicaid national average. The 2024 measure rates representing the ***access to care*** domain for **NHHF**'s adult and general child Medicaid populations was neither statistically significantly higher nor lower than the 2023 NCQA adult and general child Medicaid national averages. Additionally, the 2024 measure rates representing the ***timeliness of care*** domain for **NHHF**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2023 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 the patient reported. To properly handle customer complaints, **NHHF** could implement the

following protocols: (1) design unique ways to encourage members to provide feedback concerning their experience; (2) develop guidelines to allow staff members to address complaints autonomously; (3) create documentation and feedback loops that outline problem elimination processes; and (4) educate staff members to be able to listen to customer complaints non-defensively, empathize, handle emotion, solve problems, and follow through to closure.

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 2023.

Table 4-4—Summary of NHHF's Scores for MY 2023 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	7	5	6	3	2	**23**
Acute and Chronic Care	1	2	4	2	1	**10**
Behavioral Health	8	5	6	1	0	**20**
All Domains	**16**	**12**	**16**	**6**	**3**	**53**
Percentage	**30.19%**	**22.64%**	**30.19%**	**11.32%**	**5.66%**	**100%**

NHHF's rates ranked at or above the 50th percentile for 44 measures (83.02 percent), with 16 of these measures (30.19 percent) meeting or exceeding the 90th percentile. The rates for nine measures (16.98 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 42 of the 51 (82.35 percent) measures related to ***quality***. The following measures related to ***quality of care*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3–11 Years**, *Ages 12–17 Years**, *Ages 18–21 Years**, and *Total**
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*

- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care** and *Postpartum Care**
- *Lead Screening in Children (LSC)*
- *Appropriate Testing for Pharyngitis (CWP)—Total**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*
- *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*
- *Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Chlamydia Screening in Women (CHL)—Ages 16–20 Years*, *Ages 21–24 Years*†, and *Total*†.
- *Use of Imaging Studies for Low Back Pain (LBP)*†
- *Pharmacotherapy for Opioid Use Disorder (POD)—Total*

To improve ***quality of care***, **NHHF** should educate members to help them understand the importance of receiving preventive care and remind providers to review preventive care measures for every patient, including children and adolescents, at every visit to ensure that members receive timely preventive health screenings and immunizations. **NHHF** also could continuously inform members through member newsletters about the importance of chlamydia screenings. **NHHF** should also focus efforts on reducing readmissions, pharmacotherapy for opioid disorder, and utilizing imaging studies for low back pain.

NHHF demonstrated strength in measure indicators related to ***timeliness of care***, meeting or exceeding the 50th percentile for 18 of the 19 (94.74 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)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care** and *Postpartum Care**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Pharmacotherapy for Opioid Use Disorder (POD)*

To improve ***timeliness of care***, **NHHF** should continuously inform members through member newsletters about the importance and benefits of pharmacotherapy for opioid use disorder.

NHHF demonstrated strength in measure indicators related to ***access to care***, meeting or exceeding the 50th percentile for 19 of the 19 (100 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):

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)*
- *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits **
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3–11 Years**, *Ages 12–17 Years**, *Ages 18–21 Years**, and *Total**
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care** and *Postpartum Care**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase*

- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

EDV

For the IS review activity, **NHHF** noted that its pharmacy subcontractor changed from CVS to Express Scripts. **NHHF** performed at least one data quality check to validate the changes and also performed a quality check before and/or after submitting encounters to DHHS.

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 837P 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 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 were complete and accurate when comparing to the data extracted from **NHHF**'s data systems. Submitting accurate and complete encounter data assists DHHS in monitoring issues concerning ***quality of care*** and ***access to care***.

PQI and Well Care Visits Quality Study

PQI Results

- **NHHF** had a total rate of 57.57 per 100,000 member months for the *PQI* measures overall. The two unsuppressed *PQI* rates (i.e., *PQI-08* and *PQI-05*) for **NHHF** had similar rates.
- The rate for the *PQI-05* measure for **NHHF** was better than the median statewide performance rates (i.e., the 50th percentile) from the CMS FFY 2020 Child and Adult Health Care Quality Measures data set,[38] indicating a strength for **NHHF**. This rate represented better ***access to care*** for **NHHF** members with COPD and asthma. However, these results should be interpreted with caution due to the potential impacts that the COVID-19 pandemic may have had on inpatient admissions during SFY 2021.[39]

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[38] Centers for Medicare & Medicaid Services. 2020 Child and Adult Health Care Quality Measures. Available at: 2020 Child and Adult Health Quality Measures. Accessed on: Jan 13, 2025.

[39] Blecker S, Jones SA, Petrilli CM, et al. Hospitalizations for Chronic Disease and Acute Conditions in the Time of COVID-19. Oct 2020. *JAMA Internal Medicine*. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2772351. Accessed on: Jan 13, 2025.

- Approximately 68 percent of **NHHF** members completed an HRA and/or enrolled in care management either prior to or after the admission date, which exceeded the statewide rate by approximately 2 percentage points. A higher rate than the statewide rate for members completing an HRA or enrolled in care management contributed to improved ***quality of care*** and ***access to care*** for **NHHF** members.
- The difference in rates between members who completed an HRA and/or enrolled in care management prior to and after the admission date was small for **NHHF** (i.e., within approximately 8 percentage points); therefore, the results may indicate that a member being admitted to the hospital may not be a large contributing factor for triggering completion of an HRA or enrollment in care management.
- Approximately 50 percent of **NHHF** members did not complete an HRA or enroll in care management after an admission.

Well-Care and Preventive Visits

- **NHHF** had a decrease in the rate of overall utilization of well-care and preventive visits with any PCP within 12 months of attribution from SFY 2021 to SFY 2022 (8.24 percentage points). This decrease may have contributed to a decrease in the ***quality of care*** and ***access to care*** for **NHHF** members.
- **NHHF** had a decrease in the rate of utilization of well-care and preventive visits with an attributed PCP within 12 months of attribution from SFY 2021 to SFY 2022 (6.4 percentage points).
- **NHHF** members attributed to a PCP had a slightly higher rate of ED utilization compared to the statewide rate in SFY 2021 and SFY 2022. A higher rate of ED utilization may have contributed to a decrease in the ***quality of care*** and ***access to care*** for **NHHF** members. Additionally, **NHHF** members who had an ED visit were more likely to visit a non-attributed PCP than their attributed PCP prior to their ED visit during SFY 2021 and SFY 2022.

  Based on the results of the quality study, **NHHF** should investigate why rates of HRA completion and care management enrollment did not demonstrate a larger increase after an inpatient admission and determine if **NHHF** needs to implement mechanisms to automatically trigger an HRA and/or care management enrollment after an inpatient admission. Additionally, **NHHF** must ensure that HRA refusal data are captured to correctly determine if lower rates of HRAs were due to HRAs being offered to but refused by the member, or simply not being offered to the member.

SFY 2023 Revealed Caller Provider Survey

The following sections provide information concerning **NHHF**'s opportunities for improvement identified during the Revealed Caller Provider Survey.

- **NHHF** had an overall response rate of 61 percent; however, rates varied drastically by provider type/specialty, with 68 percent of PCPs, 75 percent of physical health specialists, and 44 percent of BH providers responding to the survey. **NHHF** should consider reviewing the processes used to

ensure that it updates and maintains provider data in an accurate and timely manner to increase members' ***access to care***.

- Among **NHHF**'s contacted locations, only 57 percent of the BH respondents indicated the location offered the requested services. **NHHF** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.
- Overall, only 52 percent of **NHHF**'s contacted locations indicated acceptance of **NHHF**. **NHHF** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **NHHF** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.
- Only 39 percent of **NHHF**'s respondent locations indicated acceptance of new patients. New patient acceptance varied by provider type/specialty: 32 percent for BH providers, 42 percent for physical health specialists, and 41 percent for PCPs. **NHHF** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **NHHF** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- The average appointment wait time for new **NHHF** members was 63 calendar days, while existing patients had a wait time of 46 calendar days. Both new and existing patients experienced wait times that exceeded DHHS' contract standard of 45 calendar days. **NHHF** should consider reviewing the appointment wait time standards with its contracted providers and identifying whether additional provider capacity is necessary to reduce overall wait times to increase the ***timeliness of care***.
- Among **NHHF**'s respondent cases accepting New Hampshire Medicaid, 23 percent indicated the sampled provider was no longer affiliated with the location. **NHHF** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

SFY 2024 Revealed Caller Provider Survey

The following sections provide information concerning **NHHF**'s strengths identified during the Revealed Caller Provider Survey and opportunities for improvement.

Strengths

- Based on the survey findings, HSAG did not identify any strengths for **NHHF**.

Opportunities for Improvement

- **NHHF** had an overall non-CMHC response rate of 33.0 percent; however, rates varied by BH category, with 31.1 percent of MH providers and 42.6 percent of SUD providers responding to the survey. Overall, 14.5 percent of **NHHF**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **NHHF** should

consider reviewing its processes for updating provider data in an accurate and timely manner to increase the data ***quality*** and members' ***access to care***.

- Among **NHHF**'s non-CMHC contacted locations, only 66.4 percent of the respondents indicated the location offered the requested services. **NHHF** should consider reviewing its methods for acquiring and maintaining this specialty information to increase data ***quality*** and allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.
- Overall, only 55.1 percent of **NHHF**'s contacted non-CMHC locations indicated acceptance of **NHHF**. MCO acceptance varied greatly by BH category, with 59.5 percent of MH locations and 39.1 percent of SUD locations confirming acceptance of **NHHF**. Additionally, only 54.2 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **NHHF** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally, **NHHF** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.
- Only 43.9 percent of **NHHF**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied by BH category, with 45.2 percent for MH providers and 39.1 percent for SUD providers. **NHHF** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **NHHF** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- Among **NHHF**'s non-CMHC respondent cases accepting New Hampshire Medicaid, 51.7 percent indicated the sampled provider was not currently affiliated with the location. **NHHF** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

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

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

Quality	Access	Timeliness	Strengths
✓		✓	**NHHF** improved the Child Medicaid CAHPS results for *Getting Care Quickly* from a measure rate that was neither statistically significantly higher nor lower than the national average in SFY 2023 to a rate that is statistically significantly higher than the national average in SFY 2024. Improvements in this CAHPS measure positively affected members' perception of their ***quality of care*** and ***timeliness of care***.

Quality	Access	Timeliness	Strengths
✓	✓	✓	**NHHF** reported efforts in its Follow-Up on Prior Recommendations section of this report to improve the HEDIS indicator rate for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care.* During MY 2022, the rate for this measure was below the 25th percentile. However, during MY 2023, the rate improved significantly to at or above the 90th percentile. **NHHF**'s implemented interventions included the Start Smart for Your Baby care management program and the Notice of Pregnancy Rewards program, which incentivized pregnant members to complete prenatal care visits. These efforts may have contributed to the increase in the rates and percentiles, and improvements in these measures positively affect members' ***quality of care***, ***access to care***, and ***timeliness of care***.

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

Quality	Access	Timeliness	Weaknesses
✓			In MY 2023, the adult Medicaid CAHPS results for *Rating of All Health Care* scored neither statistically significantly lower nor higher than the national average; however, in MY 2024, the adult Medicaid CAHPS results for *Rating of All Health Care* scored statistically significantly lower than the national average. **NHHF** should implement efforts and activities to improve this rate. Improving the rate for *Rating of All Health Care* will affect members' perception of the ***quality of care*** received at **NHHF**.
✓			**NHHF**'s MY 2023 rate for *Chlamydia Screening in Women (CHL)—Ages 21 to 24 Years* and *Chlamydia Screening in Women (CHL)—Total* decreased from MY 2022 rates (56.57 percent to 55.48 percent for *Ages 21 to 24 Years* and 50.25 percent to 47.68 percent for *Total*). Both rates were in the 25th–49th percentile range in MY 2022 and dropped below the 25th percentile in MY 2023. **NHHF** should implement efforts and activities to improve the rate, which will positively affect members' ***quality of care***.

WellSense Health Plan

MCO Contractual Compliance

This was the 11th year that **WS** completed a compliance review with HSAG in New Hampshire, and the MCO achieved an overall score of 98 percent on the review. Of the six standards reviewed that included 193 applicable elements, **WS** achieved a 100 percent score in Care Management/Care Coordination, Member Enrollment and Disenrollment, Member Services, Quality Management, and Third Party Liability. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire MCM program beneficiaries.

WS demonstrated strength in Care Management/Care Coordination by using Arcadia, a risk score system, to generate a risk stratification to identify members with high needs/high risks and ensuring that staff members contacted those members to determine if they would benefit from care management services. **WS** convened an integrated care team to discuss barriers to care and strategies to address those barriers. Team members included nurses, social workers, BH specialists, care managers, pharmacists, and a medical director. Having members receive care management services from multidisciplinary team members will assist in ensuring that the New Hampshire MCM Program members improve their ***access to care*** and ***quality of care***.

WS demonstrated strength in Member Enrollment and Disenrollment by ensuring that its eligibility files were incorporated and updated within one business day of receipt. **WS** notified DHHS within five business days of any member's circumstances that would affect his/her eligibility. **WS** assisted members with maintaining eligibility by outreaching to members 30 days prior to their eligibility expiration date to provide education and assist with paperwork. Additionally, **WS** assigned a PCP to all members who did not choose a PCP to ensure access to appropriate care. Ensuring that effective enrollment and disenrollment procedures were implemented contributed to improved ***timeliness of care*** and ***access to care*** for **WS**'s members.

WS demonstrated strength in the Member Services standard by ensuring that it sent a welcome letter to new members within seven calendar days of enrollment explaining how to access the provider directory. **WS** ensured members were informed of their rights and that it provided all member materials in easily understood language and format. Additionally, **WS** ensured the availability of written translation of materials in other languages, large print materials, oral interpretation, and auxiliary aids and services. These activities may result in improved ***quality of care*** and ***access to care*** for **WS**'s members.

WS demonstrated strength in Quality Management by ensuring that the quality committee adopted CPGs from ASAM, the U.S. Preventive Services Task Force, AAP's Bright Futures program, and Zero

Suicide Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.[40] **WS**'s member handbook and the provider manual addressed the dissemination of CPGs to providers, and the CPGs were available on request to members and potential members. The MCO also conducted a comprehensive medication review and counseling to any member upon request. Additionally, **WS** also developed a comprehensive QAPI program that included re-measurement of effectiveness, health outcomes improvement and member satisfaction, and continued development and implementation of improvement interventions. Ensuring that the MCO develops a QAPI program and that practitioners follow nationally recognized CPGs will assist the New Hampshire MCM Program members in improving their ***quality of care***.

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

WS demonstrated strength in the Utilization Management standard by ensuring that appropriately licensed clinicians made all determinations to deny services and that **WS** made all decisions within 14 calendar days for standard requests for authorization of services and 72 hours for expedited requests. **WS** ensured that it furnished all services sufficient in an amount, duration, and scope to reasonably achieve their purpose. Additionally, **WS** ensured that it notified members of denial decisions and their rights to appeal those decisions. Ensuring that **WS** makes timely and appropriate authorization decisions may result in enhanced ***quality of care***, ***timeliness of care***, and ***access to care*** for Medicaid members.

However, **WS** scored *Partially Met* in three elements from the Utilization Management standard. These elements represent an opportunity for improvement to ensure compliance with federal and State requirements in ***timeliness of care*** and ***access to care*** for New Hampshire Medicaid beneficiaries. To improve the Utilization Management requirements, **WS** must ensure it makes determinations for post-service authorizations within 30 days of the date of filing. If the member fails to provide sufficient information to determine the request, **WS** is to notify the member within 15 calendar days of the date of filing regarding what additional information is required to process the request, and **WS** must give the member at least 45 calendar days to provide the required information. Additionally, the 30-calendar-day period for determination is to be tolled until the member submits the required information. Additionally, **WS** must send a notice of a denial of payment to the member at the time of any action affecting the claim.

After finalization of the SFY 2024 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* during the compliance review. **WS** successfully submitted CAPs for all the recommendations and created documents to rectify the

[40] Zero Suicide. Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments. Available at: [Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments | Zero Suicide](). Accessed on: Jan 13, 2025.

deficiencies identified during the SFY 2024 compliance review. All standards achieved 100 percent compliance after the completion of the CAP. HSAG will include a review of the SFY 2024 Compliance Review CAP items during the SFY 2025 compliance audit.

PIPs

For the *Improving HPV Vaccinations* PIP and *Improving Health Risk Assessments* PIP, there was an opportunity to improve ***quality of care*** and ***access to care*** for the eligible members.

During SFY 2024, **WS** demonstrated the following strengths that positively impacted these identified domains of care:

- Successfully conducted methodologically sound PIPs.
- Used QI tools and processes effectively to determine barriers and develop interventions.
- Achieved statistically significant improvement over the baseline for both PIPs, and at least one of the interventions could be reasonably linked to the demonstrated improvement.

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

- When evaluating and reporting measure results over time, **WS** must report accurate analysis of results. The MCO should ensure quality checks are in place to facilitate accurate reporting of data. Accurate data reporting will provide more meaningful and actionable information to facilitate ongoing improvement.
- **WS** should develop a plan for sustaining and spreading the effective adopted interventions.
- **WS** should apply lessons learned and knowledge gained during the PIP process to make changes and revisions to current QI processes and activities as needed.

PMV

HSAG's PMV activities found all 18 performance measures representing ***quality of care***, ***timeliness of care***, and ***access to care*** acceptable for reporting, and auditors recommended that **WS**:

- Add a review of Facets customer service free text fields to its QA process to ensure the call center free text field notes align with the Facets system drop-down fields. Improving this requirement will facilitate ***quality of care***.
- Complete corrective action to maintain its call categorization crosswalk is in alignment with the PROVCOMM.07 submeasures and to improve staff member training and monitoring. **WS** should aim to reduce the risk of staff members selecting incorrect Facets drop-down reasons. Improving this requirement will facilitate ***quality of care***.

NAV

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

Strengths

- **WS** had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform calculation of network adequacy standards and indicators. HSAG had no concerns with **WS**'s data collection procedures, network adequacy method, or network adequacy results.
- **WS** had sufficient policies and procedures in place to ensure that it uses sound methods to assess the adequacy of its managed care networks as required by the State and accurately reported results to the State in the required format. HSAG has *High Confidence* in **WS**'s ability to produce and report accurate results to support the MCO's and the State's network adequacy monitoring efforts.
- **WS** met the network capacity standard for contracting with at least 75 percent of OTPs and at least 50 percent of residential SUD treatment programs.

Opportunities for Improvement

- HSAG did not identify any specific opportunities related to the data collection and management processes **WS** had in place to inform calculation of network adequacy standards and indicators.
- **WS** did not meet the 90 percent time and distance standards for several pediatric specialists. HSAG learned during the virtual review sessions that **WS** did not track taxonomy codes as DHHS recommended in its crosswalk. Instead, the MCO identified and reported providers who specialize in certain general areas (e.g. orthopedic surgery) and accept children as patients.

CAHPS

None of the 2024 measure rates for **WS**'s adult or general child population were statistically significantly lower than the 2023 NCQA adult and general child Medicaid national averages. Two of the 2024 measure rates representing the ***quality of care*** and ***timeliness of care*** domains (i.e., *Getting Care Quickly* and *How Well Doctors Communicate*) were statistically significantly higher than the 2023 NCQA general child Medicaid national averages. The 2024 measure rates representing the ***access to care*** domain for **WS**'s adult and general child Medicaid population were neither statistically significantly higher nor lower than the 2023 NCQA adult and general child Medicaid national averages. Additionally, the 2024 measure rates representing the ***timeliness of care*** domain for **WS**'s adult Medicaid population were neither statistically significantly higher nor lower than the 2023 NCQA adult Medicaid national averages.

While no measure rates were statistically significantly lower than the 2023 NCQA national averages, several measures related to ***quality of care*** fell below the 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 the comparison to national benchmarks that are based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2023.

Table 4-7—Summary of Scores for MY 2023 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	7	4	4	6	2	**23**
Acute and Chronic Care	2	4	1	2	1	**10**
Behavioral Health	7	3	5	3	2	**20**
All Domains	**16**	**11**	**10**	**11**	**5**	**53**
Percentage	**30.19%**	**20.75%**	**18.87%**	**20.75%**	**9.43%**	**100%**

WS's rates ranked at or above the 50th percentile for 37 measures (69.81 percent), with 16 of these measures (30.19 percent) meeting or exceeding the 90th percentile. The rates for 16 measures (30.19 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 34 of 51 (66.67 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)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*_
- _Child and Adolescent Well-Care Visits (WCV)—Ages 3–11 Years*, Ages 12 to 17 Years*, Ages 18 to 21 Years*,_ and _Total*_
- _Childhood Immunization Status (CIS)—Combination 3 (DTaP, IPV, MMR, Hib, HepB, VZV, PCV)_
- _Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*_
- _Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care_ and _Postpartum Care*_
- _Lead Screening in Children (LSC)_
- _Appropriate Testing for Pharyngitis (CWP)—Total*_
- _Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator_ and _Systemic Corticosteroid*_
- _Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor 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_
- _Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)_
- _Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*_
- _Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment_
- _Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total*_
- _Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total*_ and _30-Day Follow-Up—Total*_
- _Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total*_ and _30-Day Follow-Up—Total*_

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

- _Breast Cancer Screening (BCS-E)_
- _Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total_
- _Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)_ and _Combination 2 (Meningococcal, Tdap, HPV)_
- _Cervical Cancer Screening (CCS)_
- _Chlamydia Screening in Women (CHL)—Ages 16–20 Years, Ages 21–24 Years†_, and _Total†_
- _Use of Imaging Studies for Low Back Pain (LBP)†_
- _Asthma Medication Ratio (AMR)_

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase†* and *Continuation and Maintenance Phase†*
- *Pharmacotherapy for Opioid Use Disorder (POD)—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 (e.g., breast cancer, cervical cancer, chlamydia screenings). **WS** also could continuously inform members through member newsletters about the importance of adolescent immunizations, weight assessment and counseling for nutrition and physical activity for children and adolescents, with a focus on BMI. **WS** should also focus efforts on the use of psychosocial care for children and adolescents on antipsychotics. Ensuring that all PCPs and specialists follow CPGs for diabetes will positively impact the *Hemoglobin A1c Control for Patients With Diabetes* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measures. **WS** also could include information in provider newsletters concerning the importance of follow-up care for children prescribed ADHD medication, use of imaging studies for low back pain, and the benefits of pharmacotherapy for opioid use disorders.

WS demonstrated strength in measure indicators related to ***timeliness of care***, meeting or exceeding the 50th percentile for 14 of the 19 (73.68 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)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *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*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up After Emergency Department Visit for Substance Use (FUA)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase†* and *Continuation and Maintenance Phase†*
- *Pharmacotherapy for Opioid Use Disorder (POD)*

To improve ***timeliness of care***, **WS** should continuously inform members through member newsletters about 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 pharmacotherapy for opioid use disorder.

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

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*
- *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**
- *Child and Adolescent Well-Care Visits (WCV)—Ages 3–11 Years*, Ages 12 to 17 Years*, Ages 18 to 21 Years*,* and *Total**
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total**
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**

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

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase†* and *Continuation and Maintenance Phase†*

- To improve access to care, **WS** should consider focusing its efforts on encouraging providers to use an open-access scheduling model that allows for same-day appointments or to use virtual visits, which also will improve members' access to care. *Follow-Up Care for Children Prescribed ADHD Medication (ADD)* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* also need to be improved since it is evident that these indicators affect overall ***quality of care***, ***timeliness of care***, and ***access to care***.

EDV

For the IS review activity, **WS** changed requirements for its DME subcontractor by removing COVID-19 processing rules. **WS** performed at least one data quality check to validate the changes before and/or after submitting encounters to DHHS. However, **WS** should perform more quality checks on DME encounters such as reconciliation with financial reports and timeliness.

WS met the standards for the X12 EDI compliance edits; the accuracy for member identification numbers in its 837P and pharmacy encounters, and 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 837I 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 10 rates listed in Table 3-40 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 two issues as a result of its file review process, and four issues from the comparative analysis results were for a sub-category of service within an encounter type. 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***.

PQI and Well Care Visits Quality Study

PQI Results

- **WS** had a total rate of 68.52 per 100,000 member months for the *PQI* measures overall. The *PQI-05* measure rate was the lowest for **WS** (32.34 per 100,000 member months), while the *PQI-08* measure

rate was the highest (35.42 per 100,000 member months), which is expected given that heart failure is the second most frequent primary diagnosis for an inpatient admission in the United States.[41]

- The rate for the *PQI-05* measure for **WS** was better than the median statewide performance rate (i.e., the 50th percentile) from the CMS FFY 2020 Child and Adult Health Care Quality Measures data set,[42] indicating a strength for **WS**. This rate represented better ***access to care*** for **WS** members with COPD and asthma. However, these results should be interpreted with caution due to the potential impacts that the COVID-19 pandemic may have had on inpatient admissions during SFY 2021.[43]
- Approximately 75 percent of **WS** members completed an HRA and/or enrolled in care management either prior to or after the admission date, which was above the statewide rate by approximately 9 percentage points. A higher rate than the median statewide performance rate for members completing an HRA and/or enrolled in care management contributed to improved ***quality of care*** and ***access to care*** for **WS** members.
- The difference in rates between members who completed an HRA and/or enrolled in care management prior to and after the admission date was small for **WS** (i.e., within approximately 1 percentage point); therefore, the results may indicate that a member being admitted to the hospital may not be a large contributing factor for triggering an HRA or enrollment in care management.
- The majority of **WS** members did not receive an HRA or enroll in care management after an admission.

Well-Care and Preventive Visits

- **WS** had a decrease in the rate of overall utilization of well-care and preventive visits with any PCP within 12 months of attribution from SFY 2021 to SFY 2022 (11.59 percentage points). This decrease in the rate of overall utilization of well-care and preventive visits may have contributed to a decrease in the ***quality of care*** and ***access to care*** for **WS** members.
- **WS** had a decrease in the rate of utilization of well-care and preventive visits with an attributed PCP within 12 months of attribution from SFY 2021 to SFY 2022 (7.67 percentage points).
- **WS** members attributed to a PCP had a slightly higher rate of ED utilization compared to the statewide rate in SFY 2021; however, **WS** had a slightly lower rate compared to the statewide rate in SFY 2022. Additionally, **WS** members who had an ED visit were more likely to visit a non-attributed PCP than their attributed PCP prior to their ED visit during SFY 2021 and SFY 2022.

Based on the results of the quality study, **WS** should investigate why rates of HRA completion and care management enrollment did not demonstrate a larger increase after an inpatient admission and determine

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[41] McDermott KW and Roemer M. Most Frequent Principal Diagnoses for Inpatient Stays in U.S. Hospitals, 2018. HCUP Statistical Brief #277. July 2021. Agency for Healthcare Research and Quality, Rockville, MD. Available at: https://hcup-us.ahrq.gov/reports/statbriefs/sb277-Top-Reasons-Hospital-Stays-2018.pdf. Accessed on: Jan 13, 2025.

[42] CMS. 2020 Child and Adult Health Care Quality Measures. Available at: 2020 Child and Adult Health Quality Measures. Accessed on: Jan 13, 2025.

[43] Blecker S, Jones SA, Petrilli CM, et al. Hospitalizations for Chronic Disease and Acute Conditions in the Time of COVID-19. Oct 2020. *JAMA Internal Medicine*. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2772351. Accessed on: Jan 13, 2025.

if **WS** needs to implement mechanisms to automatically trigger an HRA and/or care management enrollment after an inpatient admission. Additionally, **WS** must ensure that HRA refusal data are captured to correctly determine if lower rates of HRAs were due to HRAs being offered to but refused by the member, or simply not being offered to the member.

SFY 2023 Revealed Caller Provider Survey

The following sections provide information concerning **WS**'s opportunities for improvement identified during the Revealed Caller Provider Survey.

- **WS** had an overall response rate of 51 percent; however, rates varied drastically by provider type/specialty, with 69 percent of PCPs, 69 percent of physical health specialists, and 27 percent of BH providers responding to the survey. **WS** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner to increase members' ***access to care***.
- Among **WS**'s contacted locations, only 57 percent of the BH respondents indicated the location offered the requested services. **WS** should consider reviewing its methods for acquiring and maintaining this specialty information to allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.
- Overall, only 58 percent of **WS**'s contacted locations indicated acceptance of **WS**. **WS** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **WS** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.
- Only 46 percent of **WS**'s respondent locations indicated acceptance of new patients. New patient acceptance varied greatly by provider type/specialty: 33 percent for BH providers, 46 percent for physical health specialists, and 54 percent for PCPs. **WS** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **WS** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- The average appointment wait time for new **WS** members was 49 calendar days, which exceeded DHHS' contract standard of 45 calendar days. **WS** should consider reviewing the appointment wait time standards with its contracted providers and identifying whether additional provider capacity is necessary to reduce overall wait times to increase the ***timeliness of care***.
- Among **WS**'s respondent cases accepting New Hampshire Medicaid, 25 percent indicated the sampled provider was no longer affiliated with the location. **WS** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

SFY 2024 Revealed Caller Provider Survey

The following sections provide information concerning **WS**'s strengths identified during the Revealed Caller Provider Survey and opportunities for improvement.

Strengths

- Based on the survey findings, HSAG did not identify any strengths for **WS**.

Opportunities for Improvement

- **WS** had an overall non-CMHC response rate of 31.2 percent; however, rates varied by BH category, with 29.6 percent of MH providers and 32.7 percent of SUD providers responding to the survey. Overall, 13.0 percent of **WS**'s non-CMHC cases connected to a bad phone number (i.e., reached a disconnected number, fax line, personal line, or non-medical facility). **WS** should consider reviewing its processes for updating provider data in an accurate and timely manner to increase the data ***quality*** and members' ***access to care***.
- Among **WS**'s non-CMHC contacted locations, only 49.5 percent of the respondents indicated the location offered the requested services. **WS** should consider reviewing its methods for acquiring and maintaining this specialty information to increase data ***quality*** and allow members a greater likelihood of reaching a location that provides ***access to care*** for the needed services.
- Overall, only 46.5 percent of **WS**'s contacted non-CMHC locations indicated acceptance of **WS**. MCO acceptance varied greatly by BH category, with 58.3 percent of MH locations and 35.8 percent of SUD locations confirming acceptance of **WS**. Additionally, only 42.6 percent of contacted locations indicated acceptance of New Hampshire Medicaid. **WS** should consider reviewing its processes for updating provider data in an accurate and timely manner. Additionally, **WS** should conduct outreach to its providers to ensure the providers and/or their offices routinely submit up-to-date information regarding insurance information for the provider location to increase data ***quality*** and members' ***access to care***.
- Only 33.7 percent of **WS**'s non-CMHC respondent locations indicated acceptance of new patients. New patient acceptance varied by BH category, with 41.7 percent for MH providers and 26.4 percent for SUD providers. **WS** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **WS** membership to determine whether additional provider contracts should be executed to increase members' ***access to care***.
- Among **WS**'s non-CMHC respondent cases accepting New Hampshire Medicaid, 39.5 percent indicated the sampled provider was not currently affiliated with the location. **WS** should consider reviewing its methods for acquiring and maintaining provider information to ensure data ***quality*** and that members have access to accurate provider information.

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

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

Quality	Access	Timeliness	Strengths
✓		✓	**WS** improved the Child Medicaid CAHPS results for *Getting Care Quickly* from a measure rate that was neither statistically significantly higher nor lower than the national average in SFY 2023 to a rate that is statistically significantly higher than the national average in SFY 2024. Improvements in this CAHPS measure positively affected members' perception of their ***quality of care*** and ***timeliness of care***.
✓			**WS** 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 2023 to a rate that is statistically significantly higher than the national average in SFY 2024. 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***.

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

Quality	Access	Timeliness	Weaknesses
✓			During MY 2022, **WS**'s rates for all three *Chlamydia Screening in Women (CHL)* submeasures were below the 25th percentile. While the rate for *Chlamydia Screening in Women (CHL)—Ages 16 to 20 Years* increased to the 25th–49th percentile range and all three measure rates increased slightly during MY 2023 (between 1.41–2.47 percentage points), the other two submeasures remained below the 25th percentile. **WS** reported its efforts to improve this HEDIS measure rate in its Follow-Up on Prior Recommendations section of this report, which included tracking opportunities at the provider and group level, member education, and initial assessments for high-risk pregnancies. **WS** should implement targeted efforts and activities to improve the rate. Improving this rate will affect members' ***quality of care***.
✓	✓	✓	During MY 2022, **WS**'s rate for *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* was in the 50th–74th percentile range and *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase* was below the 25th percentile. During MY 2023, both rates decreased (41.46 percent to 36.69 percent for the *Initiation Phase* and 42.28 percent to 39.44 percent for the *Continuation and Maintenance Phase*) and were below the 25th percentile. **WS** reported its efforts to improve the rate for the *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase* measure in its Follow-Up on Prior Recommendations section of this report, which included regularly monitoring performance and

Quality	Access	Timeliness	Weaknesses
			partnering with the CMHCs in New Hampshire. **WS** should implement targeted efforts and activities to improve the rates, which will positively affect members' ***quality of care***, ***access to care***, and ***timeliness of care***.

5. Assessment of the New Hampshire MCM Quality Strategy

Background

DHHS developed the New Hampshire MCM Quality Strategy dated July 2, 2024, 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 10, 2024. According to 42 CFR, the State's quality strategy must include:

- *The States goals and objectives for continuous QI which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP entity.*
- *The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP entity described in §438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website.*

Methodology

DHHS provided HSAG with Revision #8 of the New Hampshire MCM Quality Strategy for SFYs 2024–2027 dated July 2, 2024.[44] 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, PIHP, or PAHP, 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.*[45]

Findings

The New Hampshire MCM Quality Strategy dated SFY 2024 included specific goals for five preventive care measures (i.e., Objective 1.1) and three behavioral health measures (i.e., Objective 1.2). DHHS

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[44] New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy #8 2024–2027*. Available at: Care Management Quality Strategy | NH Medicaid Quality. Accessed on: Jan 13, 2025.

[45] U. S. Government Publishing Office. 2024. *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: Jan 13, 2025.

required the MCOs to evaluate all eight measures and include the rates in the HEDIS measures reported annually to the State.

HSAG based the national benchmarks used for comparison in this report on NCQA's Quality Compass national Medicaid HMO percentiles. For the HEDIS measures noted in the quality strategy, DHHS established the goal of obtaining improvement in each of the selected measures by the end of SFY 2026.

The five preventive care measures and three BH measures noted in the New Hampshire Medicaid Care Management Quality Strategy dated SFY 2024 include:

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*
- *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*
- *Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
- *Child and Adolescent Well-Care Visits (WCV)—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total*
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*

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 2021, MY 2022, and MY 2023.

Table 5-1—Comparison of MY 2021 HEDIS Statewide Rates to MY 2022 and MY 2023 HEDIS Statewide Rates for the New Hampshire MCM Program

DHHS New Hampshire MCM Quality Strategy Objective and HEDIS Measures	NH MY 2022 Rate and Percentile	NH MY 2023 Rate and Percentile	NH 2026 Goal Rate
Objective 1.1: Primary Care and Preventive Care Measures			
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care	81.86% 25th–49th Percentile	86.19% 50th–74th Percentile	86.9%
Prenatal and Postpartum Care (PPC)—Postpartum Care	80.62% 50th–74th Percentile	84.24% 75th–89th Percentile	85.6%
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	59.28% 50th–74th Percentile	62.21% 50th–74th Percentile	62.3%

DHHS New Hampshire MCM Quality Strategy Objective and HEDIS Measures	NH MY 2022 Rate and Percentile	NH MY 2023 Rate and Percentile	NH 2026 Goal Rate
Well-Child Visits in the First 30 Months of Life (W30)—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	75.95% 75th–89th Percentile	79.57% ≥90th Percentile	78.9%
Child and Adolescent Well-Care Visits (WCV)—Total	57.55% 75th–89th Percentile	66.15% ≥90th Percentile	60.5%
Objective 1.2: Behavioral Health Measures			
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Total	63.34% ≥90th Percentile	66.60% ≥90th Percentile	67.3%
Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total	24.96% NC	28.16% ≥90th Percentile	29.0%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	76.33% <25th Percentile	79.72% 50th–74th Percentile	80.3%

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate because HEDIS MY 2021 was the first year this measure is being reported.

Evaluation

Comparing the three years of rates for the eight measures listed in Table 5-1 must be done with caution since the rates generated for MY 2021 and MY 2022 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.

Rates increased for all eight measures, with increases ranging from 2.93–8.60 percentage points, and the percentile ranking increased for five measures: *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care, Prenatal and Postpartum Care (PPC)—Postpartum Care, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits, Child and Adolescent Well-Care Visits (WCV)—Total* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).* Although the percentile ranking did not increase for the remaining two measures that improved, one measure, *Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total,* had a percentile ranking at or above the 90th percentile. All eight rates were in the 50th–74th percentile or better for MY 2023.

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 selecting performance measures that are currently in the 25th–49th percentile range or below in New Hampshire to focus improvement on measures that consistently fall below national averages.

The quality strategy is the State's foundation for managed care, and its purpose is to improve quality of care. Table 5-1 shows that five of the eight measures DHHS chose were already at or above the 50th percentile in MY 2022. As recommended in the CMS *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*, *June 2021*,[46] DHHS should assess New Hampshire's performance on publicly reported measures across all states, the national median, and the HEDIS 75th percentile. DHHS should then use this information to determine which measures need improvement and set iterative goals for rate improvement over time. While it is important to monitor all performance measures to ensure they continue to demonstrate high performance, only those measures needing improvement should be identified as goals and objectives in the State's quality strategy.

Recommendation 2: Consider endorsing the distribution of the CDC's pregnancy planner, *Steps to a Healthier me and baby-to-be!* to improve timeliness of prenatal care.

Although the HEDIS statewide rate for *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* has improved from 81.86 percent in MY 2022 to 86.19 percent in MY 2023, there is room to improve this rate, which is currently in the 50th–74th percentile range. The American College of Obstetricians and Gynecologists recommends that the first visit for prenatal care occur during the first trimester of pregnancy. Seeing a doctor early and often during pregnancy can set the stage for a healthy pregnancy and birth.

While DHHS should continue to work with the MCOs to ascertain what barriers pregnant women experience in receiving prenatal care within the first trimester of pregnancy, other efforts to ensure timeliness of prenatal care can occur concurrently. Conversations with patients prior to a pregnancy concerning family planning (i.e., planning whether and when to become pregnant) can also help prevent unintended pregnancies and therefore increase planned pregnancies. Harvey et al. (2019)[47] report that much research has supported that the intendedness of pregnancy leads to patients obtaining more timely

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[46] CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit. (2021). Available at: https://www.medicaid.gov/sites/default/files/2021-12/managed-care-quality-strategy-toolkit.pdf. Accessed on: Jan 13, 2025.

[47] Harvey M, Oakley L, and Yoon J. Coordinated Care Organizations: Neonatal and Infant Outcomes in Oregon. *Medical Care Research and Review*. 2019: 76(5): 627–642. Available at: EBSCO HOST database. Accessed on: Jan 13, 2025.

and adequate prenatal care, which can improve birth outcomes. The CDC's pregnancy planner, *Steps to a Healthier Me and baby-to-be!*, is a tool MCOs and providers can use with patients to discuss both contraception and/or healthy behaviors leading up to a pregnancy.

Conclusions

The rates achieved for the eight measures indicate that all of the measures improved over the prior year. Two measures exceeded the MY 2026 goal rate. Achieving high percentages of measures scoring at or above the 75th percentile positively impacts ***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 technical report (i.e., SFY 2023 EQR Technical Report) and an assessment of the actions that were implemented to correct the areas of improvement. The results are reported for **ACNH**, **NHHF**, and **WS**.

AmeriHealth Caritas New Hampshire

The SFY 2023 EQR Technical Report contained opportunities for improvement for **ACNH** related to contract compliance, PIPs, NAV, CAHPS, HEDIS, and EDV. Except for contract compliance, the following tables display the self-reported activities conducted by **ACNH** during SFY 2024 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2023 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 2024 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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element requiring the MCO to evaluate the subcontractor's ability to perform the delegated activities prior to any delegation and at least annually or when there is a substantial change in the scope or terms of the subcontractor agreement. To correct the deficiency, **ACNH** submitted the subcontractor's 2022 Performance Summary Report that presented outreach performance results by month. **ACNH** explained that initially the subcontractor was designated as a software platform vendor only, which did not require a pre-assessment. The scope of work the subcontractor performed for **ACNH** has since expanded, and the subcontractor is now classified as a delegated entity. **ACNH** has implemented a mechanism through the monthly Procurement Governance Meeting to ensure that vendors and delegates are classified appropriately to ensure that pre-assessment of delegated entities is conducted to align with internal policies and contract requirements. 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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element requiring the MCO to have a written agreement with the subcontractor that includes several requirements. To correct the deficiency, **ACNH** presented the Seventh Amendment To the Master Services Agreement Between the subcontractor and AmeriHealth Caritas Services, LLC, effective 1/1/23. The seventh amendment was signed by the subcontractor and **ACNH** on 2/28/23 and 3/6/23, respectively. **ACNH** explained that due to a system upgrade, the MCO was unable to produce a version of the amendment that was signed in calendar year 2022. **ACNH** did provide a screen shot of an email from **ACNH** to the subcontractor, dated 9/29/22, that included the NH regulatory requirements language amendment as an attachment. **ACNH** has implemented internal mechanisms to ensure proper retention and backup of subcontractor documents. 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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant for the element requiring the MCO to include in its contract that the subcontractor can be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later. To correct the deficiency, **ACNH** presented the Seventh Amendment To the Master Services Agreement Between the subcontractor and AmeriHealth Caritas Services, LLC, effective 1/1/23. The seventh amendment was signed by the subcontractor and **ACNH** on 2/28/23 and 3/6/23, respectively. **ACNH** explained that due to a system upgrade, the MCO was unable to produce a version of the amendment that was signed in calendar year 2022. **ACNH** did provide a screen shot of an email from **ACNH** to the subcontractor, dated 9/29/22, that included the NH regulatory requirements language amendment as an attachment. **ACNH** has implemented internal mechanisms to ensure proper retention and backup of subcontractor documents. The seventh amendment to the subcontractor's delegation agreement included the language related to subcontractor agreement to be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later. 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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the subcontractor agreement to include the requirement to notify the MCO within one business day of being cited by any State or federal regulatory authority. To correct the deficiency, **ACNH** presented the Seventh Amendment To the Master Services Agreement Between the subcontractor and AmeriHealth Caritas Services, LLC, effective 1/1/23. The seventh amendment was signed by the subcontractor and **ACNH** on 2/28/23 and 3/6/23, respectively. **ACNH** explained that due to a system upgrade, the MCO was unable to produce a version of the amendment that was signed in calendar year 2022. **ACNH** did provide a screen shot of an email from **ACNH** to the subcontractor, dated 9/29/22, that included the NH regulatory requirements language amendment as an attachment. **ACNH** has implemented internal mechanisms to ensure proper retention and backup of subcontractor documents. The seventh amendment to the subcontractor's delegation agreement included the requirements to notify the MCO within one business day of being cited by any State or federal regulatory authority. This element is *Met.*			

Table 6-5—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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the MCO to require the subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act (DRA) of 2005 requirements. To correct the deficiency, **ACNH** presented the Seventh Amendment To the Master Services Agreement Between the subcontractor and AmeriHealth Caritas Services, LLC, effective 1/1/23. The seventh amendment was signed by the subcontractor and **ACNH** on 2/28/23 and 3/6/23, respectively. **ACNH** explained that due to a system upgrade, the MCO was unable to produce a version of the amendment that was signed in calendar year 2022. **ACNH** did provide a screen shot of an email from **ACNH** to the subcontractor, dated 9/29/22, that included the NH regulatory requirements language amendment as an attachment. **ACNH** has implemented internal mechanisms to ensure proper retention and backup of subcontractor documents. The seventh amendment to the subcontractor's delegation agreement included the requirement that the subcontractor have a compliance plan that meets the requirements of 42 CFR §438.608 and policies and procedures that meet the DRA of 2005 requirements. This element is *Met.*			

Table 6-6—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 I—Delegation and Subcontracting	88.6%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the MCO and subcontractor agreement to include a provision for revocation of delegation activities or obligations; issues pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965 (non-discrimination in hiring and employment of governmental contractors) unless exempted by rules, regulations, or orders of the Secretary of Labor; and implementing policies and procedures for reporting of all overpayments identified to the State. To correct the deficiency, **ACNH** presented the Seventh Amendment To the Master Services Agreement Between the subcontractor and AmeriHealth Caritas Services, LLC, effective 1/1/23. The seventh amendment was signed by Icario and **ACNH** on 2/28/23 and 3/6/23, respectively. **ACNH** explained that due to a system upgrade, the MCO was unable to produce a version of the amendment that was signed in calendar year 2022. **ACNH** did provide a screen shot of an email from **ACNH** to the subcontractor, dated 9/29/22, that included the NH regulatory requirements language amendment as an attachment. **ACNH** has implemented internal mechanisms to ensure proper retention and backup of subcontractor documents. This element is *Met.*			

Table 6-7—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 XI—Network Management	99.5%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the MCO to develop and furnish provider education materials to ensure that physical health providers know when to refer members who need BH services to a BH provider, and BH providers know when to refer members who need physical health services to physical health providers. To correct the deficiency, **ACNH** presented the updated Provider Training slide deck that discussed the Behavioral Health Toolkit, which includes information regarding referring members needing physical or BH services. The updated Provider Manual specified that providers must review the Behavioral Health Tool Kit and other training resources available on the **ACNH** website and refer members who are identified as having risk factors for either physical or BH to be connected with their assigned primary care or BH provider using resources outline in chapter seven of the Behavioral Health Tool Kit. The Provider Training slide deck and Provider Manual require DHHS review and approval. **ACNH**'s target date for completion is 10/1/23. This element is *Met.*			

Table 6-8—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 XI—Network Management	99.5%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the MCO to develop and make available provider support services including a dedicated contact number to MCO staff located in New Hampshire available from 8:00 am to 6:00 pm Monday through Friday and 9:00 am to 12:00 pm on Saturday for the purposes of answering questions related to contracting, billing, and service provision. To correct the deficiency, **ACNH** explained that the provider recruitment line, a toll-free telephone number (855-332-0104), will be included on the **ACNH** website as well as in the Provider Manual. Messages left on the provider recruitment line are automatically forwarded to two **ACNH** account executives. The receiving account executives are expected to respond to provider messages left on the provider recruitment line or forward to covering personnel to respond as soon as possible. A review of the **ACNH** website and Provider Manual revealed that the specified toll-free provider recruitment number was not found; however, when dialing the specified toll-free telephone number, the call connected to the **ACNH** Provider Recruitment voice mailbox, as described by **ACNH**. **ACNH** must ensure that its website offers the Provider Recruitment telephone number for MCO staff located in New Hampshire is available from 8:00 am to 6:00 pm Monday through Friday, and 9:00 am to 12:00 pm on Saturday for the purposes of answering questions related to contracting, billing, and service provision. **ACNH** also must ensure that the inclusion of the dedicated provider telephone number in the Provider Manual is completed as soon as possible after DHHS approval. The proposed plan of action, once approved by DHHS and implemented, will meet the requirements of this element. This element is *Met*.			

Table 6-9—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 XI—Network Management	99.5%	100%
ACNH's Contract Compliance Response			
ACNH was found non-compliant with the element requiring the parties to a State fair hearing to include the MCO as well as the provider. To correct the deficiency, **ACNH** submitted proposed new language for the Provider Manual that included information specifying that the parties to a State fair hearing include the MCO as well as the provider. The updated Provider Manual must undergo DHHS review and approval. **ACNH** anticipates a 10/1/23 target completion date. This element is *Met*.			

PIPs

The SFY 2023 EQR Technical Report contained opportunities for improvement for **ACNH** in the PIP report. The activities implemented by **ACNH** during SFY 2024 to improve those results are shown below.

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

ACNH's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**ACNH** 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.		

ACNH's PIP Response

- **ACNH** will apply monthly or more frequent as needed, review of data collection and analysis of effect of intervention being tested.
- **ACNH** will meet with HSAG with conclusions of limited time intervention regarding whether outcome of review of data obtained within limited time frame and analysis and data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal is being met.
- **ACNH** will define each PDSA cycle with this own independent start and stop date and completed worksheet and share with HSAG during 2023 to assure that **ACNH** is following HSAG process.
- Implementation of routine follow-up technical assistance calls for feedback pertaining to intervention testing periods as well as review of revisions to interventions and additional interventions for implementation based on data review.
- Non-Clinical PIP-HRA: Intervention #1- extended the initial planned testing period based on failure modes and effects analysis (FMEA) to allow for additional training for true evaluation of impact. This intervention was modified (#2) at the end of the initial extended testing period based on the data obtained with validation gained from HSAG during an additional technical assistance call and implementation of any recommendations received from the review of PIP intervention progress forms and worksheets. To date **ACNH** has incorporated frequent technical assistance (TA) calls with HSAG to ensure proper progress reporting and is now in process of collecting data from the revised intervention to facilitate data-driven analysis for consideration of an additional cycle for modification or new implementation to support achievement of the SMART Aim goal.
- PIP-IMA-HPV: Intervention #1 was completed and abandoned after cycle #1 based on data review at the completion of the cycle with an additional intervention in progress at present. HSAG feedback from technical assistance calls was implemented and approval of a new module 3 was granted. An additional technical assistance call is being planned after a complete review of data has been obtained to present for evaluation and consideration of any necessary revisions or interventions to follow.
- **ACNH** has been successful in implementing shorter testing periods throughout the process for both PIPs during 2022–2023. Routine additional TA calls have assisted with ensuring proper protocol for PIP implementations and documentation for validation.

ACNH's PIP Response
• **ACNH** is utilizing shorter testing periods as advised and has implemented weekly data collection for the analysis of effect of all interventions being tested with clearly identified start and stop dates for each PDSA cycle. • **ACNH** has implemented as part of their present and future PIPs, processes to evaluate for sound data-driven interventions that may allow for shorter testing periods. • **ACNH** has and will continue to utilize HSAG technical assistance calls for review of any changes, modifications, planned timing of PDSA testing cycles and implementation of interventions as well as review of all data utilized to determine effectiveness.

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

ACNH's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**ACNH** 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.		
ACNH's PIP Response			
• All worksheets, including PDSA and data reporting sheets, are reviewed with HSAG and **ACNH** will continue to conduct review and analysis of data from each rapid cycle at conclusion to determine effectiveness for possible further testing, adaption, adoption, or abandonment and will continue to review during all future planned TA calls for validation and recommendations. • **ACNH** has referred to its key driver diagram and identified failure modes within the FMEA table for determination of new interventions. This has resulted in successful implementation of modifications to interventions as well implementation of additional interventions for testing based on data driven PDSA cycle results which have all gained approval for testing from HSAG. • As of June 2023, **ACNH** has passed all Modules 1-3 and gained approval for current modification of one intervention and implementation of a new intervention with a passed additional Module 3. Both PIP interventions are currently being tested as approved and advised by HSAG and at current data collection continues for evaluation and submission of additional modifications or interventions needed. • **ACNH** will continue to utilize all worksheets, including PDSA and data reporting sheets, to be reviewed with HSAG, and **ACNH** will continue to conduct review and analysis of data from each rapid cycle at conclusion to determine effectiveness for possible further testing, adaption, adoption, or abandonment and will continue to review during all future planned TA calls for validation and recommendations.			

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

ACNH's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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.		
ACNH's PIP Response			
• **ACNH** will utilize and complete the supplemental Intervention Progress Form as it tests all interventions to capture successes, challenges, and/or confounding factors related to intervention-specific events and/or activities as they occur. • **ACNH** utilizes the supplemental Intervention Progress Form for each intervention being tested throughout the PIP process and will refer for review with HSAG during TA calls. • **ACNH** has been able to identify any challenges and successes by utilizing the form in conjunction with ongoing data evaluation, which in turn has assisted in not only identification of any challenges but specific issues that may warrant consideration for activities related to the intervention for modification or rectification. • This has resulted in successful implementation of modifications to interventions as well as implementation of additional interventions for testing based on data driven PDSA cycle results which have all gained approval for testing from HSAG.			

NAV

The SFY 2023 EQR Technical Report contained opportunities for improvement for **ACNH** in the NAV report. The activities implemented by **ACNH** during SFY 2024 to improve those results are shown below.

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

ACNH's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	Network Capacity Analysis Results for MLADCs—Percent of Providers in the State	34.2%	70% of all providers
	Residential SUD Treatment Programs—Percent of Regions With Required Number of Providers per Region	38.5%	100%
	Percent of Members with Required Access to Pediatric Allergists	77.0%	100%
	Percent of Members with Required Access to Pediatric Ophthalmologists	0.0%	100%
	Counties Not Meeting the Required Time/Distance Standards—Coos County	18	26

ACNH's NAV Response
• ACNH will research additional contracting opportunities to meet State and regional standards for MLADCs, buprenorphine prescribers, residential SUD treatment programs, and peer recovery programs by reviewing the NH Medicaid listing and the Substance Abuse and Mental Health Services Administration (SAMHSA) provider listing for providers of these types and outreach to those providers for interest in participation with ACNH. • ACNH will analyze possible contracting opportunities in bordering states of Coos County, NH, to determine if there are any providers that can assist with filling the gaps for the lack of providers in Coos County to meet network adequacy standards. • ACNH believes that members may have access to providers that are not defined by the specific taxonomy codes provided by DHHS for the measurement categories of pediatric allergy and pediatric ophthalmology and will conduct outreach to providers whose specialty is not specific to those taxonomy codes to determine if they treat pediatric patients. The ACNH online provider directory provides an option to search by age of the member being treated. ACNH will also work specifically with the subcontractor for vision on contracting opportunities for pediatric ophthalmology. • ACNH has reviewed data and made outreach where applicable. • ACNH contracted with Confidant, a behavioral health / SUD provider that provides care statewide. • ACNH reviewed providers in Maine and Vermont to ensure all potential providers have been contacted.

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

ACNH's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	ACNH should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG, particularly with respect to identifying pediatric specialists and residential SUD treatment programs.		
ACNH's NAV Response			
• ACNH utilizes the requirements as defined by the NH DHHS network adequacy template for defining provider types for the HSAG file submission and will conduct quality checks on that data prior to submission. • ACNH will complete the above analysis and outreach to providers over the coming months and will track changes concerning if recruiting efforts that are successful in closing the gaps. • ACNH has implemented a quality review for HSAG requests to ensure accuracy of the data files being submitted including that all required data elements are included in the submissions. • ACNH has several associates that review HSAG requests, and that validation is completed on the outlined requirements prior to submission.			

CAHPS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **ACNH** in the CAHPS measures. The activities implemented by **ACNH** during SFY 2024 to improve those results are shown below.

Table 6-15—CAHPS—Opportunities for Improvement and MCO Response

ACNH's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**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 has implemented and continues with a broadened approach to outreach members for engagement and recruitment to join the **ACNH** Member Advisory Board, including an incentive for members actively involved. **ACNH** has conducted additional focus surveys from members to obtain timely feedback and collaboration related to improvement for programming and identifying areas for improvement. These surveys and follow-up outreach are being conducted to include those members immediately following disenrollment in an attempt to gain timely feedback and identification of opportunities. **ACNH** has opened a community wellness center and has implemented several programs and events as a result of such feedback obtained from members.			

Table 6-16—CAHPS—Opportunities for Improvement and MCO Response

ACNH's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
CAHPS	Child Medicaid CAHPS Results: *Rating of Personal Doctor*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average
ACNH's CAHPS Response			
ACNH has implemented additional and ongoing recruiting efforts to include all providers for both primary care and specialist care providers in an effort to expand member options. Additional efforts have been focused on member communication related to providing assistance with assuring proper provider designation based on member preference or change in geography. The member website has been updated to streamline information and assist with provider assignment.			

HEDIS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **ACNH** in 11 HEDIS measures. The activities implemented by **ACNH** during SFY 2024 to improve the HEDIS results are shown below.

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
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
ACNH's HEDIS Response			
Continued education of appropriate documentation to providers has been included with all gaps in care reviews with providers as well as with medical record requests. **ACNH** continues to gain feedback from providers for identification of barriers. Both physician and member incentives were implemented during 2023 for promotion of wellness visits and closing gaps in care. **ACNH** continues to promote the use of data exchange with providers.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*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
ACNH's HEDIS Response			
Continued education of appropriate documentation to providers has been included with all gaps in care reviews as well as with record requests. **ACNH** continues to gain feedback from providers for identification of barriers. In addition to the member incentives for promotion of healthy behaviors and well visits, a provider incentive was implemented for completion of well visits for identified members with gaps in care. **ACNH** continues to promote the use of data exchange with providers.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*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
ACNH's HEDIS Response			
Continued education of appropriate documentation to providers has been included with all gaps in care reviews as well as with record requests. **ACNH** continues to gain feedback from providers for identification of barriers. Member outreach for promotion of annual visits via texting campaigns, calls, and mailings was completed in 2023. In addition to the member incentives for promotion of healthy behaviors and well visits, a provider incentive was implemented for completion of well visits for identified members with gaps in care. **ACNH** continues to promote the use of data exchange with providers.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO 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
ACNH's HEDIS Response			
HEDIS measurement year 2023 *Immunizations for Adolescents (IMA)—Combination 1* did result in an increase over the prior year 2022 results, from 62.26% to 64.96%. **ACNH** implemented targeted outreach to parents of adolescents identified with gaps in care for well visits both via mailing and calls for the promotion of education related to immunizations and available incentives for completing well visits and closing gaps in care. **ACNH** conducted outreach efforts with PCPs for provision of education related to closing identified gaps in care and resolutions as well as continued promotion of data exchange with providers for collection of the needed data.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV [human papillomavirus])*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
ACNH implemented several interventions including: • Both member and provider outreach via email, texting campaigns, fax, mailing, and telephone to address identified gaps in care. • Additional member incentives were implemented for adolescents who completed the necessary vaccination series. • This measure is included in the **ACNH** provider value-based payment program for providers. HEDIS MY 2023 *Immunizations for Adolescents (IMA)—Combination 2* did result in an increase over the prior year 2022 results, from 22.04% to 24.22%. In addition to promotion of annual well visits, **ACNH** has focused on the HPV element of the IMA measure as part of a performance improvement project in 2023. Initiatives that were implemented included: • Mailings to parents of members aged 9–12 who were identified with a gap in care. • Telephonic outreach for reminders of annual well visits and/or vaccinations due. • Outreach to providers for review of gaps in care and for scheduling visits for closing those gaps in care. • Outreach efforts with PCPs for provision of education related to closing identified gaps in care and resolutions as well as continued promotion of data exchange with providers for collection of the needed data.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Cervical Cancer Screening (CCS)*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
The **ACNH** MY 2023 *Cervical Cancer Screening* rate has demonstrated an increased rate of 5% over the prior MY 2022 rate. **ACNH** implemented and will continue to include the women's health value-based payment program for providers and continue outreach with reminders to those members who have not had a cervical cancer screening by our care management team. The **ACNH** Provider Network Management team continues outreach efforts with PCPs for provision of education related to closing identified gaps in care and resolutions as well as continued promotion of data exchange with providers for collection of the needed data for this measure.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
ACNH has implemented programming for women's health and continues to outreach providers and members for not only identification of barriers, but to provide education on the need for screening. The **ACNH** Provider Network Management team continues outreach efforts with PCPs for provision of education related to closing identified gaps in care and resolutions.			

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

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
ACNH has implemented incentive programs and outreach to members to provide education and awareness including: • Enrollment in the **ACNH** Bright Start program and care management outreach. • Programs for both prenatal and postpartum mothers including wellness center events, such as baby showers.			

ACNH's HEDIS Response
• **ACNH** has implemented and continues to offer incentives for both members and providers for closing gaps in care including a women's health value-based program. **ACNH** will continue to outreach to members to encourage timely prenatal visits and education and to provide information of upcoming programming and eligible incentives. Continued outreach to providers and members has ensued for not only identification of barriers, but to provide education on the need for timely visits and follow up. The **ACNH** Provider Network Management team continues outreach efforts with PCPs for provision of education related to closing identified gaps in care and resolutions as well as continued promotion of data exchange with providers for collection of the needed data for this measure.

Table 6-25—HEDIS—Opportunities for Improvement and MCO Response

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Poor Control (>9.0%)*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
• **ACNH** implemented a provider incentive for the submission of CPT II codes in an effort to gain additional evidence or documentation needed to improve results. • Outreach efforts were expanded with providers by the **ACNH** Provider Network Management team to educate them concerning the use of the **ACNH** provider portal for care gaps inquiry and resolutions as well as available data exchange options and use of CPT II codes. • **ACNH** continues to promote HEDIS data exchange with providers to collect needed information for this hybrid measure.			

Table 6-26—HEDIS—Opportunities for Improvement and MCO Response

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control (<8.0%)*	Below the 25th Percentile	Equal to or Higher than the National Average
ACNH's HEDIS Response			
ACNH demonstrated an increase in the HEDIS *Hemoglobin A1c Control for Patients With Diabetes (HBD)—HbA1c Control* rate for patients with diabetes during HEDIS MY 2023 from the HEDIS MY 2022 rate of 40.39% to 50.12%. **ACNH** implemented several actions during 2023: • Inclusion of this as a priority measure included in provider value-based program. • Implementation of an incentive for the utilization of CPT II codes.			

ACNH's HEDIS Response
• Expand outreach efforts with providers by the **ACNH** Provider Network Management team to educate them concerning the use of the **ACNH** provider portal for care gaps inquiry and resolutions as well as available data exchange options and use of CPT II codes. • **ACNH** continues to promote HEDIS data exchange with providers to collect needed information for this hybrid measure.

Table 6-27—HEDIS—Opportunities for Improvement and MCO Response

ACNH's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**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			
The *Asthma Medication Ratio (AMR)—Total* rate for HEDIS MY 2023 of 56.02% showed an increase over the MY 2022 rate of 52.61%. **ACNH** implemented several actions in an effort to increase compliance during MY 2023 including: • Additional review of medication adherence data in conjunction with the Pharmacy Benefits Management program reporting and the **ACNH** Director of Pharmacy services to identify potential opportunities from any identified trends noted. • Outreach to prescribing providers for review of identified gap in care. • Expanded provider outreach by Network Management Account Executives with PCPs to educate providers on the use of the **ACNH** provider portal care gaps inquiry and resolutions on how to close gaps in care. • Medication review and follow-up: **ACNH** care management staff has detailed protocol for member transitions of care from inpatient to ambulatory care including follow-up of medications as well as outreach for engagement into programming and education for members with identified chronic conditions and gaps in care.			

EDV

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

ACNH's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837 Professional (P): Initial Submission Within 14 Days of Claim Payment	99.9%	100%
ACNH's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

New Hampshire Healthy Families

The SFY 2023 EQR Technical Report contained opportunities for improvement for **NHHF** in contract compliance, PIP, NAV, CAHPS, HEDIS, and EDV. Except for contract compliance, the following tables display the self-reported activities conducted by **NHHF** during SFY 2024 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2023 EQR Technical Report contained opportunities for improvement in contract compliance for **NHHF**. 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 2024 to improve the contract compliance results are shown below.

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to have a written agreement that includes several requirements. To correct this deficiency, on 12/12/23, **NHHF** submitted the subcontractor's Amendment to Services Agreement, effective 12/1/23. The Amendment included specific information related to the subcontractor's reporting responsibilities and the process to transition services when the agreement expires or terminates. The Amendment specified that the subcontractor is not delegated for grievances or appeals and noted that **NHHF** and the subcontractor will work together to resolve a member grievance or appeal that is received by either party. The Amendment to Services Agreement, effective 8/16/23, noted that the subcontractor must adhere to all applicable State and federal laws and applicable regulations and sub-regulatory guidance that provides further interpretation of law, including subsequent revisions whether or not listed in the Amendment or the State Contract. The 8/16/23 Amendment mentioned 42 CFR §438.100 and §438.414, referencing enrollee rights and the grievance and appeal system. HSAG suggests that **NHHF** include the enrollee rights in the subcontractor agreement. This element is *Met.*			

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to include in its contract that the subcontractor can be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later. To correct the deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment that addressed the subcontractor's obligation to agree to the possibility of being audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later. This element is *Met.*			

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the subcontractor agreement to include the requirement to notify the MCO within one business day of being cited by any State or federal regulatory authority. To correct the deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and required the subcontractor to notify **NHHF** within one business day of being cited by any state or federal regulatory authority. This element is *Met.*			

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to require its subcontractors to investigate and disclose to the MCO any identified persons who have been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those			

NHHF's Contract Compliance Response
programs. To correct this deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and discussed the items pertaining to ownership and controlling interests and criminal convictions, as required by this element. This element is *Met.*

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

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to require its subcontractors to screen its directors, officers, employees, contractors, and subcontractors against each of the Exclusions Lists on a monthly basis and report to the MCO any person or entity appearing on any of the Exclusion Lists and begin termination proceedings within 48 hours. To correct this deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and included the requirement that subcontractors screen its directors, officers, employees, contractors, and subcontractors against each of the Exclusion Lists on a monthly basis 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. This element is *Met.*			

Table 6-34—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to require the subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the DRA of 2005 requirements. To correct the deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and addressed the requirement for the subcontractor to have a compliance plan that meets the requirements of 42 CFR Section 438.608 and policies and procedures that meet the Deficit Reduction Act of 2005 requirements. This element is *Met.*			

Table 6-35—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to ensure the subcontractor's agreement prohibits the subcontractor from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories. To correct this deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and maintained that subcontractors are prohibited from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories. This element is *Met.*			

Table 6-36—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO and subcontractor agreement to include provisions for revocation of delegation activities or obligations; complying with the Americans with Disabilities Act; issues pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965 (non-discrimination in hiring and employment of governmental contractors) unless exempted by rules, regulations, or orders of the Secretary of Labor; implementing policies and procedures for reporting of all overpayments identified to the State; and complying with all applicable Medicaid laws and regulations. To correct this deficiency, **NHHF** presented the updated subcontractor agreement (effective 8/16/23) as evidence of compliance with the requirements of this element. Attachment A of the agreement included the NH Medicaid Product Attachment and contained language specific to the items as required by this element. This element is *Met.*			

Table 6-37—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard I—Delegation and Subcontracting	79.5%	100%

NHHF's Contract Compliance Response
NHHF was found non-compliant with the element requiring the MCO to include in its subcontractor agreement the activities and obligations, related reporting responsibilities, and a provision for revocation of the delegation of activities or obligations when the subcontractor has not performed satisfactorily. To correct this deficiency, **NHHF** submitted the subcontractor Amendment to Services Agreement, effective 12/1/23. The Amendment included specific information related to the subcontractor's reporting responsibilities. Exhibit A: New Hampshire Medicaid Reporting Requirements information contained within the Amendment offered the report name, report description, reporting frequency, and the submission schedule/reporting period. The updated Amendment language met the requirements of this element. This element is *Met.*

Table 6-38—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XI—Network Management	94.8%	100%
NHHF's Contract Compliance Response			
New Hampshire MCOs must follow credentialing requirements established by NCQA to obtain accreditation from that organization. The MCM Contract between the MCOs and DHHS also requires MCOs to follow New Hampshire Revised Statutes RSA 420-J:4 Credentialing Verification Procedures. Although NCQA no longer requires verification of hospital privileges, that requirement is found in RSA 420-J:4. In past years, HSAG has accepted a letter from hospitals as verification of privileges. On 9/19/23, HSAG conducted a Microsoft Teams meeting with **NHHF** to explain that hospital privileges now could be verified by receiving a letter from the hospital or by viewing the hospital's website to confirm that a provider had privileges at that facility. This change, approved by DHHS, meant that two files found non-compliant for hospital privileges would be rescored from *Not Met* to *Met*. Fourteen initial credentialing files and five recredentialing files did not contain evidence of verification of hospital privileges by either electronic verification or by producing a letter from a hospital verifying a provider's privileges. In a previous response to this CAP, **NHHF** confirmed that corrective measures would include refresher training for all credentialing specialists and operations auditors, as well as a separate focused quality monitoring of this element. Because the credentialing and recredentialing file reviews are *point in time* reviews, **NHHF** has implemented a plan of action to correct the deficiencies and ensure that future provider credentialing and recredentialing files include evidence of verification of hospital privileges during the credentialing/recredentialing process. Acceptable verifications for hospital privileges include either electronic verification including the date the electronic file was reviewed and the initials of the person viewing the information or by producing a letter from the hospital. This element is *Met.*			

Table 6-39—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XI—Network Management	94.8%	100%
NHHF's Contract Compliance Response			
NHHF was found non-compliant with the element requiring the MCO to ensure that all initial credentialing and recredentialing files include PSV of the practitioner's malpractice insurance. To correct this deficiency, **NHHF** explained that corrective measures will include refresher training for all credentialing specialists and operations auditors, as well as a separate focused quality monitoring of this element. Because the credentialing file reviews are *point in time* reviews, **NHHF** has a plan of action to address the deficiency and ensure that future provider credentialing and recredentialing files include PSV of practitioners' malpractice insurance during the credentialing/recredentialing process. This element is *Met.*			

PIPs

The SFY 2023 EQR Technical Report contained opportunities for improvement for **NHHF** in the PIP report. The activities implemented by **NHHF** during SFY 2024 to improve those results are shown below.

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

NHHF's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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's PIP Response			
• **NHHF** will identify shorter time periods for the current PIP interventions. • **NHHF** will evaluate each intervention timelier to identify opportunities and barriers. • Recommendations received through this audit are being implemented in the current PIP process. • PIP team has been informed of the recommendations to shorten testing periods and will implement in current PIP process for future interventions.			

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

NHHF's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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.		
NHHF's PIP Response			
• The **NHHF** PIP workgroups meet on a regular basis to review the QI tools and determine new interventions. • The key driver diagram, barrier ranking, and fishbone diagram are reviewed during intervention brainstorming to provide guidance for possible new interventions. • The **NHHF** PIP workgroups are currently working on implementation on five initiatives across the two PIPs. • The **NHHF** PIP workgroups will continue to review the QI tools at all meetings.			

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

NHHF's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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.		
NHHF's PIP Response			
• **NHHF** will use the supplemental Intervention Progress form going forward to capture information on factors related to interventions as they occur. • The form will be used during PIP team meetings to organize information related to interventions. • Activities are currently ongoing. It is anticipated that documenting this information will be useful in creating reports about interventions going forward. • The Intervention Progress form will be completed for each new intervention as it is discussed in the PIP team meetings.			

NAV

The SFY 2023 EQR Technical Report contained opportunities for improvement for **NHHF** in the NAV report. The activities implemented by **NHHF** during SFY 2024 to improve those results are shown below.

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

NHHF's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	Network Capacity Analysis Results for MLADCs—Percent of Providers in the State	16.5%	70% of all providers
	Network Capacity Analysis Results for MLADCs—Percent of Regions With Required Number of Providers per Region	92.3%	100%
	Residential SUD Treatment Programs—Percent of Regions With Required Number of Providers per Region	38.5%	100%
	Counties Not Meeting the Required Time/Distance Standards—Coos County	20	26

NHHF's NAV Response

- Continue quarterly standing review of all open network adequacy gaps.
- Add a review by public health region into our quarterly standing review process.
- Utilize Quarterly Out of Network claims data analysis reports to review for potential available providers.
- Encourage telehealth provider utilization for Coos County.
- Work with DHHS to provide feedback on the list of "available providers" via our Network 01 report.

The above identified activities are ongoing and will be continued via the remainder of 2023. Specific steps include:

- A quarterly review of all standing gaps utilizing the state Medicaid Management Information System (MMIS) file, National Plan & Provider Enumeration System (NPPES), SAMHSA provider lists, review of competitor networks and Quest Access and Adequacy monitoring system.
- Going forward our quarterly network monitoring process will add in steps to compare the public health networks as available through our Quest monitoring system.
- Quarterly our Corporate partners have established a Top 20 Out of Network (OON) Report analyzing providers and practitioners that our members are utilizing. We use these reports to determine if there are practitioners under a participating provider that have not yet been enrolled. In these instances, we reach out to the provider and request an enrollment form be submitted and the practitioner be enrolled into our system. For Providers who are not yet contracted the information is shared with the Contracting team to engage the provider.
- Members are informed of telehealth availability and our Utilization Management teams encourage use of telehealth providers in cases where availability is limited by specialty or location.

NHHF's NAV Response
• We continue to provide feedback to DHHS annually via our Network 01 report on the specialists who are listed as "available" for the SUD specialties. Many of the practitioners are not truly available in that they do not have a NH license or Medicaid ID or are no longer practicing in NH. Activities above are completed regularly and result in additional practitioners/providers continually being added to our network. **NHHF** will continue to regularly monitor our network to ensure ample provider availability to our members.

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

NHHF's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	**NHHF** should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.		
NHHF's NAV Response			
• **NHHF** will work with DHHS and HSAG to ensure the data pulled to support the audit are accurate and complete prior to submission. • The Network Reporting Analyst will review the instructions and template provided by DHHS and HSAG. • The Network Reporting Analyst will attend any meetings scheduled by DHHS/HSAG regarding the file completion instructions. • The Network Reporting Analyst will quality check the file prior to submission			

CAHPS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **NHHF** in one CAHPS measure. The activities implemented by **NHHF** during SFY 2024 to improve the CAHPS results are shown below.

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

NHHF's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
CAHPS	Child Medicaid CAHPS Results: *Rating of All Health Care*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average

NHHF's CAHPS Response
NHHF implemented several targeted interventions and activities during SFY 2024. These initiatives focused on enhancing health care experiences for young children and young adults, as well as promoting preventive care and wellness. 1. My Health Pays: o **NHHF**'s My Health Pays platform is a comprehensive wellness program designed for children aged 0–18, focusing on both physical and mental health. This program encourages healthy behaviors by offering incentives, such as the opportunity for children to earn up to $250 annually for participating in preventive health behaviors. This initiative supports preventive care efforts, aligning with CAHPS' goals of improving health care satisfaction and engagement among young members. 2. Programs and Campaigns: o Kicks for Kids: To promote wellness visits for members aged 12–17, **NHHF** launched the "Kicks for Kids" initiative, offering 10 $100 Nike gift cards monthly as rewards. This program is designed to increase engagement in routine health care, improving access to preventive services. o Lead Screening Program: For children aged 0–2, **NHHF** introduced a lead screening incentive, offering a monthly drawing for five $100 Amazon gift cards. This initiative aims to encourage early detection and prevention, which can improve both clinical outcomes and member satisfaction. 3. Community Programs: o **NHHF** expanded its outreach beyond members, engaging the broader community through various social support programs and events: ▪ Green to Go Mobile Food Pantry: Serving communities across the State with fresh produce and other healthy foods, supporting overall wellness and addressing food insecurity. This program runs eight times per year and helps reinforce **NHHF**'s commitment to holistic health care and well-being. ▪ Strong Youth, Strong Communities: A mental health initiative in partnership with the Pro Football Hall of Fame, designed to address the mental health needs of young people. This aligns with **NHHF**'s focus on both physical and mental health in the My Health Pays program.

HEDIS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **NHHF** in two HEDIS measures. The activities implemented by **NHHF** during SFY 2024 to improve the HEDIS results are shown below.

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

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

NHHF's HEDIS Response

NHHF conducted several activities during SFY 2024 to improve this metric. These initiatives focused on ensuring that pregnant members receive timely prenatal care, which is critical for positive maternal and infant health outcomes.

1. Start Smart for Your Baby:
    - Start Smart for Your Baby is a comprehensive care management program provided at no cost to pregnant members. The program offers a range of services, including maternity case management, health education, smoking cessation support, and referrals for SUD management. These services are designed to ensure that expecting mothers receive the education and care they need throughout their pregnancy to support healthy pregnancies and positive birth outcomes.
    - Through personalized education and frequent communication, this program encourages early engagement in prenatal care, which is critical for reducing complications and promoting the well-being of both mother and baby.
2. Notice of Pregnancy (NOP) Rewards:
    - The NOP Rewards incentivize members to engage in early prenatal care:
        - NOP Reward: Members who complete their NOP within the first trimester (up to 12 weeks) receive a $100 reward. This encourages expecting mothers to establish care early, improving the chances of timely interventions and monitoring for potential risks.
        - NOP Reward: Members who complete their NOP within the second trimester (13-24 weeks) receive a $50 reward.

The Start Smart for Your Baby program, combined with the financial incentives offered through the NOP Rewards, aims to improve the timeliness of prenatal care for **NHHF** members, and ultimately raise **NHHF**'s performance to meet or exceed the national average for this HEDIS measure.

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

NHHF's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Below the 25th Percentile	Equal to or Higher than the National Average

NHHF's HEDIS Response

NHHF conducted several targeted actions during SFY 2024 to improve this metric. These efforts focus on closing care gaps and ensuring that members receiving antipsychotic medications undergo appropriate diabetes screenings, which are essential for managing health risks associated with their medication.

NHHF's HEDIS Response
1. Member Care Gaps Reports: - These reports were distributed to providers and CMHCs to ensure timely intervention and encourage providers to take proactive steps in addressing care gaps. The reports help monitor and track members' health care activities, providing targeted outreach to those in need of screenings. 2. CMHC Scorecards: - CMHC Scorecards were developed and distributed to CMHCs to showcase their performance on the SSD measure. These scorecards highlight how each CMHC is performing in terms of completing diabetes screenings for individuals with schizophrenia or bipolar disorder on antipsychotic medications. By providing this performance data, CMHCs are able to see where they stand in relation to benchmarks and take action to improve their scores. 3. HEDIS Quick Reference Guide (QRG): - The HEDIS QRG is an important resource that **NHHF** distributes to providers and CMHCs along with the care gap reports. This guide outlines the SSD measure requirements, including best practices for managing and tracking diabetes screenings. Quality Provider Liaisons play a critical role in distributing these materials, ensuring that providers and CMHCs have the necessary tools and information to close care gaps. The QRG is also available on-demand through the **NHHF** website, providing easy access for providers and CMHCs to reference whenever needed. This resource serves as a reminder of the importance of diabetes screenings for this vulnerable population and reinforces the best practices for ensuring members receive appropriate care. Through the use of Member Care Gaps Reports, CMHC Scorecards, and the distribution of the HEDIS Quick Reference Guide, **NHHF** is actively working with providers and CMHCs to improve diabetes screening rates for members with schizophrenia or bipolar disorder who are using antipsychotic medications. These initiatives are aimed at improving performance on the SSD measure and ensuring that **NHHF** meets or exceeds the national average, ultimately leading to better health outcomes for this high-risk population.

EDV

Table 6-48—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	**NHHF** should perform more quality checks, such as field-level completeness and validity, reconciliation with financial reports, Electronic Data Interchange (EDI) compliance edits, and claim volume by submission month on the non-emergency medical transportation (NEMT) encounters.	NA	NA
NHHF's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-49—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	**97.0%**	100%
NHHF's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-50—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	**99.7%**	100%
NHHF's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-51—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Element Accuracy (Institutional [I])–Procedure Code	**92.8%**	≥95.0%
NHHF's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-52—Contract Compliance—Opportunities for Improvement and MCO Response

NHHF's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Element Accuracy (I)–Detail Paid Amount	**92.1%**	≥95.0
NHHF's Contract Compliance Response			
DHHS did not require the MCO to follow up on this recommendation.			

WellSense

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in contract compliance, PIP, NAV, CAHPS, HEDIS, and EDV. Except for contract compliance, the following tables display the self-reported activities conducted by **WS** during SFY 2024 to correct the issues identified as requiring improvement.

Contract Compliance

The SFY 2023 EQR Technical Report contained opportunities for improvement in contract compliance for **WS**. 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 2024 to improve the contract compliance results are shown below.

Table 6-53—Contract Compliance—Opportunities for Improvement and MCO Response

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XI—Network Management	96.9%	100%
WS's Contract Compliance Response			
WS was found non-compliant with the element requiring the MCO to monitor the credentialing delegate's activities to ensure that the provider verification requirements are met. To correct the deficiency, **WS** reported that the MCO will collaborate with the subcontractor to develop a standard operating procedure for credentialing and recredentialing activities. **WS** also maintained that the MCO will work with the subcontractor to include credentialing and recredentialing specific metrics in the quarterly Joint Operating Committee meetings beginning 4Q23. **WS** must ensure that the MCO's oversight monitoring includes verifying that the provider files of all credentialing delegates contain the required information to meet the requirements of the NH Code of Administrative Rules. This element is *Met.*			

Table 6-54—Contract Compliance—Opportunities for Improvement and MCO Response

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XI—Network Management	96.9%	100%

WS's Contract Compliance Response
New Hampshire MCOs must follow credentialing and recredentialing requirements established by NCQA to obtain accreditation from that organization. The MCO contract between the MCOs and DHHS also required MCOs to follow New Hampshire Revised Statutes RSA 420-J:4. Although NCQA no longer requires verification of hospital privileges, that requirement is found in RSA 420-J:4. Final results revealed that all but two initial credentialing files and two recredentialing file contained evidence of verification of hospital privileges. Because the credentialing and recredentialing file reviews are *point in time* reviews, **WS** must monitor the credentialing and recredentialing process to ensure that future provider credentialing and recredentialing files include evidence of verification of hospital privileges. Acceptable verifications for hospital privileges include either electronic verification including the date the electronic file was reviewed and the initials of the person viewing the information or by producing a letter from the hospital. This element is *Met*.

Table 6-55—Contract Compliance—Opportunities for Improvement and MCO Response

WS's Contract Compliance Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
Contract Compliance Audit	Standard XI—Network Management	96.9%	100%
WS's Contract Compliance Response			
WS was found non-compliant with the element requiring the MCO to ensure all initial credentialing files contain a copy of a signed attestation statement and attestation concerning the correctness and completeness of an application. To correct this deficiency, **WS** presented additional provider credentialing file information. After re-reviewing the provider credentialing files, **WS** had four initial credentialing files that did not contain evidence of the providers' signed attestation statement and five initial credentialing files that did not contain evidence of an attestation statement regarding the correctness and completeness of the provider's application. Although **WS** indicated there was a portable document format (PDF) error with a page showing up as blank due to a technical error, **WS** must ensure that provider files submitted for credentialing review include copies of all required information. Because the credentialing file review is a *point in time* review, **WS** must monitor the credentialing process to ensure that future provider credentialing files include the required information. This element is *Met.*			

PIPs

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in the PIP report. The activities implemented by **WS** during SFY 2024 to improve those results are shown below.

Table 6-56—PIP—Opportunities for Improvement and MCO Response

WS's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**WS** should continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. The		

WS's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
	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's PIP Response

- **WS** will continue to make data-driven decisions and continue to drive performance through data. We believe strongly in the continuous process methodologies and aim to ensure we follow the model with our strategic process improvement activities.
- **WS** will continue to utilize tools and trainings that are conducted to ensure the PIP process meets HSAG expectations.
- **WS** has dedicated monthly PIP meetings to review PIP progress, data requirements and obstacles (if any).
- **WS** will continue to work collaboratively with departments across the organization to ensure data and required information are obtained accurately and timely.
- **WS** will work to continuously improve the PIP program and associated data driven topics to better serve our members.
- **WS** will incorporate short testing periods into future PIP projects to ensure quick and timely data collection and analyses of effectiveness for each intervention. **WS** has a dedicated PIP project manager involved in PIP development and ensuring HSAG recommendations are pulled into future PIPs.

Table 6-57—PIP—Opportunities for Improvement and MCO Response

WS's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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 as interventions as possible. This will give the MCO the greatest opportunity for achieving the desired outcomes for each PIP.		

WS's PIP Response

- **WS** will continue to utilize tools and trainings that are conducted to ensure the PIP process meets HSAG expectations.
- **WS** has dedicated monthly PIP meetings to review PIP progress, data requirements and obstacles (if any).
- **WS** will continue to work collaboratively with departments across the organization to ensure data and required information is obtained accurately and timely.
- **WS** will work to continuously improve the PIP program and associated data driven topics to better serve our members.

Table 6-58—PIP—Opportunities for Improvement and MCO Response

WS's PIP Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
PIPs	**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.		
WS's PIP Response			
• **WS** will continue to utilize tools and trainings that are conducted to ensure the PIP process meets HSAG expectations. • **WS** has dedicated monthly PIP meetings to review PIP progress, data requirements and obstacles (if any). • **WS** will continue to work collaboratively with departments across the organization to ensure data and required information is obtained accurately and timely. • **WS** will work to continuously improve the PIP program and associated data driven topics to better serve our members. • **WS** will include the Supplemental intervention Progress Form with both current and future PIPs. The form will be a part of the PIP Job Aid being developed by the Quality Department. Quality will obtain updated Supplemental intervention Progress Form from HSAG.			

NAV

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in the NAV report. The activities implemented by **WS** during SFY 2024 to improve those results are shown below.

Table 6-59—NAV—Opportunities for Improvement and MCO Response

WS's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	Network Capacity Analysis Results for MLADCs—Percent of Providers in the State	11.9%	70% of all providers
	Network Capacity Analysis Results for MLADCs—Percent of Regions With Required Number of Providers per Region	76.9%	100%
	Network Capacity Analysis Results for OTPs—75% of all providers	61.5%	75% of all providers
	Network Capacity Analysis Results for OTPs—Percent of Regions With Required Number of Providers per Region	76.9%	100%
	Counties Not Meeting the Required Time/Distance Standards—Coos County*	22	26
	Counties Not Meeting the Standard for Pediatric Ophthalmologists	10	10

HSAG HEALTH SERVICES ADVISORY GROUP

WS's NAV Response

WS's BH subcontractor is contracted with all opioid treatment program (OTP) sites in New Hampshire and disagrees with the findings related to MLADCs, residential SUD treatment programs that are Medicaid enrolled, and peer recovery programs. **WS**'s BH subcontractor will continue to maintain current levels of access to care and continue to address network gaps through the following activities:
• Engage with NH provider community to correct provider held myths about being a Medicaid provider.
• Advocating with NH DHHS for provider rate increases.
• Investigate opportunities for alternative payment arrangements with high volume BH providers.
• Integration with Elevance provider network to increase provider pool.
• Leveraging single case agreements to encourage out of network providers to contract with **WS**'s BH subcontractor.
• Restructure of **WS**'s BH subcontractor's Network department, Provider relations, Value based payment innovations team and Provider quality managers to improve client value and provider service.
• NH Provider Town Hall meetings to encourage new provider contracting.
 	
Implementation:
• **WS**'s BH subcontractor Network integration completed: regional teams now include contracting, provider relations, provider quality management function, as well as our alliance partner relationship model which improves provider relationships through specific targeted activities to drive a localized network strategy focused on increasing access for **WS** members.
• Monthly meetings with DHHS Division of BH standing agenda includes discussion about provider network challenges.
• Integration with the Elevance network is in process and the goal is to have the network integration complete by end of Q2 2024. The Elevance providers were sent notice of the integration and informed that they would be integrated in the NH Medicaid network unless they opted out.
• The NH Town Hall attendance was poor, few providers joined which did not allow **WS**'s BH subcontractor to hear from the provider community.
• **WS**'s BH subcontractor Network strategy and integration has increased the in-network provider pool.
• Investigating an alternative payment structure is in process.
 	
Future Plans:
• **WS**'s BH subcontractor continually monitors its BH network for access and availability. As needed, **WS**'s BH subcontractor's Contracting team engages in contracting efforts.
• The Contracting team focuses network development efforts in the following areas:
  o Underserved areas
  o Alternate levels of care
  o Underrepresented specialties
  o Cultural/language diversity
  o Staff identifies and establishes recruitment needs for practitioners and facilities in specific areas. The need is identified by one or more of the following methods:
  o An analysis of the demand for the practitioners and services in a particular geographic area based on covered lives using a commercially available mapping software (GeoAccess)
  o A client request for increased access or availability
  o Specific practitioner and clinical staff feedback
  o Single-case agreements and out-of-panel authorizations

Table 6-60—NAV—Opportunities for Improvement and MCO Response

WS's NAV Opportunities for Improvement			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
NAV	**WS** should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.		
NHHF's NAV Response			
• **WS** and its vendors will continue to review and monitor data files against requirements prior to the submission process. • **WS** has drafted a policy which is currently under internal review by all respective impacted departments. This step is required to ensure all aspects of the policy are thoroughly evaluated before its official publication. • **WS** will ensure provider network data file accuracy through a systematic approach. This includes clear monitoring protocols, quality control measures, comprehensive documentation, file reviews. • **WS**'s internal review process for the drafted policy is actively underway. • The policy has been circulated among all relevant departments to collect feedback, ensure alignment with organizational goals, and validate compliance with regulatory requirements. • Meetings and discussions are being held to address any concerns or suggested revisions. • Following the review, the policy will be finalized and submitted for executive approval, after which it will be formally published and implemented. • The target date for policy publication is set for end of September 2024.			

CAHPS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in three CAHPS measures. The activities implemented by **WS** during SFY 2024 to improve the CAHPS results are shown below.

Table 6-61—CAHPS—Opportunities for Improvement and MCO Response

WS's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
CAHPS	Child Medicaid: *Rating of All Health Care*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average
WS's CAHPS Response			
September 2024 update: **WS**: 1. Outreached telephonically to caregivers of child members between February and March 2024 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. Caregivers of child members			

WS's CAHPS Response
who were successfully outreached received healthcare assistance from Member Services regarding PCP selection, appointment scheduling, or benefits education. 2. Emailed caregivers of child members in March 2024 as part of our CAHPS "Just in Time" effort encouraging caregivers of high risk child members to call Member Services for help or assistance getting their healthcare needs met. **WS** sent emails in either English or Spanish. Analysis of call data showed 4% of the caregivers emailed did contact Member Services for assistance.

Table 6-62—CAHPS—Opportunities for Improvement and MCO Response

WS's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
CAHPS	Child Medicaid: *Rating of Personal Doctor*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average
WS's CAHPS Response			
September 2024 update: **WS**: 1. Utilized a data-driven approach to identify child members with open care gaps and are likely to report negative CAHPS scores for access and provider satisfaction measures. Caregivers of identified child members were outreached telephonically between August and December 2023 in an effort 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 to get important screenings. Some members did not need help scheduling appointments, while others received assistance with healthcare questions or finding a new PCP. 2. Mailed benefit reminders to caregivers of child members in February 2024 to remind them about covered services, the important role of the PCP, and available member rewards for healthy behaviors, as well as encourage caregivers of child members to schedule an annual checkup and respond to a survey if they received one in the mail. A new Spanish translation version of the benefit reminder postcard was added in the February 2024 campaign. 3. Implemented a PCP Workgroup in Member Services beginning in March 2024, focused on responding to members who call and request assistance in finding a provider accepting new patients or is open for scheduling appointments.			

Table 6-63—CAHPS—Opportunities for Improvement and MCO Response

WS's CAHPS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
CAHPS	Child Medicaid: *Rating of Specialist Seen Most Often*	Statistically significantly lower than the National Average	Equal to or Higher than the National Average

WS's CAHPS Response
September 2024 update: **WS** will include an open-ended custom question in our 2024 Simulation CAHPS Child survey: If you had a problem seeing a specialist as soon as your child needed, what type of specialist were you trying to see? Responses to this question will enable **WS** to identify specialties receiving lower Rating of Specialist scores and design an improvement plan.

HEDIS

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in six HEDIS measures. The activities implemented by **WS** during SFY 2024 to improve the HEDIS results are shown below.

Table 6-64—HEDIS—Opportunities for Improvement and MCO Response

<table>
<tr><th colspan="4">WS's HEDIS Opportunities for Improvement</th></tr>
<tr><th>EQR Activity</th><th>Measure</th><th>MCO Results</th><th>Standard</th></tr>
<tr><td>HEDIS</td><td>Immunizations for Adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)</td><td>Below the 25th Percentile</td><td>Equal to or Higher than the National Average</td></tr>
<tr><th colspan="4">WS's HEDIS Response</th></tr>
<tr><td colspan="4">September 2024 update:
WS efforts to improve the performance on this measure during SFY 2024 include the following:
For HEDIS hybrid measures, WS conducts year-round chart chase to assist with gap closure.
WS publishes Provider Newsletters on our website related to immunization best practices to help promote member compliance.
On the WS website, there is a Quality Corner for providers that contains Tip Sheets and vaccination resources with active links.
On the WS website, there is member education related to immunizations and a link to the CDC's recommended immunizations for children.
In January through August of 2023, WS had a texting campaign to parents/guardians of eligible adolescents that included one brief introductory sentence about the importance of early HPV vaccination, an educational video, and a suggestion to combine HPV vaccination with other vaccines that are due at an annual WCV, this campaign ended early (August 2023) due to unexpected termination of WS's contract with the texting vendor.</td></tr>
</table>

Table 6-65—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—Ages 16–20 Years*	Below the 25th Percentile	Equal to or Higher than the National Average

WS's HEDIS Response

September 2024 update:
WS efforts to improve the performance on this measure during SFY 2024 include the following:

- **WS** has a robust Quality Improvement Program whereby metric performance is monitored on a regular basis.
- Tracking opportunities at provider and group level details has been initiated and is ongoing.
- On the **WS** website, there is member education related to recommended screenings including chlamydia.
- An initial assessment is conducted for high-risk pregnancy members that are identified by case management through a bi-weekly census. Following the assessment, if a possible risk for sexually transmitted infections (STIs), including chlamydia, is identified then educational resources are sent to the member, and the member is encouraged to follow up with their healthcare provider for testing.

Table 6-66—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—21–24 Years*	Below the 25th Percentile	Equal to or Higher than the National Average

WS's HEDIS Response

September 2024 update:
WS efforts to improve the performance on this measure during SFY 2024 include the following:

- **WS** has a robust Quality Improvement Program whereby metric performance is monitored on a regular basis.
- Tracking opportunities at provider and group level details has been initiated and is ongoing.
- On the **WS** website, there is member education related to recommended screenings including chlamydia.
- An initial assessment is conducted for high-risk pregnancy members that are identified by case management through a bi-weekly census. Following the assessment, if a possible risk for STIs, including chlamydia, is identified then educational resources are sent to the member, and the member is encouraged to follow up with their healthcare provider for testing.

Table 6-67—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average

WS's HEDIS Response

September 2024 update:

WS efforts to improve the performance on this measure during SFY 2024 include the following:

- **WS** has a robust Quality Improvement Program whereby metric performance is monitored on a regular basis.
- Tracking opportunities at provider and group level details has been initiated and is ongoing.
- On the **WS** website, there is member education related to recommended screenings including chlamydia.
- An initial assessment is conducted for high-risk pregnancy members that are identified by case management through a bi-weekly census. Following the assessment, if a possible risk for STIs, including chlamydia, is identified then educational resources are sent to the member, and the member is encouraged to follow up with their healthcare provider for testing.

Table 6-68—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Below the 25th Percentile	Equal to or Higher than the National Average

WS's HEDIS Response

September 2024 update:

WS efforts to improve the performance on this measure during SFY 2024 include the following:

- **WS** has a robust Quality Improvement Program whereby metric performance is monitored on a regular basis.
- Tracking opportunities at provider and group level details has been initiated and is ongoing.
- Leverage provider incentive payments from the QIP/Shared Savings alternative payment model (APM) focused on member care
  - Share monthly performance and gap lists with QIP provider groups
  - Hold QIP meetings with provider groups to discuss performance and opportunities
  - Provide end of year settlement details based on performance, highlighting missed opportunities

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
• On the **WS** website, there is provider education about the SSD measure and the needed diabetes screening test. • **WS** partners with its BH subcontractor to assist providers and members, bringing BH care services to where it's needed. Through these partnerships, we are able to provide education to providers and members on the importance of being screened for diabetes when taking specific medications.			

Table 6-69—HEDIS—Opportunities for Improvement and MCO Response

WS's HEDIS Opportunities for Improvement			
EQR Activity	**Measure**	**MCO Results**	**Standard**
HEDIS	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Continuation and Maintenance Phase*	Below the 25th Percentile	Equal to or Higher than the National Average
WS's HEDIS Response			
September 2024 update: **WS** efforts to improve the performance on this measure during SFY 2024 include the following: • **WS** has a robust Quality Improvement Program whereby metric performance is monitored on a regular basis. • **WS** has partnered with the CMHCs in New Hampshire, which allow members more timely access to behavioral health medication management, including ADHD medications.			

EDV

The SFY 2023 EQR Technical Report contained opportunities for improvement for **WS** in EDV. The activities implemented by **WS** during SFY 2024 to improve those results are shown below.

Table 6-70—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	**WS** should perform more quality checks such as Reconciliation With Financial Reports and Electronic Data Interchange (EDI) Compliance Edits on the NEMT encounters that are submitted to DHHS.	NA	NA

WS's EDV Response
WS is in the planning phase of ingesting its transportation subcontractor's pass-through files into the Enterprise Data Cloud Transformation project. The Enterprise Data Cloud Transformation project will include data quality validations and rejecting incomplete claims/encounter data. The Enterprise Data Cloud Transformation project is expected to go live in 2025.

Table 6-71—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Validity of Member Identification Number—Percent Valid	99.9%	100%
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-72—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Validity of Member Identification Number—Percent Valid	99.9%	100%
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-73—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837P: Initial Submission Within 14 Days of Claim Payment	94.5%	100%
WS's EDV Response			
WS has: • Established internal reporting to actively monitor the encounter submission timeliness.			

WS's EDV Response
• Documented the 'as-is' encounter submission process for NH DHHS and is actively working on optimizing the current processes. • With the establishment of new leadership, **WS** is in the process of re-instituting the steering committee to ensure better oversight and efficiency. Internal reporting is established and being utilized. **WS** has continuously met timeliness criteria since January 2024.

Table 6-74—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	837I: Initial Submission Within 14 Days of Claim Payment	99.8%	100%
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-75—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Pharmacy: Initial Submission Within 14 Days of Claim Payment	99.7%	100%
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-76—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Record Omission: Institutional (I)	4.5%	≤4.0%
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-77—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	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
WS's EDV Response			
DHHS did not require the MCO to follow up on this recommendation.			

Table 6-78—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter Submitted to DHHS' Data Warehouse and to HSAG			
EQR Activity	**Measure Standard**	**MCO Results**	**Standard**
EDV	Element Missing: P (Vision)—Secondary Diagnosis Code and Procedure Code Modifier	NA	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS
WS's EDV Response			
WS is now submitting Secondary Diagnosis Code to DHHS for the professional vision encounters. **WS** has modified and tested the extraction processing to include secondary diagnosis code, and are now seeing the secondary diagnosis codes being sent. This is a one-time fix we had to make and going forward this issue should not reoccur.			

Table 6-79—EDV—Opportunities for Improvement and MCO Response

WS's EDV Opportunities for Improvement Comparative Analysis Between Encounter 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 Surgical Procedure Codes	NA	All values submitted by providers to the subcontractors for these fields should be submitted to DHHS

WS's EDV Response
WS's DME vendor is not currently sending **WS** the referring provider NPI. **WS** is planning to address this issue by Q3 of 2023. **WS**'s DME vendor reviewed **WS** data and did not identify claims with referring physician present; hence we don't have this information on the claim.

Appendix A. Performance Measure Rates

This appendix presents the audited performance measure rates for **ACNH**, **NHHF**, and **WS** for SFY 2024.

Table A-1—ACNH, NHHF, and WS Performance Measure Rates

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—A. Belknap*	Quarterly	10/01/2022–12/31/2022	0.3%	3.5%	1.1%
		01/01/2023–03/31/2023	0.0%	3.0%	1.2%
		04/01/2023–06/30/2023	0.0%	2.4%	1.8%
		07/01/2023–09/30/2023	0.0%	2.8%	1.0%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—B. Carroll*	Quarterly	10/01/2022–12/31/2022	0.0%	3.1%	1.2%
		01/01/2023–03/31/2023	0.0%	3.4%	2.7%
		04/01/2023–06/30/2023	0.0%	6.8%	1.9%
		07/01/2023–09/30/2023	0.6%	3.3%	2.5%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—C. Cheshire*	Quarterly	10/01/2022–12/31/2022	0.0%	1.5%	0.6%
		01/01/2023–03/31/2023	0.3%	5.5%	0.5%
		04/01/2023–06/30/2023	0.3%	6.1%	0.6%
		07/01/2023–09/30/2023	0.0%	2.8%	0.4%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—D. Coos*	Quarterly	10/01/2022–12/31/2022	0.0%	2.8%	1.0%
		01/01/2023–03/31/2023	0.0%	1.6%	0.9%
		04/01/2023–06/30/2023	0.0%	0.6%	0.4%
		07/01/2023–09/30/2023	0.0%	2.0%	0.0%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—E. Grafton*	Quarterly	10/01/2022–12/31/2022	0.0%	2.4%	1.2%
		01/01/2023–03/31/2023	0.3%	1.8%	1.5%
		04/01/2023–06/30/2023	0.0%	4.6%	1.3%
		07/01/2023–09/30/2023	0.4%	2.6%	0.4%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—F. Hillsborough*	Quarterly	10/01/2022–12/31/2022	0.2%	4.4%	2.8%
		01/01/2023–03/31/2023	0.3%	4.9%	2.3%
		04/01/2023–06/30/2023	0.0%	8.1%	2.2%
		07/01/2023–09/30/2023	0.1%	4.0%	1.0%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—G. Merrimack*	Quarterly	10/01/2022–12/31/2022	0.5%	3.0%	1.8%
		01/01/2023–03/31/2023	0.2%	3.7%	1.2%
		04/01/2023–06/30/2023	0.0%	7.7%	2.3%
		07/01/2023–09/30/2023	0.3%	4.2%	1.4%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—H. Rockingham*	Quarterly	10/01/2022–12/31/2022	0.3%	7.3%	5.3%
		01/01/2023–03/31/2023	0.5%	8.5%	3.5%
		04/01/2023–06/30/2023	0.1%	8.2%	4.0%
		07/01/2023–09/30/2023	0.2%	6.1%	2.3%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—I. Strafford*	Quarterly	10/01/2022–12/31/2022	0.0%	3.7%	1.9%
		01/01/2023–03/31/2023	0.0%	4.5%	2.3%
		04/01/2023–06/30/2023	0.2%	5.6%	1.5%
		07/01/2023–09/30/2023	0.0%	6.9%	1.0%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County—J. Sullivan*	Quarterly	10/01/2022–12/31/2022	0.0%	1.3%	0.5%
		01/01/2023–03/31/2023	0.0%	1.5%	0.0%
		04/01/2023–06/30/2023	0.0%	0.6%	0.8%
		07/01/2023–09/30/2023	0.0%	4.4%	0.6%
ACCESSREQ.06: *Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County K—Non-New Hampshire/Unknown Counties*	Quarterly	10/01/2022–12/31/2022	0.0%	10.2%	1.5%
		01/01/2023–03/31/2023	0.0%	0.0%	0.0%
		04/01/2023–06/30/2023	0.0%	0.0%	0.0%
		07/01/2023–09/30/2023	0.0%	0.0%	0.0%
APPEALS.01: *Resolution of Standard Appeals Within 30 Calendar Days*	Quarterly	10/01/2022–12/31/2022	100%	100%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	100%	100%	97.0%
		07/01/2023–09/30/2023	100%	100%	98.0%
APPEALS.02: *Resolution of Extended Standard Appeals Within 44 Calendar Days*	Quarterly	10/01/2022–12/31/2022	0.0%	100%	100%
		01/01/2023–03/31/2023	0.0%	100%	0.0%
		04/01/2023–06/30/2023	0.0%	100%	0.0%
		07/01/2023–09/30/2023	0.0%	100%	100%
CLAIM.21: *Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt*	Monthly	06/01/2023–06/30/2023	100%	97.5%	81.9%
		07/01/2023–07/31/2023	99.9%	93.2%	83.9%
		08/01/2023–08/31/2023	98.0%	94.4%	84.5%
		09/01/2023–09/30/2023	95.8%	87.0%	84.3%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—A. Professional Claims Excluding Behavioral Health*	Quarterly	10/01/2022–12/31/2022	100%	99.8%	100%
		01/01/2023–03/31/2023	100%	97.7%	99.6%
		04/01/2023–06/30/2023	100%	99.8%	92.6%
		07/01/2023–09/30/2023	100%	99.6%	98.0%
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—B. Facility Claims Excluding Behavioral Health*	Quarterly	10/01/2022–12/31/2022	100%	99.8%	99.9%
		01/01/2023–03/31/2023	100%	100%	96.4%
		04/01/2023–06/30/2023	99.9%	99.4%	100%
		07/01/2023–09/30/2023	100%	99.8%	100%
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—C. Pharmacy Point Of Service (POS) Claims*	Quarterly	10/01/2022–12/31/2022	100%	100%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	100%	100%	100%
		07/01/2023–09/30/2023	100%	100%	100%
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—D. Non-Emergent Medical Transportation (NEMT) Claims*	Quarterly	10/01/2022–12/31/2022	100%	100%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	100%	100%	100%
		07/01/2023–09/30/2023	100%	100%	100%
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—E. Behavioral Health Professional Claims*	Quarterly	10/01/2022–12/31/2022	100%	98.9%	100%
		01/01/2023–03/31/2023	100%	99.7%	99.7%
		04/01/2023–06/30/2023	99.8%	99.6%	99.9%
		07/01/2023–09/30/2023	99.8%	89.3%	99.1%
CLAIM.26: *Claims Quality Assurance: Claims Financial Accuracy—F. Behavioral Health Facility Claims*	Quarterly	10/01/2022–12/31/2022	100%	95.8%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	94.7%	94.1%	100%
		07/01/2023–09/30/2023	98.1%	99.5%	100%
CMS_A_CDF: *Screening for Clinical Depression and Follow-up Plan—A. Age 12 to 17 Years*	Annually	01/01/2022–12/31/2022	0.1%	0.0%	0.0%
CMS_A_CDF: *Screening for Clinical Depression and Follow-up Plan—B. Age 18 to 64 Years*	Annually	01/01/2022–12/31/2022	0.1%	0.1%	0.0%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
CMS_A_CDF: *Screening for Clinical Depression and Follow-up Plan—C. Age 65 and Older*	Annually	01/01/2022–12/31/2022	0.0%	0.0%	0.0%
CMS_CH_DEV: *Developmental Screening in the First Three Years of Life—A. Children who turned 1 year of age*	Annually	01/01/2022–12/31/2022	40.9%	44.5%	51.1%
CMS_CH_DEV: *Developmental Screening in the First Three Years of Life—B. Children who turned 2 years of age*	Annually	01/01/2022–12/31/2022	49.6%	27.0%	41.6%
CMS_CH_DEV: *Developmental Screening in the First Three Years of Life—C. Children who turned 3 years of age*	Annually	01/01/2022–12/31/2022	44.5%	23.4%	43.1%
CMS_A_INP_PQI01: *Diabetes Short-Term Complication Admissions—A. Age 18–64 Years*	Annually	01/01/2022–12/31/2022	9.7%	13.9%	14.4%
CMS_A_INP_PQI01: *Diabetes Short-Term Complication Admissions—B. Age 65 and Older*	Annually	01/01/2022–12/31/2022	0.0%	12.0%	0.0%
GRIEVANCE.05: *Timely Processing of All Grievances*	Quarterly	07/01/2022–09/30/2022	100%	100%	100%
		10/01/2022–12/31/2022	100%	100%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	97.7%	100%	100%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—A. Benefit Question Non-Rx*	Monthly	07/01/2023–07/31/2023	8.9%	18.9%	14.9%
		08/01/2023–08/31/2023	7.3%	20.6%	14.2%
		09/01/2023–09/30/2023	9.3%	20.1%	15.0%
		10/01/2023–10/31/2023	9.8%	20.3%	15.1%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—B. Rx-Question*	Monthly	07/01/2023–07/31/2023	4.2%	12.1%	5.2%
		08/01/2023–08/31/2023	3.0%	9.8%	5.3%
		09/01/2023–09/30/2023	4.2%	11.1%	5.5%
		10/01/2023–10/31/2023	4.3%	10.9%	5.0%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—C. Billing Issue*	Monthly	07/01/2023–07/31/2023	2.3%	4.5%	2.4%
		08/01/2023–08/31/2023	1.9%	3.9%	2.3%
		09/01/2023–09/30/2023	2.3%	3.7%	2.3%
		10/01/2023–10/31/2023	2.3%	3.1%	2.3%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—D. Finding/Changing a PCP*	Monthly	07/01/2023–07/31/2023	5.6%	9.6%	12.1%
		08/01/2023–08/31/2023	4.3%	10.2%	12.5%
		09/01/2023–09/30/2023	5.3%	9.5%	12.3%
		10/01/2023–10/31/2023	6.3%	10.0%	13.3%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—E. Finding a Specialist*	Monthly	07/01/2023–07/31/2023	2.4%	0.0%	0.6%
		08/01/2023–08/31/2023	2.0%	0.0%	0.9%
		09/01/2023–09/30/2023	2.5%	0.0%	0.9%
		10/01/2023–10/31/2023	2.9%	0.0%	0.8%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—F. Complaints About Health Plan*	Monthly	07/01/2023–07/31/2023	0.1%	0.4%	0.7%
		08/01/2023–08/31/2023	0.1%	0.3%	0.7%
		09/01/2023–09/30/2023	0.2%	0.3%	1.0%
		10/01/2023–10/31/2023	0.2%	0.2%	0.6%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—G. Enrollment Status*	Monthly	07/01/2023–07/31/2023	20.4%	8.1%	24.1%
		08/01/2023–08/31/2023	36.7%	8.6%	23.0%
		09/01/2023–09/30/2023	16.8%	9.0%	21.4%
		10/01/2023–10/31/2023	13.8%	7.7%	20.5%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—H. Material Request*	Monthly	07/01/2023–07/31/2023	5.8%	7.1%	5.4%
		08/01/2023–08/31/2023	4.9%	6.4%	5.8%
		09/01/2023–09/30/2023	6.2%	6.9%	5.5%
		10/01/2023–10/31/2023	6.6%	7.4%	6.0%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—I. Information/Demographic Update*	Monthly	07/01/2023–07/31/2023	11.6%	20.6%	18.4%
		08/01/2023–08/31/2023	8.2%	21.3%	20.4%
		09/01/2023–09/30/2023	10.9%	21.3%	19.3%
		10/01/2023–10/31/2023	11.7%	20.7%	18.7%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—J. Giveaways*	Monthly	07/01/2023–07/31/2023	3.8%	10.9%	4.1%
		08/01/2023–08/31/2023	4.1%	11.7%	4.0%
		09/01/2023–09/30/2023	6.7%	10.5%	6.0%
		10/01/2023–10/31/2023	5.3%	11.0%	4.6%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—K. Other*	Monthly	07/01/2023–07/31/2023	8.5%	7.1%	10.7%
		08/01/2023–08/31/2023	5.8%	7.2%	8.9%
		09/01/2023–09/30/2023	7.3%	7.2%	8.6%
		10/01/2023–10/31/2023	8.4%	8.3%	10.8%
MEMCOMM.06: *Member Communications: Reasons for Telephone Inquiries—L. NEMT Inquiry*	Monthly	07/01/2023–07/31/2023	—	0.8%	1.5%
		08/01/2023–08/31/2023	21.8%	0.0%	2.0%
		09/01/2023–09/30/2023	28.4%	0.5%	2.3%
		10/01/2023–10/31/2023	28.4%	0.5%	2.3%
PDN.04: *Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter—A. Day/Evening Hours*	Quarterly	07/01/2022–09/30/2022	15.7%	24.1%	33.7%
		10/01/2022–12/31/2022	6.7%	20.5%	31.0%
		01/01/2023–03/31/2023	18.4%	17.9%	31.7%
		04/01/2023–06/30/2023	16.2%	14.3%	37.6%
PDN.04: *Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter—B. Night/Weekend Hours*	Quarterly	07/01/2022–09/30/2022	2.5%	3.4%	8.9%
		10/01/2022–12/31/2022	1.3%	2.3%	7.5%
		01/01/2023–03/31/2023	1.2%	2.6%	6.6%
		04/01/2023–06/30/2023	0.4%	2.8%	7.5%
PDN.04: *Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter—C. Intensive Care (Ventilator Dependent) Hours*	Quarterly	07/01/2022–09/30/2022	0.0%	9.8%	4.3%
		10/01/2022–12/31/2022	0.0%	8.7%	3.9%
		01/01/2023–03/31/2023	0.0%	7.0%	3.7%
		04/01/2023–06/30/2023	0.0%	7.1%	4.8%
PDN.04: *Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter—D. Unbilled Hours*	Quarterly	07/01/2022–09/30/2022	81.9%	62.7%	53.2%
		10/01/2022–12/31/2022	92.0%	68.6%	57.5%
		01/01/2023–03/31/2023	80.4%	72.5%	58.1%
		04/01/2023–06/30/2023	83.4%	75.9%	50.0%
PHARM_PDC.01: *Proportion of Days Covered–Diabetes All Class Rate (PDC-DR)*	Annually	01/01/2022–12/31/2022	56.5%	71.4%	68.2%
PHARMUTLMGT.03: *Pharmacy Utilization Management: Generic Drug Substitution*	Quarterly	10/01/2022–12/31/2022	98.0%	98.4%	99.5%
		01/01/2023–03/31/2023	98.0%	98.3%	99.4%
		04/01/2023–06/30/2023	99.0%	98.7%	99.4%
		07/01/2023–09/30/2023	98.0%	99.1%	99.3%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—A. Verifying Member Eligibility*	Monthly	07/01/2023–07/31/2023	5.8%	46.0%	14.4%
		08/01/2023–08/31/2023	6.2%	44.5%	15.9%
		09/01/2023–09/30/2023	6.3%	47.2%	14.1%
		10/01/2023–10/31/2023	7.0%	46.9%	13.8%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—B. Billing/Payment*	Monthly	07/01/2023–07/31/2023	53.9%	27.4%	54.8%
		08/01/2023–08/31/2023	51.2%	27.6%	53.5%
		09/01/2023–09/30/2023	54.4%	32.2%	54.7%
		10/01/2023–10/31/2023	53.6%	32.4%	54.6%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—C. Service Authorization*	Monthly	07/01/2023–07/31/2023	15.1%	15.8%	25.7%
		08/01/2023–08/31/2023	13.8%	20.9%	23.6%
		09/01/2023–09/30/2023	13.0%	16.1%	24.9%
		10/01/2023–10/31/2023	13.4%	16.8%	24.9%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—D. Change of Address, Name, Contact Info., etc.*	Monthly	07/01/2023–07/31/2023	0.1%	0.1%	0.0%
		08/01/2023–08/31/2023	0.2%	0.0%	0.0%
		09/01/2023–09/30/2023	0.1%	0.0%	0.0%
		10/01/2023–10/31/2023	0.2%	0.0%	0.0%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—E. Enrollment/Credentialing*	Monthly	07/01/2023–07/31/2023	0.5%	0.0%	0.4%
		08/01/2023–08/31/2023	0.9%	0.0%	0.3%
		09/01/2023–09/30/2023	0.9%	0.0%	0.4%
		10/01/2023–10/31/2023	0.8%	0.0%	0.3%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—F. Complaints about Health Plan*	Monthly	07/01/2023–07/31/2023	0.4%	0.0%	0.0%
		08/01/2023–08/31/2023	0.1%	0.0%	0.0%
		09/01/2023–09/30/2023	0.4%	0.0%	0.0%
		10/01/2023–10/31/2023	0.4%	0.1%	0.0%
PROVCOMM.07: *Provider Communications: Reasons for Telephone Inquiries—G. Other*	Monthly	07/01/2023–07/31/2023	24.2%	10.7%	4.6%
		08/01/2023–08/31/2023	27.6%	7.1%	6.7%
		09/01/2023–09/30/2023	24.9%	4.5%	5.9%
		10/01/2023–10/31/2023	24.5%	3.8%	6.4%
SERVICEAUTH.01: *Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests*	Quarterly	10/01/2022–12/31/2022	99.2%	98.7%	100%
		01/01/2023–03/31/2023	100%	98.4%	100%
		04/01/2023–06/30/2023	100%	98.6%	100%
		07/01/2023–09/30/2023	96.0%	99.5%	100%

Performance Measure	Reporting Frequency	Period Evaluated	ACNH Rate	NHHF Rate	WS Rate
SERVICEAUTH.03: *Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests*	Quarterly	10/01/2022–12/31/2022	99.7%	99.0%	100%
		01/01/2023–03/31/2023	100%	99.2%	100%
		04/01/2023–06/30/2023	99.5%	99.4%	100%
		07/01/2023–09/30/2023	99.8%	99.0%	100%
SERVICEAUTH.04: *Pharmacy Service Authorization Timely Determination Rate*	Quarterly	10/01/2022–12/31/2022	100%	100%	99.8%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	100%	100%	100%
		07/01/2023–09/30/2023	100%	100%	100%
SUD.42: *MCO Contacts and Contact Attempts Following ED Discharges for SUD—A. Age 0 to 17 Years*	Quarterly	07/01/2022–09/30/2022	100%	16.7%	100%
		10/01/2022–12/31/2022	100%	83.3%	100%
		01/01/2023–03/31/2023	100%	100%	100%
		04/01/2023–06/30/2023	87.5%	100%	100%
SUD.42: *MCO Contacts and Contact Attempts Following ED Discharges for SUD—B. Age 18 or Older*	Quarterly	07/01/2022–09/30/2022	95.4%	46.1%	98.9%
		10/01/2022–12/31/2022	100%	82.4%	100%
		01/01/2023–03/31/2023	99.4%	97.4%	100%
		04/01/2023–06/30/2023	97.5%	100%	100%

— Indicates that indicator data were not provided for the performance measure; therefore, no rate is displayed.

Appendix B. 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
- **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
- **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*
- **APRN—**Advanced Practice Registered Nurse
- **ASAM—**American Society of Addiction Medicine
- **BBA—**Federal Balanced Budget Act of 1997
- **BCS—***Breast Cancer Screening*
- **BH—**behavioral health
- **BMI—**body mass index
- **CAHPS—**Consumer Assessment of Healthcare Providers and Systems
- **CAP—**corrective action plan
- **CASS—**Coding Accuracy Support System of the United States Postal Service
- **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
- **CHL—***Chlamydia Screening in Women*

- **CIS—***Childhood Immunization Status*
- **CM—**clinical modification; case management
- **CMHC—**Community Mental Health Center
- **CMS—**Centers for Medicare & Medicaid Services
- **COPD—**chronic obstructive pulmonary disease
- **COVID-19—**coronavirus disease 2019
- **CPT—**Current Procedural Terminology
- **CWP—***Appropriate Testing for Children with Pharyngitis*
- **CY—**calendar year
- **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
- **DRA—**Deficit Reduction Act
- **DRG—**diagnosis related group
- **EBI—**enterprise business intelligence
- **ED—**emergency department
- **EDA—**encounter data accuracy
- **EDC—**encounter data completeness
- **EDI—**electronic data interchange
- **EDT—**encounter data timeliness
- **EDV—**encounter data validation
- **ENT—**ears, nose, throat; otolaryngologist
- **EPSDT—**Early and Periodic Screening, Diagnostic, and Treatment
- **EQR—**external quality review
- **EQRO—**external quality review organization
- **FAR—**final audit report
- **FFS—**fee-for-service
- **FFY—**federal fiscal year
- **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
- **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*
- **IS**—information systems
- **ISCAT**—Information Systems Capability Assessment Tool
- **IT**—information technology
- **LBP**—*Use of Imaging Studies for Low Back Pain*
- **LO**—National Committee for Quality Assurance Licensed Organization
- **LSA**—legal services agreement
- **LSC**—*Lead Screening in Children*
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MLADC**—Master's Level Alcohol and Drug Counselor
- **MMIS**—Medicaid Management Information System
- **MTM**—Medical Transportation Management
- **MY**—measurement year
- **NA**—not applicable; for HEDIS, small denominator
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NCS**—*Non-Recommended Cervical Cancer Screening in Adolescent Females*
- **NDC**—national drug code

- **NEMT**—non-emergency medical transportation
- **NHHF**—New Hampshire Healthy Families
- **NIA**—National Imaging Associates
- **NOP**—notice of pregnancy
- **NPI**—National Provider Identifier
- **NPPES**—National Plan and Provider Enumeration System
- **NR**—not reported
- **OB/GYN**—obstetrician/gynecologist
- **OON**—out of network
- **OT**—occupational therapist
- **OTP**—opioid treatment provider
- **OUD**—opioid use disorder
- **P**—professional
- **PAHP**—prepaid ambulatory health plan
- **PCE**—*Pharmacotherapy Management of COPD Exacerbation*
- **PCP**—primary care provider
- **PCR**—*Plan All-Cause Readmissions*
- **PDF**—portable document format
- **PDSA**—Plan-Do-Study-Act
- **PDV**—provider directory validation
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project
- **PMV**—performance measure validation
- **PNM**—provider network management
- **POD**—*Pharmacotherapy for Opioid Use Disorder*
- **POS**—place of service or point of service
- **PPC**—*Prenatal and Postpartum Care*
- **PQI**—Prevention Quality Indicator
- **PSV**—primary source verification
- **PT**—physical therapy
- **QA**—quality assurance
- **QAPI**—quality assessment and performance improvement
- **QI**—quality improvement
- **QIP**—Quality Improvement Program (WellCare)

- **QR**—quick response
- **QRG**—HEDIS Quick Reference Guide
- **R**—report
- **RSA**—Revised Statutes Annotated (New Hampshire)
- **RV**—rotavirus
- **SAA**—*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- **SAC**—submission accuracy and completeness
- **SAMHSA**—Substance Abuse and Mental Health Services Administration
- **SFTP**—secure file transfer protocol
- **SFY**—state fiscal year
- **SMART**—specific, measurable, attainable, relevant, and time-bound
- **SMD**—*Diabetes Monitoring for People With Diabetes and Schizophrenia*
- **SSD**—*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- **STI**—sexually transmitted infection
- **SUD**—substance use disorder
- **TA**—technical assistance
- **TBD**—to be determined
- **Tdap**—tetanus, diphtheria, and acellular pertussis vaccine
- **TIN**—taxpayer identification number
- **TOB**—type of bill
- **TPL**—third-party liability
- **UM**—utilization management
- **URI**—*Appropriate Treatment for Children with Upper Respiratory Infection*
- **W30**—*Well-Child Visits in the First 30 Months of Life*
- **WCC**—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- **WCV**—*Child and Adolescent Well-Care Visits*
- **WEDI SNIP**—Workgroup for Electronic Data Interchange Strategic National Implementation Process
- **WS**—WellSense Health Plan

Appendix C. 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, or PAHP 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.[48]
- ***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."[49] 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).[50]

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[48] U. S. Government Publishing Office. (2024). *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: Jan 13, 2025.

[49] NCQA. *2023 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2023: UM5.

[50] U. S. Government Publishing Office. (2024). *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: Jan 13, 2025.

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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),[51] 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.[52,53,54] To create the process, tools, and interview questions used for the compliance reviews, HSAG follows the guidelines set forth in the CMS EQR Protocol 3. 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 EQR Protocols published in February 2023[55] define the five activities included in the review of compliance with Medicaid and CHIP managed care regulations. Table C-1 displays the activities and indicates the process HSAG uses to ensure compliance with those requirements.

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[51] 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: Jan 13, 2025.

[52] State of New Hampshire Department of Health and Human Services. (2019). *Amendment #10 to the Medicaid Care Management Services Contract.* Available at: https://www.dhhs.nh.gov/documents/mcm-services-contract-amendment-10. Accessed on: Jan 13, 2025.

[53] 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: Jan 13, 2025.

[54] 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: Jan 13, 2025.

[55] Ibid.

Table C-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

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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 2024 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., 12/31/2023)
- The member handbook and additional documents sent to members
- The provider manual and other MCO communication to providers/subcontractors
- The automated member and provider portal
- Automated Provider Directory
- Third-party liability documents
- Denials file review
- Narrative and/or data reports across a broad range of performance and content areas
- MCO Questionnaire sent to the MCO with the pre-site documents

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

How Conclusions Were Drawn

HSAG uses scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCOs' performance complies with the requirements. HSAG uses a designation of *NA* when a requirement is not applicable to the MCO during the period covered by HSAG's review. The scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as either of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the rates assigned for each of the requirements, HSAG calculates a total percentage-of-compliance rate for the standards and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

While the focus of a compliance review is to evaluate if the MCOs correctly implement the required federal and State requirements, the results of the review can also determine areas of strength and weakness for the MCOs related to ***quality of care***, ***timeliness of care***, or ***access to care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met, Partially Met*, and *Not Met* to determine how the elements relate to the three domains as defined on page B-1. At that point, HSAG 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 2022–2024 Compliance Review Results

HSAG conducts the compliance review for all standards over a three-year period. Table C-2 through Table C-4 present information concerning the compliance reviews conducted in SFY 2022–SFY 2024. 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 C-2 includes the rates achieved by **ACNH** during the most recent three-year period of reviews.

Table C-2—Standards and Scores Achieved by ACNH in the Compliance Reviews From SFY 2022–SFY 2024

	42 CFR	Standard Name	2022	2023	2024
		§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			100%
		Member Enrollment and Disenrollment			
VII.	§438.100 §438.224	Enrollee Rights			100%
		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			100%
		UM			

	42 CFR	Standard Name	2022	2023	2024
		§438.358(b)(iii)			
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	91.7%		
XVI.	NA	Financial		100%	
XVII.	NA	Third Party Liability			100%
XVIII	§438.242	Health IS*	100%		
OVERALL RESULTS			**99.2%**	**98.6%**	**100%**
CONFIDENCE LEVEL			**High**	**High**	**High**

*HSAG added this standard to the review in 2022.

A comparison of the overall results from the compliance review in 2024 to the previous year (i.e., 2023) indicates that **ACNH** increased its score by 1.4 percentage points.

NHHF

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

Table C-3—Standards and Scores Achieved by NHHF in the Compliance Reviews From SFY 2022–SFY 2024

	CFR	Standard Name	2022	2023	2024
		§438.358(b)(iii)			
I.	§438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting		79.5%	
II.	§438.114	Emergency and Post-Stabilization Care	100%		
III.	§438.208	Coordination and Continuity of Care Care Management/Care Coordination			100%
IV.	NA	Wellness and Prevention	100%		
V.	NA	BH		100%	
VI.	§438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment			100%
VII.	§438.100	Enrollee Rights Member Services			100%

	CFR	Standard Name	2022	2023	2024
		§438.358(b)(iii)			
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			99.2%
		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	Third Party Liability			100%
XVIII.	NA	Health Information Services	100%		
OVERALL RESULTS			**99.6%**	**94.5%**	**99.7%**
CONFIDENCE LEVEL			**High**	**High**	**High**

A comparison of the overall results from the compliance review score from 2024 to the previous year (i.e., 2023) indicates that **NHHF's** score increased by 5.2 percentage points.

WS

Table C-4 includes the rates achieved by **WS** during the most recent three-year period of reviews.

Table C-4—Standards and Scores Achieved by WS in the Compliance Reviews From SFY 2022–SFY 2024

	WS	Standard Name	2022	2023	2024
		§438.358(b)(iii)			
I.	§438.230	Subcontractual Relationships and Delegation		100%	
		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			
VII.	§438.100	Enrollee Rights			100%
		Member Services			
VIII.	NA	Cultural Considerations	100%		
IX.	§438.228	Grievances and Appeals Systems	99.3%		
X.	§438.206	Availability of Services	97.3%		
		Access to Care			
XI.	§438.214 §438.207	Provider Selection		96.9%	
		Assurance of Adequate Capacity and Services			
		Network Management			
XII.	§438.210 §438.224	Coverage and Authorization of Services			95.3%
		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	Third Party Liability			100%

	WS	Standard Name	2022	2023	2024
		§438.358(b)(iii)			
XVIII.	NA	Health Information Services	100%		
OVERALL RESULTS			**98.8%**	**97.7%**	**98.4%**
CONFIDENCE LEVEL			**High**	**High**	**High**

A comparison of the overall results from the compliance review score from 2024 to the previous year (i.e., 2023) indicates that **WS's** score increased by 0.7 percentage points.

Table C-5—Timeline for the SFY 2024 Compliance Review Activity

MCO	Review Period	Collecting Data	Virtual Reviews	Writing Report	Finalizing Report
ACNH	01/01/23–12/31/23	02/19/24–04/03/24	04/04/24–04/12/24	04/15/24–05/09/24	05/10/24–06/20/24
NHHF	01/01/23–12/31/23	02/19/24–04/03/24	04/04/24–04/12/24	04/15/24–05/09/24	05/10/24–06/20/24
WS	01/01/23–12/31/23	02/19/24–04/03/24	04/04/24–04/12/24	04/15/24–05/09/24	05/10/24–06/20/24

PIPs

Validation of PIPs, as set forth in 42 CFR §438.358(b)(1)(i),[56] 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),[57] 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.

[56] U. S. Government Printing Office. (2019). *Activities related to external quality review.* Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358. Accessed on: Jan 13, 2025.
[57] Ibid.

The primary objective of PIP validation is to determine each MCO's compliance with requirements set forth in 42 CFR §438.330(d)(2), including:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* February 2023.[58]

At the request of DHHS, HSAG used a rapid-cycle PIP approach and developed the PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[59] 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.

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[58] 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: Jan 13, 2024.

[59] 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: Jan 13, 2025.

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 is able to resubmit the module for a final validation.

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 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 PIPs in SFY 2024, 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 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.

Table C-6—Timeline for the SFY 2024 PIP Activity

MCO	Review Period	Collecting Data	Conducting Validation	Writing Report	Finalizing Report
ACNH	07/01/22–12/31/23	07/01/23–11/03/23	07/02/23–05/17/24	05/20/24–06/21/24	07/08/24–07/17/24
NHHF	07/01/22–12/31/23	07/01/23–11/03/23	07/02/23–05/17/24	05/20/24–06/21/24	07/08/24–07/17/24
WS	07/01/22–12/31/23	07/01/23–11/03/23	07/02/23–05/17/24	05/20/24–06/21/24	07/08/24–07/17/24

PMV

Objectives

Validation of performance measures, as set forth in 42 CFR §438.358(b)(1)(ii),[60] 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 C-7 presents the 18 State-selected performance measures for the SFY 2024 validation activities in New Hampshire. HSAG completed the reports for this activity in May 2024.

Table C-7—Performance Measures Audited by HSAG for SFY 2024

Performance Measures
ACCESSREQ.06: Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County
APPEALS.01: Resolution of Standard Appeals Within 30 Calendar Days
APPEALS.02: Resolution of Extended Standard Appeals Within 44 Calendar Days
CLAIM.21: Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt
CLAIM.26: Claims Quality Assurance: Claims Financial Accuracy
CMS_A_CDF: Screening for Clinical Depression and Follow-Up Plan
CMS_CH_DEV: Developmental Screening in the First Three Years of Life
CMS_A_INP_PQI01: Diabetes Short-Term Complication Admissions
GRIEVANCE.05: Timely Processing of All Grievances
MEMCOMM.06: Member Communications: Reasons for Telephone Inquiries
PDN.04: Private Duty Nursing—Authorized Hours for Children Delivered and Billed by Quarter
PHARM_PDC.01: Proportion of Days Covered—Diabetes All Class Rate (PDC-DR)
PHARMUTLMGT.03: Pharmacy Utilization Management: Generic Drug Substitution
PROVCOMM.07: Provider Communications: Reasons for Telephone Inquiries
SERVICEAUTH.01: Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests

[60] U. S. Government Printing Office. (2020). *Activities related to external quality review.* Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358. Accessed on: Jan 13, 2025.

Performance Measures
SERVICEAUTH.03; Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests
SERVICEAUTH.04: Pharmacy Service Authorization Timely Determination Rate
SUD.42: MCO Contacts and Contact Attempts Following ED Discharges for SUD

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS EQR Protocol 2.

Table C-8—Timeline for the SFY 2024 PMV Activity

MCO	Review Period*	Collecting Data	Conducting Review	Drafting Report	Finalizing Report
ACNH	01/01/22–10/31/23	08/07/23–12/15/23	01/22/24	02/01/24–05/09/24	05/10/24–05/17/24
NHHF	01/01/22–10/31/23	08/07/23–12/15/23	01/25/24	02/01/24–05/09/24	05/10/24–05/17/24
WS	01/01/22–10/31/23	08/07/23–12/15/23	01/29/24	02/01/24–05/09/24	05/10/24–05/17/24

*HSAG evaluated multiple measures, and each measure had a specific review period that fell within these dates.

HSAG followed the same process for each PMV conducted in New Hampshire and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed MCO responses to the Information Systems 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 EQR Protocol 2, 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 C-9.

Table C-9—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.
Not Applicable (NA)	The MCO was not required to report the measure.
Not Reported (NR)	Measure was not reported because the MCO did not offer the required benefit.

Description of Data Obtained

HSAG used 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 each MCO per measure, HSAG establishes an overall level of confidence for the performance validation review based on the MCO following state-specific measure guidelines as defined below:

> The measure was determined *Reportable*: High confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measure during the reporting period.
>
> The measure was determined *Do Not Report:* No confidence in the MCO's ability to comply with New Hampshire's technical specifications for the measure during the reporting period.

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

This section describes the DHHS-approved methodology for the SFY 2024 NAV activities, including HSAG's NAV analysis and its ISCA-specific methodology and activities.

Table C-10 outlines the timelines of SFY 2024 NAV activities by MCO.

Table C-10—Timeline for the SFY 2024 NAV Activity

MCO	Collecting Data	Conducting Review	Writing Report	Finalizing Report
ACNH	03/15/24–06/28/24	05/08/24–08/30/24	08/30/24–09/30/24	09/30/24–11/21/24
NHHF	03/15/24–06/28/24	05/08/24–08/30/24	08/30/24–09/30/24	09/30/24–11/21/24
WS	03/15/24–06/28/24	05/08/24–08/30/24	08/30/24–09/30/24	09/30/24–11/21/24

NAV ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the MCOs, HSAG obtained all DHHS-defined network adequacy standards and indicators that DHHS requires for validation.

HSAG prepared and submitted a document request packet to each MCO outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCOs' IS and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents that HSAG requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the MCOs, such as network data files or directories and member enrollment files, through a single documentation request packet that HSAG provided to each MCO.

HSAG hosted a webinar for all MCOs that focused on providing technical assistance to the MCOs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring**: HSAG conducted an ISCA by using each MCO's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCO tracks providers over time, across multiple office locations, and through changes in participation in the MCO's network. HSAG used the ISCAT to assess the ability of the MCO's IS to collect and report accurate data

related to each network adequacy indicator. To do so, HSAG sought to understand the MCO's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Validate network adequacy logic for calculation of network adequacy indicators**: HSAG required each MCO that calculated the DHHS-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG identified whether the required variables were in alignment with the DHHS-defined indicators used to produce the MCO's indicator calculations. HSAG required each MCO that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCO took for indicator calculation.
- **Validate network adequacy data and methods**: HSAG assessed data and documentation from MCOs that included, but was not limited to, network data files or directories, member enrollment data files, and appointment availability surveys. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results**: HSAG assessed the MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCO and DHHS network adequacy monitoring results. HSAG validated network adequacy reporting against DHHS-defined indicators. HSAG assessed whether the results were valid, accurate, and reliable, and if the MCO's interpretation of the data was accurate.
- **Supporting documentation**: HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with each MCO. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCO staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- **Review of the ISCAT and supporting documentation:** HSAG designed this session to be interactive with key MCO staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing the MCO's IS required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified

outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

- **Evaluation of underlying systems and processes:** HSAG evaluated the MCO's IS, focusing on the MCO's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCO oversight of external IS, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.
- **Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the MCO produced the analytics files to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCO and DHHS network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table C-11.

Table C-11—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that the MCO used acceptable methodology for all phases of data collection, analysis, and interpretation of the

network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table C-12. HSAG assigns a rating once it has calculated the validation score for each indicator.

Table C-12—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Table C-13 and Table C-14 present sample validation rating determinations. Table C-13 presents an example of a validation rating determination based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table C-14 presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table C-13—Example Validation Rating Determination—No Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	16	*Moderate Confidence*
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* elements determined to have significant bias on the results	0	

Table C-14—Example Validation Rating Determination—Includes Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	15	*No Confidence*
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* elements determined to have significant bias on the results	1	

HSAG determined significant bias based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCO to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Tasking HSAG's NAV Oversight Review Committee with reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.
- Tasking HSAG's NAV Oversight Review Committee with finalizing a bias determination based on the following threshold:
  – The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or HSAG was unable to quantify the impact and therefore determined the potential for significant bias.

NAV Methodology

Technical Methods of Data Collection and Analysis

To conduct the NAV analysis, HSAG requested data from DHHS and the MCOs.

Member Data

HSAG requested Medicaid member files from DHHS and from each MCO. HSAG submitted a detailed member data requirements document to DHHS and the MCOs and offered a technical assistance call to review the data request in detail and clarify any questions regarding the data request. HSAG requested data for members actively enrolled in an MCO as of December 31, 2023, including these key data elements: member's street address, city, state, ZIP Code, date of birth, dates of enrollment, and MCO affiliation.

Provider Data

HSAG requested Medicaid provider files from DHHS reflecting all providers enrolled in the State's Medicaid program. From the MCOs, HSAG requested provider files reflecting all active providers serving Medicaid members. HSAG requested the following key data elements: provider name, NPI, address, provider type, specialty, taxonomy codes, and New Hampshire Medicaid provider type codes, if available.

MCO Provider Network Reports

Table C-15 lists the annual and ad hoc network adequacy reports and data that the MCOs submitted to DHHS, along with their respective reporting dates. HSAG requested these reports from both the MCOs and DHHS.

Table C-15—Required Network Reports and Reporting Periods

Report Name and Entity Submitting	Report Frequency	Template	Data Period	Date Submitted to DHHS
MCOs				
Comprehensive Provider Network and Equal and Timely Access Annual Filing	Annual	Network.01_2021.5.4	01/01/2023–12/31/2023	02/14/2024
Corrective Action Plan to Restore Provider Network Adequacy: Annual Template	Annual, and ad hoc if necessary	Network.10_2021.5.26	01/01/2023–12/31/2023	02/14/2024
Access to Care Provider Survey	Annual	Network.11_2021.09.01	07/01/2022–06/30/2023	08/14/2023

Methods of Analysis and How Conclusions Were Drawn

Time and Distance

For each MCO, HSAG calculated the percentage of members with required access to care according to the time and distance standards and evaluated whether 90 percent of members met either the time or distance standard. HSAG used Quest Analytics software to calculate the travel time and physical distance between the addresses of specific members for all provider categories identified in the analysis. HSAG also visually compared its results to MCO-submitted results included in the Network.01 Report for general consistency and reasonability.

Network Capacity

For the two SUD provider types evaluated in this study, HSAG compared provider MCO-submitted data files to the SUD provider lists contained in the Network.01 template worksheet, SUD Provider Net, as shown in Table C-16. For each provider listed in the SUD Provider Net worksheet in the Network.01 report, HSAG assessed the extent to which every MCO-submitted provider record matched the listed provider information. For each listed provider and each submitted provider record, HSAG calculated a matching score based on provider category (ProvCat), NPI, provider name, street address, street name, city, and ZIP Code. HSAG sought exact matches on ProvCat, NPI, city, and ZIP Code, and also identified "fuzzy" (approximate) matches for provider name, street address, and street name. HSAG

gave NPI substantial weight in the assessment, while HSAG gave ProvCat and fuzzy matches reduced weight. For each listed provider, HSAG identified the submitted provider record most closely resembling the listed provider and determined whether it should consider the submitted record a match. HSAG refined the algorithm making this determination to work around issues in the source data, such as missing NPI or missing address components in the SUD Provider Net list. HSAG reviewed these determinations and in a small number of instances reversed them based on detailed review.

Table C-16—MCO Provider Capacity Standards

Provider Type/Service	Requirement
Opioid Treatment Programs (OTPs)	The MCO Participating Provider Network shall include seventy-five percent (75%) of the OTP providers licensed and practicing in New Hampshire, as set out in the Network.01 2021.5.4 template, Tab C, SUD Provider Net.
Residential SUD Treatment Programs	The MCO Participating Provider Network shall include fifty percent (50%) of all such providers licensed and practicing in New Hampshire, as set out in the Network.01 2021.5.4 template, Tab C, SUD Provider Net.

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 general child Medicaid populations. SPH Analytics, an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2024 CAHPS surveys for **ACNH, NHHF**, and **WS**. The MCOs provided the CAHPS data to HSAG for inclusion of results within this report on July 31, 2024.

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 general child Medicaid

populations.[61] Adult members and parents/caretakers of child members completed the surveys in 2024, following NCQA's data collection protocol.

The CAHPS 5.1H Health Plan Surveys included a set of standardized items (39 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.[62] 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 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 2023 NCQA CAHPS adult and general child Medicaid national averages.[63]

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.

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[61] 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.

[62] For this report, the 2024 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.

[63] National data were obtained from NCQA's 2023 Quality Compass.

Description of Data Obtained

The CAHPS survey asks members or parents/caretakers to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. **ACNH**, **NHHF**, and **WS** contracted with a CAHPS vendor to administer the survey to adult members and parents/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 2023).

The MCOs' CAHPS vendors administered the surveys from February to May 2024. 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.[64] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, 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 2024 CAHPS survey results to the 2023 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 2024 CAHPS rates for **ACNH**, **NHHF**, and **WS** revealed that one general child measure rate for **ACNH,** one general child measure rate for **NHHF**, and two general child measure rates for **WS** were statistically significantly higher than the national averages. Conversely, one adult measure rate for **ACNH** and one adult measure rate for **NHHF** were statistically significantly lower than the national averages. The remaining rates for all three MCOs for both adult and general child 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

[64] 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.

ratings and composite measures presented in this report and relating the questions to the definitions of the three domains as noted on page C-1. This assignment to domains is depicted in Table C-17.

Table C-17—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 2023 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 2023 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 2023 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 2023 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 C-18 The measures marked NA relate to utilization of services.

Table C-18—HEDIS MY 2023 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-E)	✓		
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)	✓		

Performance Measures	Quality	Timeliness	Access
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)	✓		
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 Substance Use Disorder Treatment (IET)	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use (FUA)	✓	✓	
Pharmacotherapy for Opioid Use Disorder (POD)	✓	✓	

EDV

Table C-19—Timeline for the SFY 2024 EDV Activity

<table>
<tr><th>MCO</th><th>Activity</th><th>Review Period</th><th>Collecting Data</th><th>Conducting Review</th><th>Drafting Report</th><th>Finalizing Report</th></tr>
<tr><td rowspan="3">ACNH</td><td>IS Review</td><td>03/11/24–04/05/24</td><td>03/11/24–04/05/24</td><td>04/08/24–06/11/24</td><td rowspan="2">06/06/24–07/31/24</td><td rowspan="2">08/01/24–08/30/24</td></tr>
<tr><td>Comparative Analysis</td><td>07/01/22–06/30/23</td><td>11/09/23–03/15/24</td><td>01/31/24–06/05/24</td></tr>
<tr><td>Ongoing Encounter Data Quality Reports</td><td>07/01/23–06/30/24</td><td>Weekly</td><td>Monthly/ Quarterly</td><td>Not applicable</td><td>Not applicable</td></tr>
<tr><td rowspan="3">NHHF</td><td>IS Review</td><td>03/11/24–04/05/24</td><td>03/11/24–04/05/24</td><td>04/08/24–06/11/24</td><td rowspan="2">06/06/24–07/31/24</td><td rowspan="2">08/01/24–08/30/24</td></tr>
<tr><td>Comparative Analysis</td><td>07/01/22–06/30/23</td><td>11/09/23–03/15/24</td><td>01/31/24–06/05/24</td></tr>
<tr><td>Ongoing Encounter Data Quality Reports</td><td>07/01/23–06/30/24</td><td>Weekly</td><td>Monthly/ Quarterly</td><td>Not applicable</td><td>Not applicable</td></tr>
<tr><td rowspan="3">WS</td><td>IS Review</td><td>03/11/24–04/05/24</td><td>03/11/24–04/05/24</td><td>04/08/24–06/11/24</td><td rowspan="2">06/24/24–07/31/24</td><td rowspan="2">08/01/24–08/30/24</td></tr>
<tr><td>Comparative Analysis</td><td>07/01/22–06/30/23</td><td>11/09/23–06/14/24</td><td>01/31/24–06/21/24</td></tr>
<tr><td>Ongoing Encounter Data Quality Reports</td><td>07/01/23–06/30/24</td><td>Weekly</td><td>Monthly/ Quarterly</td><td>Not applicable</td><td>Not applicable</td></tr>
</table>

During SFY 2024, DHHS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR Protocol 5, HSAG conducted the following three core evaluation activities for all three MCOs:

- IS review—assessment of DHHS' and/or MCOs' IS and processes. The goal of this activity is to examine the extent to which DHHS' and 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 changes made by the MCOs since April 1, 2023.
- 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, 2023, and June 30, 2024, HSAG included encounter data with dates of service between July 1, 2022, and June 30, 2023, in the comparative analysis. The following sections describe the methodology for each activity.

IS Review

Objectives

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to DHHS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. This activity corresponds to *Activity 2: Review the MCO's Capability* in the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DHHS. Documents for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and DHHS' current encounter data submission requirements, among others. The information obtained from this review is important for developing a targeted questionnaire to address important topics of interest to DHHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the MCOs' most recent ISCAT collected through the CMS EQR Protocol 2. 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 changes made by MCOs since April 1, 2023.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DHHS and MCO IT personnel to clarify any questions from the questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Description of Data Obtained

Representatives from each MCO completed the DHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the MCO's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

How Conclusions Were Drawn

HSAG made conclusions based on the CMS EQR Protocol 5, 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 ***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 the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

HSAG uses the same general process and files as DHHS' fiscal agent, Conduent, when collecting and processing encounter data for the monthly/quarterly encounter data quality reports. For example, daily or weekly, participating MCOs prepare and translate claims and encounter data into the 837P, 837I, and the proprietary pharmacy files. The files are simultaneously transmitted via secure file transfer protocol (SFTP) to HSAG and DHHS (and Conduent), where the files are downloaded and processed. The MCOs' 837P/I files are processed through an EDI translator by both vendors (Conduent and HSAG). It is important to note that the application and function of compliance edits implemented by Conduent and HSAG are slightly different due to the overall intent of processing. HSAG's process includes a subset of edits designed to capture (1) an MCO's overall compliance with submission requirements (e.g., filename confirmation); and (2) key encounter data quality elements (e.g., data field compliance and completeness). Additionally, while failure to pass certain edits during Conduent's processing may lead to rejection and resubmission of files/encounters by the MCOs, HSAG's edit processing is used for reporting only.

Once HSAG successfully translates the 837P/I files, the files are loaded into HSAG's data warehouse. HSAG then runs a secondary set of edits. These edits are used for reporting only and are designed to identify potential issues related to encounter data quality. Additionally, HSAG processes the MCOs' pharmacy files simultaneously through a comparable process; however, the pharmacy files do not undergo EDI translation. Instead, HSAG processes the pharmacy files directly into HSAG's data warehouse.

In general, the ongoing encounter data quality reports assess measures in four domains such as submission accuracy and completeness (SAC), encounter data accuracy (EDA), encounter data timeliness (EDT), and encounter data completeness (EDC). For the SFY 2024 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, plan, and All MCOs

- **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, plan, and All MCOs

- **Study Indicator EDA.1**—Percentage of records with values present for key data element (see Table C-20)

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

Measure Element	Specification
File Type	Final paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, plan, and All MCOs

- **Study Indicator EDA.2**—Percentage of records with valid values for key data element (see Table C-20).

Measure Element	Specification
Numerator	Number of records with valid values for a specific data element
Denominator	Number of records with values present for a specific data element
File Type	Final paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type, plan, and All MCOs

Table C-20 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 C-20—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 Provider Number	✓			In provider file
Attending Provider Number		✓		In provider file
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)/Current Dental Terminology (CDT)/Healthcare Common Procedure Coding System (HCPCS) Code(s)	✓	✓		In national CPT, CDT, and HCPCS code sets

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Surgical Procedure Code(s)		✓		In national ICD-10-CM surgical procedure code sets
Revenue Code		✓		In national revenue code sets
National Drug Codes (NDCs)			✓	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, plan, and All MCOs

- **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 All MCOs

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 2023 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 All MCOs

[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 2023 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 will include encounters paid between April 1, 2023, and June 30, 2023, and submitted to DHHS by August 31, 2023) b. Total plan 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 will include encounters paid between April 1, 2023, and June 30, 2023, and submitted to DHHS by August 31, 2023)
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, 2023, and June 30, 2024. These results are based on the data stored in HSAG's data warehouse, and for measures *EDA.1*, *EDA.2*, *EDA.3*, *EDC.4,* and *EDC.5*, HSAG determined the final encounters as of July 1, 2024.

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:[65]

- 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."
- 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 the 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.

[65] 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: Jan 13, 2025.

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 C-21. The analyses focused on an element-level comparison for each data element.

Table C-21—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Beneficiary ID	✓	✓	✓
Detail Service From Date	✓		
Detail Service To Date	✓		
Header Service From Date		✓	✓
Header Service To Date		✓	
Billing Provider Number/NPI	✓	✓	✓
Rendering Provider Number/NPI	✓		
Attending Provider Number/NPI		✓	
Prescribing Provider Number/NPI			✓
Referring Provider Number/NPI	✓	✓	
Primary Diagnosis Code	✓	✓	
Secondary Diagnosis Codes	✓	✓	
Procedure Code	✓	✓	
Procedure Code Modifiers	✓	✓	
Surgical Procedure Codes		✓	
NDC			✓
Drug Quantity			✓
Revenue Code		✓	
Diagnosis related group (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, HSAG stratified results 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, 2022, and June 30, 2023, 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, 2023, and submitted to DHHS on or before December 31, 2023. This anchor date allowed sufficient time for the SFY 2024 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 C-22 displays the criteria used. In addition, HSAG noted a few recommendations based on the file review responses from the MCOs.

Table C-22—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 ***quality of care*** since determining quality can be challenging if the MCOs do not submit accurate and timely encounter data.

Semi-Structured Interviews

Table C-23—Timeline for the Spring 2023 Semi-Structured Interview Activity

MCO	Review Period	Collecting Data	Writing Report	Finalizing Report
ACNH	07/01/22–06/26/23	06/26/23–08/02/23	08/03/23–09/01/23	09/02/23–09/22/23
NHHF	07/01/22–06/26/23	06/26/23–08/02/23	08/03/23–09/01/23	09/02/23–09/22/23
WS	07/01/22–06/26/23	06/26/23–08/02/23	08/03/23–09/01/23	09/02/23–09/22/23

Table C-24—Timeline for the Fall 2023 Semi-Structured Interview Activity

MCO	Review Period	Collecting Data	Writing Report	Finalizing Report
ACNH	01/01/23–12/27/23	12/27/23–02/08/24	02/09/24–03/04/24	03/05/24–04/11/24
NHHF	01/01/23–12/27/23	12/27/23–02/08/24	02/09/24–03/04/24	03/05/24–04/11/24
WS	01/01/23–12/27/23	12/27/23–02/08/24	02/09/24–03/04/24	03/05/24–04/11/24

Table C-25—Timeline for the Spring 2024 Semi-Structured Interview Activity

MCO	Review Period	Collecting Data	Writing Report	Finalizing Report
ACNH	01/01/24–08/26/24	08/27/24–10/18/24	10/21/24–11/20/24	11/21/24–12/16/24
NHHF	01/01/24–08/26/24	08/27/24–10/18/24	10/21/24–11/20/24	11/21/24–12/16/24
WS	01/01/24–08/26/24	08/27/24–10/18/24	10/21/24–11/20/24	11/21/24–12/16/24

Objectives

The DHHS studies involved semi-structured qualitative interviews with members enrolled in the MCM program with specific demographics, service experiences, or diagnoses. The studies explored varying Key Points of Inquiry (e.g., description of participants, experience with Medicaid managed care, quality of care, access to information, experience with providers, suggestions for improvement, experience with MCOs' processes) depending on the study topic. 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 SFTP site and selected the sample of members who were contacted by mail requesting their participation in the study.

Members interested in the study responded by calling a toll-free number, texting, or emailing the researcher who scheduled and conducted the 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.

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***.

PQI and Well Care Visits Quality Study

Table C-26—Timeline for the PQI and Well Care Visits Quality Study

MCO	Review Period	Collecting Data	Writing Report	Finalizing Report
ACNH	07/01/20–06/30/22	02/09/23–05/02/23	06/01/23–07/20/23	07/21/23–08/24/23
NHHF	07/01/20–06/30/22	02/09/23–05/02/23	06/01/23–07/20/23	07/21/23–08/24/23
WS	07/01/20–06/30/22	02/09/23–05/02/23	06/01/23–07/20/23	07/21/23–08/24/23

Objectives

DHHS contracted with HSAG to calculate performance measures as part of the quality study activity for each of the following MCOs: **ACNH**, **NHHF**, and **WS**. The PQI and Well Care Visits Quality Study activity included two parts: (1) PQI, and (2) Well-Care and Preventive Visits. For the PQI analysis, HSAG assessed whether members who had an inpatient event also had a completed HRA and/or were enrolled in care management. For the Well-Care and Preventive Visits analysis, HSAG assessed whether members received primary care services from their attributed PCP. Additionally, HSAG also assessed ED utilization for those members attributed to a PCP.

Technical Methods of Data Collection and Analysis

PQI Analysis

HSAG calculated the following PQI measures for each MCO for the SFY 2021 measurement period in alignment with the CMS FFY 2022 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measure specifications[66] using administrative data provided by DHHS:

- *PQI-01: Diabetes Short-Term Complications Admission Rate*
- *PQI-05: COPD or Asthma in Older Adults Admission Rate*
- *PQI-08: Heart Failure Admission Rate*
- *PQI-15: Asthma in Younger Adults Admission Rate*

After identifying all members with numerator positive events for each PQI measure, HSAG provided the MCOs with a list of all members who had at least one numerator positive event in the PQI template. The MCOs then populated the PQI template to provide the following information related to HRAs and care management enrollment for each member included in the PQI template:

- For HRAs, MCOs indicated whether an HRA was completed and the HRA completion date.
- For care management enrollment, MCOs indicated whether the member was enrolled in care management and all time spans the member was enrolled with care management.

Well-Care and Preventive Visits Analysis

HSAG conducted a statewide assessment of the proportion of members who received well-care/preventive services from their attributed PCP during SFY 2021 and SFY 2022 measurement periods. HSAG used the PCP attribution files received from the MCOs to perform the following analyses:

- Utilization of Well-Care and Preventive Visits by PCP Attribution
- Utilization of Well-Care and Preventive Visits With a Non-Attributed PCP
- ED Utilization

For all three metrics, HSAG limited the eligible population to members in the PCP attribution file with a start date that occurred during the measurement period. Additionally, HSAG presented the results stratified by age group (i.e., pediatric or adult) and by MCO.

[66] Centers for Medicare & Medicaid Services. Core Set of Adult Health Care Quality Measures for Medicaid. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1674153622. Accessed on: Jan 13, 2025.

Description of Data Obtained

PQI Analysis

HSAG provided the MCOs with a template to provide HRA and care management enrollment information for each member with numerator positive events identified for any of the selected PQI measures. The file provided to the MCOs included the member identification (ID) for each numerator positive event for each PQI measure. The MCOs then provided all available HRA and care management enrollment information for each member included in the file.

Well-Care and Preventive Visits Analysis

HSAG provided the MCOs with a template to furnish members' PCP attribution information. The MCOs provided a supplemental PCP attribution file for all members attributed to a PCP during SFY 2021 (i.e., July 1, 2020–June 30, 2021) and SFY 2022 (i.e., July 1, 2021–June 30, 2022). At a minimum, HSAG requested that the MCOs provide the Member ID, PCP Provider Medicaid ID, PCP attribution start/stop date(s), PCP NPI, Practice NPI, Practice Provider Medicaid ID, PCP taxpayer identification number (TIN), and a flag that identified whether the member was auto-attributed.

How Conclusions Were Drawn

PQI Analysis

Once the MCOs provided the HRA and care management enrollment information for each member with a numerator positive event, HSAG performed the following analyses for each MCO:

Percentage of Admissions Wherein Members Received an HRA or Enrolled in Care Management

For each PQI measure and overall, HSAG evaluated the percentage of admissions wherein the member received an HRA or enrolled in care management around the admission date. HSAG evaluated the following:

- Percentage of admissions wherein the member received an HRA or enrolled in care management within 12 months prior to the admission date.
- Percentage of admissions wherein the member received an HRA or enrolled in care management within 12 months after the admission date.
- Percentage of admissions wherein the member received an HRA or enrolled in care management within 12 months prior to or after the admission date.

Well-Care and Preventive Visits Analysis

Utilization of Well-Care and Preventive Visits by PCP Attribution

For members in the eligible population, HSAG utilized the encounter data to determine if the member had a well-care or preventive visit with his or her attributed PCP. HSAG used the Well-Care Value Set from the CMS Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Plan (CHIP) (Child Core Set)[67] to identify well-care services for the pediatric population and the following value sets for the adult population: Ambulatory Visits Value Set, Other Ambulatory Visits Value Set, Telephone Visits Value Set, and Online Assessments Value Set.[68]

HSAG identified all well-care visits and preventive visits during the measurement period with dates of service between the member's PCP attribution start date and end date. HSAG determined which visits (if any) the member had with his or her attributed PCP. HSAG evaluated a number of time horizons (e.g., three months, six months) from the PCP attribution start date.

For members who did not have a well-care or preventive visit with their attributed PCP, HSAG determined if any well-care or preventive visits occurred with another PCP within the attributed PCP's group practice. HSAG identified visits as being from the same group practice if the rendering or billing provider ID matched the attributed PCP's Practice NPI or the Practice Medicaid ID from the PCP attribution file.

Utilization of Well-Care and Preventive Visits With a Non-Attributed PCP

For members who did not receive a well-care or preventive visit with their attributed PCP or their attributed PCP's group practice, HSAG determined whether the member had any visits with a different PCP during the measurement period with dates of service between the PCP attribution start and end dates. HSAG classified providers as PCPs if they were included in any of the PCP attribution files received from the MCOs or based on the provider type and provider specialty codes in the provider data received from DHHS.

ED Utilization

HSAG evaluated the number of ED visits for all members attributed to a PCP. HSAG identified ED visits with dates of service between each member's attributed start and end dates using the ED Visits Value Set from CMS' Child Core Set.

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[67] Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Available at: https://www.medicaid.gov/sites/default/files/2022-07/medicaid-and-chip-child-core-set-manual.pdf. Accessed on: Jan 13, 2025.

[68] Horizon Blue Cross Blue Shield of New Jersey. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.horizonblue.com/providers/resources/hedis-resources/hedis-measurement-year-my-2023-provider-tips-optimizing-hedis-results/adults-access-preventive-ambulatory-health-services-aap. Accessed on: Jan 13, 2025.

HSAG stratified the results by whether or not members received a well-care or preventive visit from their attributed PCP or another PCP prior to the ED visit.

Service Authorization Quality Study

Table C-27—Timeline for the Service Authorization Quality Study

MCO	Review Period	Collecting Data	Writing Report	Finalizing Report
ACNH	04/1/23–09/30/23	02/27/24–07/23/24	07/24/24–10/30/24	10/31/24–12/18/24
NHHF	04/1/23–09/30/23	02/27/24–07/23/24	07/24/24–10/30/24	10/31/24–12/18/24
WS	04/1/23–09/30/23	02/27/24–07/23/24	07/24/24–10/30/24	10/31/24–12/18/24

Objectives

The MCOs submitted quarterly SERVICEAUTH.05 Reports with details concerning the number of requested service authorizations that the plans approved and denied. DHHS wanted to understand the specifications that each MCO used to determine the number of denied authorizations and therefore requested that HSAG conduct a quality study to investigate the information. HSAG examined the information submitted by the MCOs as denials in Q2 and Q3 2023 to determine the specifications each MCO used to submit information concerning denied authorizations.

Technical Methods of Data Collection and Analysis

HSAG followed a 12-step process to complete the Service Authorization Quality Study, which included the technical methods of data collection and analysis as shown below:

Table C-28—Process to Conduct the Service Authorization Study

Step 1:	Meeting with DHHS to define study parameters
	HSAG met with DHHS to determine the information needed to determine how each MCO submitted the number of service authorization denials included in the quarterly SERVICEAUTH.05 Report.
Step 2:	**Receiving SERVICEAUTH.05 Reports from DHHS**
	HSAG requested two quarters of SERVICEAUTH.05 Reports from DHHS to review the information submitted in the report.
Step 3:	**Determining the scope of the study**
	After reviewing the number of denials for the 32 service categories included on the SERVICEAUTH.05 Reports, DHHS determined to limit the study to the DME and pharmacy denials.

Step 4:	Sending a questionnaire to the MCOs
	HSAG worked with DHHS to develop a questionnaire concerning how the MCOs determined the number of DME and pharmacy denials submitted in the SERVICEAUTH.05 Reports provided to DHHS.
Step 5:	**Receiving and reviewing questionnaires from the MCOs**
	Once the MCOs returned the questionnaire, HSAG reviewed the information to ensure that the MCOs answered all the questions on the documents.
Step 6:	**Compiling the MCO responses**
	HSAG evaluated the responses and determined whether the MCOs submitted complete answers concerning how they determined the number of DME and pharmacy denials. HSAG then created a document with answers from the MCOs to facilitate the comparison of information across the three MCOs.
Step 7:	**Meeting with DHHS to review questionnaire responses**
	HSAG met with DHHS to review the information submitted by the MCOs on the questionnaire and determined the need for additional clarification concerning the responses.
Step 8:	**Determining if a second questionnaire or meeting was needed**
	If additional information was required from the MCOs, the MCOs sent written responses or met with DHHS and HSAG to provide the information.
Step 9:	**Gathering additional information until complete information was obtained from the MCOs**
	HSAG continued to work with DHHS and the MCOs until complete information was obtained from the MCOs concerning the number of denials submitted in the SERVICEAUTH.05 Report.
Step 10:	**Preparing a final document with all responses by each MCO**
	After receiving the final responses from each MCO, HSAG prepared a document showing all responses received from the MCOs. The report included information concerning how the MCOs determined the cases to be included in the Total Denied column on the SERVICEAUTH.05 Report.
Step 11:	**Writing the report**
	HSAG prepared a report providing details of the information obtained during the study.
Step 12:	**Receiving DHHS' approval of the draft report**
	HSAG sent a draft report to DHHS for approval. After approval of the information contained in the draft report, HSAG sent a finalized version of the report to DHHS.

Description of Data Obtained

DHHS and the MCOs submitted both quantitative and qualitative data for the study. The quantitative data included 1915b and State Plan member data that DHHS submitted to HSAG on the Q2 and Q3 SERVICEAUTH.05 Reports from 2023. The first part of the study included reviewing the number of requested, approved, and denied authorizations for the 32 service categories displayed on the quarterly reports. DHHS then restricted the review to State Plan members and four of the 32 service categories as shown below:

- DME:
  - Adult excluding orthotics and prosthetics
  - Child (0–21 years) excluding orthotics and prosthetics
- Pharmacy:
  - BH drugs (mental health and SUD) including office-based (including injections)
  - Non-BH drugs (including injections)

HSAG obtained the qualitative data for the study by sending a questionnaire to the MCOs to explain the processes they used to determine the denial numbers submitted on the SERVICEAUTH.05 Reports. After reviewing answers submitted on the first questionnaire, HSAG sent a follow-up questionnaire to clarify the information submitted. HSAG completed the final step to obtain information by meeting individually with the MCOs and DHHS. After those meetings, HSAG began compiling and analyzing the information.

How Conclusions Were Drawn

After reviewing the questionnaires and meeting notes, HSAG compared and contrasted the MCOs' statements to identify similar or divergent processes. From that information, HSAG drew conclusions and formulated recommendations for DHHS to improve the ***quality***, ***timeliness***, and ***access to care*** for the New Hampshire Medicaid members.

SFY 2023 Revealed Caller Provider Survey

Table C-29—Timeline for the SFY 2023 Revealed Caller Provider Survey

MCO	Review Period*	Collecting Data	Conducting Review	Writing Report	Finalizing Report
ACNH	NA	04/17/23–05/23/23	05/24/23–07/10/23	07/11/23–08/02/23	08/04/23–10/13/23
NHHF	NA	04/17/23–05/23/23	05/24/23–07/10/23	07/11/23–08/02/23	08/04/23–10/13/23
WS	NA	04/17/23–05/23/23	05/24/23–07/10/23	07/11/23–08/02/23	08/04/23–10/13/23

*The Review Period is NA for the Revealed Caller Provider Survey as it is a point in time study.

Objectives

The goal of the telephone survey was to determine if the information in the MCOs' provider data was supported by information supplied when speaking to someone at the provider location. Additionally, survey calls requested information to determine the extent to which timely appointments for routine care were available to Medicaid members.

HSAG identified two types of cases:

1. Cases with identified discrepancies from the SFY 2022 NAV study
2. A new sample of SFY 2023 cases

HSAG resurveyed all SFY 2022 discrepancy[69] cases unless the provider was no longer contracted with the MCO. In that instance, the case was removed and replaced with a new SFY 2023 case.

For the new SFY 2023 cases, HSAG generated a list of provider locations (i.e., cases). In order to reduce respondent burden, HSAG selected the sample so that no more than one provider per phone number was selected, when possible. Furthermore, HSAG selected only one provider per location (i.e., address). To reduce the likelihood of sampling the same provider locations within and between the MCOs, HSAG standardized the providers' address data to align with the United States Postal Service (USPS) Coding Accuracy Support System (CASS). Address standardization did not affect the study population; provider records requiring address standardization remained in the eligible population. HSAG retained the original provider address data values for locations where potential CASS address changes may have impacted data validity (e.g., the address is standardized to a different city or county). HSAG included out-of-state offices for providers located in Maine, Massachusetts, and Vermont in the study. HSAG excluded records for providers who cover services at a specified location rather than accepting appointments to see patients at the location included in the study.

HSAG equally divided the new SFY 2023 cases among the following provider categories:

- PCPs

[69] HSAG identified a case as a discrepancy case during the SFY 2022 survey if the information between the MCO's provider directory did not align with the information obtained when calling the provider's office.

- Physical health specialists—evenly divided to select the same number of providers from each specialty category[70]
- BH providers

Technical Methods of Data Collection and Analysis

Using a DHHS-approved data request document, each MCO submitted its online provider data files to HSAG. At a minimum, the data elements requested from the MCOs for each provider included: provider name, Medicaid ID, national provider identifier (NPI) number, provider specialty (e.g., primary care, gastroenterology, psychology), physical (practice) address, telephone number, provider taxonomy code, gender, new patient acceptance, primary and secondary languages, and accommodations for patients with physical disabilities.

Upon receipt of the MCOs' data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values were attributed to each provider category.

Description of Data Obtained

Interviewers contacted the providers and collected survey responses using a standardized script approved by DHHS. HSAG instructed interviewers not to schedule actual appointments. HSAG's interviewers made two attempts to contact each survey case during standard business hours (i.e., 9 a.m. to 5 p.m. Eastern Standard Time). If the interviewer was put on hold at any point during the call, he or she waited on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the interviewer made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical practice or facility.
- Office personnel refused to participate in the survey.
- The interviewer was unable to speak with office personnel during either call attempt (e.g., the call went to voicemail or call center that prevented the interviewer from speaking with office staff).

[70] The survey included the following physical health specialty categories: allergists & immunologists, gastroenterologists, obstetricians/gynecologists (OB/GYNs), ophthalmologists, orthopedists, otolaryngologists (ENT specialists), pulmonologists, and urologists.

How Conclusions Were Drawn

After completion of the calls, the data were tabulated electronically, and HSAG employees analyzed the information obtained during the telephone calls. HSAG reviewed the answers to the survey questions and drew conclusions based on the provider locations' responses. Recommendations from the report included items to improve ***data quality***, ***timeliness of care***, and ***access to care***.

SFY 2024 Revealed Caller Provider Survey

Objectives

The goal of the survey was to evaluate New Hampshire's Medicaid managed care network of BH locations for CMHC providers, non-CMHC providers, and methadone clinics. Specific survey objectives included the following:

- Determine whether the contact information (i.e., phone number, address) was accurate for the contracted BH providers reported by the MCOs.
- Determine whether the BH locations accepted patients enrolled with a Medicaid MCO.
- Determine whether the BH locations accepted new patients.
- Determine appointment availability with the sampled BH locations for non-urgent/routine services.

Using the DHHS-approved data request document, the MCOs identified providers potentially eligible for survey inclusion and submitted the data files to HSAG. The eligible population included service locations associated with BH providers who were actively contracted with the MCO, at the time the data file was created, to serve individuals enrolled in the New Hampshire Medicaid program. Service locations with addresses in states other than New Hampshire were included in the sample frame if they were contracted with a New Hampshire MCO. The eligible population included non-CMHC providers, CMHCs, and methadone clinics. DHHS provided HSAG with the location information for the CMHCs and the methadone clinics.

HSAG assembled the sample frame using records from all BH provider service locations identified by each MCO. To minimize duplicate provider records within each MCO, HSAG standardized the providers' address data to align with the USPS CASS. Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. The original provider address data values were retained for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county).[71] The sample frame included non-CMHC providers, CMHCs, and methadone clinics. HSAG reconciled the CMHC and methadone clinic lists that were submitted by DHHS with the MCO data to remove CMHC and methadone clinic addresses and telephone numbers from the MCO data prior to sampling. Upon

[71] To minimize the number of repeated phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple addresses within a plan, HSAG randomly assigned the number to a single plan and its standardized address, prioritizing assignment to the least-represented plans.

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receiving the CMHC and methadone clinic data from DHHS, HSAG generated a sample that contained each CMHC and methadone clinic location. For locations with multiple addresses and one centralized phone number, HSAG included all addresses within the eligible sample.[72] HSAG excluded records from the sample frame for provider locations that the MCO indicated were not listed in the online directory or for providers who covered services at the specified location rather than accepting appointments to see patients at the location.

HSAG conducted the Revealed Caller Provider Survey on the following timeline.

Table C-30—Timeline for the SFY 2024 Revealed Caller Provider Survey

MCO	Review Period*	Collecting Data	Conducting Review	Drafting Report	Finalizing Report
ACNH	NA	03/04/2024–04/05/2024	04/08/2024–05/03/2024	05/06/2024–07/12/2024	07/15/2024–07/19/2024
NHHF	NA	03/04/2024–04/05/2024	04/08/2024–05/03/2024	05/06/2024–07/12/2024	07/15/2024–07/19/2024
WS	NA	03/04/2024–04/05/2024	04/08/2024–05/03/2024	05/06/2024–07/12/2024	07/15/2024–07/19/2024

*The Review Period is NA for the Revealed Caller Provider Survey as it is a point in time study.

Technical Methods of Data Collection and Analysis

Upon receipt of the MCOs' data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values would be attributed to each provider domain or an applicable BH specialty category.

Description of Data Obtained

Interviewers contacted the providers and collected survey responses using a standardized script approved by DHHS. HSAG instructed interviewers not to schedule actual appointments. HSAG's interviewers made four attempts to contact each survey case during standard business hours (i.e., 9 a.m. to 5 p.m. Eastern Standard Time). If the interviewer was put on hold at any point during the call, he or she waited on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the interviewer made an additional call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number was no longer in service).

[72] To minimize the number of repeated phone calls to the central scheduling locations, HSAG asked about all associated addresses during each phone call. If a representative could not provide survey information for multiple locations during one call, additional calls were placed to the telephone number to capture information for the remaining locations.

- Telephone number connected to an individual or business unrelated to a medical practice or facility.
- Office personnel refused to participate in the survey.
- The interviewer was unable to speak with office personnel during any of the call attempts (e.g., the call went to voicemail or a call center that prevented the interviewer from speaking with office staff).

How Conclusions Were Drawn

After completion of the calls, the data were tabulated electronically, and HSAG employees analyzed the information obtained during the telephone calls. HSAG reviewed the answers to the survey questions and drew conclusions based on the provider locations' responses. Recommendations from the report included items to improve ***data quality***, ***timeliness of care***, and ***access to care***.