New Hampshire Medicaid Care Management Quality Performance Report

Effectiveness Analysis of the Comprehensive Medicaid Quality Strategy - 2024

A Report Prepared by the Medicaid Quality Program
Division of Program Quality and Integrity
New Hampshire Department of Health and Human Services

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The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

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Quality Strategy Effectiveness Analysis

In accordance with 42 CFR 438.340, the Department of Health and Human Services (Department) on August 19, 2019, published its Medicaid Care Management quality strategy[1] to assess and improve the quality of health care services provided by Managed Care Organizations (MCO) in New Hampshire to Medicaid and Children's Health Insurance Program (CHIP) recipients. The MCM quality strategy was updated in 2022 to incorporate the new adult dental program. No less than every three years, the Department completes an evaluation of the quality strategy. While the review is a stand-alone effort, it is primarily a compilation of separate quality activities and ongoing monitoring efforts that are conducted throughout the data period reviewed.

Background

This analysis, required by 42 CFR 438.340(c), evaluates the effectiveness of the quality strategy and is publicly available on the NH Medicaid Quality website[2]. The review comprehensively evaluates the 25 objectives contained within 7 goals to determine whether the Department met or made progress on its quality strategy goals and objectives. In addition, the review evaluates whether the state is continuing or revising goals and objectives based on the findings of the review. While there is no formal structure federally required by the regulation, the Department has utilized the CMS guidance from the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*[3] to shape the analysis.

Methodology

Data Period

The evaluation primarily focuses on the 36-month performance period of 7/1/2021 – 6/30/2024. The beginning of the performance period marks the approximate midpoint of the most recent 5-year MCO procurement, and the end of the performance period marks 3 years from the last NH managed care quality strategy effectiveness analysis. The data period covers a significant portion of the public health emergency (PHE) due to the Covid-19 global pandemic. In NH, some processes were altered or canceled to comply with regulations regarding in-person gatherings. Additionally, the healthcare system underwent significant delivery and landscape changes during this time. The results of this effectiveness analysis must be interpreted within this context.

Goals and Objectives

The NH Medicaid managed care quality strategy identifies goals and objectives that focus on

[1] https://medicaidquality.nh.gov/sites/default/files/MCM%202.0%20Quality%20Strategy%20SFY%202020_0.pdf
[2] https://medicaidquality.nh.gov/care-management-quality-strategy
[3] https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf

process as well as achieving outcomes. Goal 1 "Assure Quality and Appropriate Care Delivery to the NH Medicaid population enrolled in managed care" is an example of an outcome. Goal 3 "Assure MCO and DO contract compliance" is an example of a process goal. NH has determined that both are essential to operating an effective Medicaid quality program.

"The *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit* emphasizes the importance of goals and objectives that achieve outcomes. While NH will continue to evaluate goals and objectives that focus on both process and outcomes, *Appendix A: Outcome Goals and Objectives* provides the CMS recommended table that isolates outcome measures.

Data Sources

The NH Medicaid managed care quality strategy relies on multiple data sources to analyze effectiveness, including: Medicaid and CHIP Child[4] and Adult[5] Core Sets; patient experience of health care collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[6] survey; the National Committee for Quality Assurance (NCQA) Quality Compass[7]; findings from the External Quality Review Organization (EQRO) activities; and required MCO quality and data reporting items.

Alignment with CMS Adult and Child Core Set Measures

The CMS Quality Strategy Toolkit encourages states to review performance on the Adult and Child Core Set of measures relative to other states and use the quality strategies to prioritize and articulate quality improvement goals in those areas where performance can improve.

New Hampshire has included the following CMS core set measures in the NH Medicaid Care Management Quality strategy based on opportunities for improvement identified by comparing NH rates to the national 75th percentile of Medicaid health plans:

- CMS Adult Core Sec (PPC-AD) – Prenatal and Postpartum Care: Timeliness of Prenatal Care
- CMS Adult Core Set (PPC-AD) – Prenatal and Postpartum Care: Postpartum Care;
- CMS Adult and Child Core Set (CHL-CH) (CHL-AD) – Chlamydia Screening in Women;
- CMS Child Core Set (ADD-CH) – Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance;
- CMS Child Core Set (IMA-CH) – Immunizations for Adolescents Combination 1;
- CMS Child Core Set (IMA-CH) – Immunizations for Adolescents Combination 2; and
- CMS Child Core Set (APP-CH) – Use of First-Line Psychosocial Care for Children and

[4] More Information about Child Core Set
[5] More Information about Adult Core Set
[6] More information about CAHPS
[7] More information about NCQA Quality Compass

Adolescents on Antipsychotics.

- CMS Adult Core Set (HBD-AD) – Hemoglobin A1c Control for Patients with Diabetes <8%
- CMS Adult Core Set (CBP-AD) – Controlling High Blood Pressure
- HEDIS (POD) – Pharmacotherapy for Opioid Use Disorder
- CMS Adult Core Set (WCC-CH) – Weight Assessment and Counseling in Adolescents/Children – BMI

External Quality Review Organization's Recommendations in the Quality Strategy

The CMS Quality Strategy Toolkit recommends states consider whether the state has acted on external quality review recommendations in the state quality strategy.

The NH Medicaid Care Management Quality Strategy includes process objective 5.2 "Ensure MCOs and DOs have acted upon each EQR recommendation/finding in the Organization's annual QAPI report or the semi-annual EQRO.01 report." DHHS monitors and quantifies MCO-directed EQRO recommendations through the QAPI and EQRO reporting. DHHS-specific EQRO recommendations are presented to internal stakeholders and acted upon as needed.

Evaluation Process

The table below outlines the criteria used to evaluate the effectiveness of each objective. While the review is a stand-alone effort, it is primarily a compilation of separate quality activities and ongoing monitoring efforts that are conducted throughout the data period reviewed.

Review Criteria	Description
Activity Conducted	The criteria verifies whether the process outlined in the objective was conducted.
Baseline Data	The criteria provides initial data for outcome objectives prior to the establishment of performance goals.
Current Results	The criteria provides point in time information about the Department's results in achieving the objective.
Progress on Objective (Met/ Progress Made /Not Met)	The criteria provides a score to evaluate the Department's progress in meeting the objective. Met = Objective was fully achieved. Progress Made = Objective was not fully achieved, but the evaluation identified progress towards achieving the objective.

	Not Met = Objective was not fully achieved and the evaluation does not identify progress towards achieving the objective.
Plans for plan/provider level corrective action	The criteria identifies specific activities that will be conducted by individual health plans or providers to better meet the objective.
Plans for system-level changes	The criteria identifies specific activities that will be conducted by the Department to better meet the objective.
Revisions based on evaluation (if any)	The criteria identifies revisions that will be made to the objective in the next version of the quality strategy based on the effectiveness evaluation.

Results

Summary Results

Quality Strategy Objective	Process / Outcome Objective	Results (Met / Progress Made / Not Met)
Objective 1.1 – Ensure that by the end of State Fiscal Year 2022 annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	Outcome	Progress Made
Objective 1.2 – Ensure that by the end of State Fiscal Year 2022 annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	Outcome	Progress Made
Objective 1.3 – Ensure MCOs adopt of evidence-based clinical practice guidelines that meet the requirements of 42 CFR 438.340(b)(1).	Process	Met
Objective 1.4 - DHHS establishes a statewide transition of care policy that meets the requirements of 42 CFR 438.340(b)(5).	Process	Met
Objective 2.1 – Ensure that the MCO and DO provider networks meet the 90% standard of time or distance for each New Hampshire	Process	Met

County.		
Objective 2.2 – Ensure MCO and DO access performance measures do not indicate an access issue.	Process	Met
Objective 2.3 Ensure that MCOs and DO provide accurate information in their organization's provider directories.	Process	Progress Made[8]
Objective 2.4 – Ensure that annual member experience of care survey rates are equal to or higher than the national average for Medicaid managed care health plans.	Outcome	Progress Made
Objective 2.5- Ensure that annual member experience of care survey MCO and DO customer service quality rates are equal to or higher than the national average for Medicaid managed care plans.	Outcome	Progress Made
Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO and DO system wide performance measure evaluation.	Process	Met
Objective 3.2 – Ensure annual EQRO contract compliance audit results demonstrate MCO and DO contract standards are being met; and, for those standards that are not met, corrective action plans are approved.	Process	Met
Objective 4.1 - Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO and DO performance measures.	Process	Met
Objective 4.2 - Ensure that monthly EQRO encounter data validation results demonstrate MCO and DO contract compliance for timeliness and accuracy of encounter data.	Process	Progress Made
Objective 5.1 – Maintain MCO and DO performance improvement projects that are validated and align with DHHS goals and	Process	Met

[8] Additional follow-up activity and processes added.

objectives.		
Objective 5.2 – Ensure MCOs and DOs have acted upon each EQR recommendation/finding in the organization’s annual QAPI report or semi-annual EQRO.01 report.	Process	Met
Objective 5.3 – Maintain Quality Withhold and Incentive Program.	Process	Met
Objective 5.4 – Maintain Quality Performance Based Auto-Assignment Program.	Process	Met
Objective 5.5 – Maintain liquidated damages program that includes sanctions that are compliant with 42 CFR 438 Subpart I.	Process	Met
Objective 5.6 – Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators.	Process	Met
Objective 6.1 – Identify, evaluate, and to the extent possible reduce health disparities.	Process	Progress Made
Objective 6.2 – Identify, evaluate and to the extent possible reduce health disparities in the behavioral health population.	Process	Progress Made
Objective 6.3 – Increase care coordination in the Managed Care Population.	Outcome	Progress Made
Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.	Outcome	Met
Objective 7.2 – Ensure state meets goals of the Community Mental Health Program directed payment.	Outcome	Progress Made
Objective 7.3 – Ensure state meets goals of the Critical Access Hospital directed payment.	Outcome	Progress Made

Detailed Results

Goal 1 – Assure quality and appropriate care delivery to the NH Medicaid population enrolled in managed care.

Objective 1.1 – Ensure that by the end of State Fiscal Year 2025 NH identified priority annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	
Confirm activity was conducted	See report: *NH Medicaid Care Management Quality Improvement Priority Update – SFY 2024* - https://medicaidquality.nh.gov/sites/default/files/SFY%202023%20NH%20MCM%20Quality%20Improvement%20Priority%20Update%20Recommendations_Final.pdf The report provides analysis of the annual data collected from the three MCOs for the 6 prevention measures selected as performance improvement priorities. The Medicaid Quality Program collects annual data on preventive care from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of prevention. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets. Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Result are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.
Baseline Data	Calendar Year 2020– 6 out of 6 measures did not meet the goal.
Current Results	Calendar Year 2022: • 3 out of 6 measures made progress toward meeting the goal; and • 3 out of 6 measures did not make progress or meet the goal. The measures that did not meet the goal were Immunizations for Adolescents Combination Including HPV Vaccinations (IMA-CH), Immunizations for Adolescents Combination without HPV Vaccinations (IMA-CH), and

	Timeliness of prenatal care (PPC-prenatal). See Appendix A for complete results.
Progress on Objective (Met/Made Progress/Not Met)	Progress made.
Describe plan /provider-level corrective action (if any)	To incentivize and drive improvement in adolescent immunizations, the Department has included Adolescent Well Child Visits (WCV-CH) in the NH Medicaid Care Management Withhold and Incentive Program beginning in SFY 2021. To continue improving timely and adequate prenatal and postpartum care, the Department has included Timeliness of Prenatal Care (PPC) and Postpartum Care (PPC) in the NH Medicaid Care Management Withhold and Incentive Program beginning in SFY 2021.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 1.2 – Ensure that by the end of State Fiscal Year 2025 NH identified priority annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	
Confirm activity was conducted	See report: *NH Medicaid Care Management Quality Improvement Priority Update – SFY 2024* - https://medicaidquality.nh.gov/sites/default/files/SFY%202023%20NH%20MCM%20Quality%20Improvement%20Priority%20Update%20Recommendations_Final.pdf The report provides analysis of the 5 treatment measures that were selected as performance improvement priorities.

	The Medicaid Quality Program collects annual data on treatment from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of treatment. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets. Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Results are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov/.
Baseline Data	Calendar Year 2020 – 5 out of 5 measures did not meet the goal.
Current Results	Calendar Year 2022: • 3 out of 5 measures made progress meeting the goal; and • 2 out of 5 measures did not make progress or meet the goal. The measure was Pharmacotherapy for Opioid Use Disorder (POD) and Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance (ADD-CH) See Appendix A for complete results.
Progress on Objective	Progress made.
Describe plan/provider-level corrective action (if any)	One of the measures not making progress is Pharmacotherapy for Opioid Use Disorder (POD). To incentivize improvement, this measure was added to the NH Medicaid Care Management Withhold and Incentive Program beginning with SFY 2022.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.

Revisions based on evaluation (if any)	None at this time.

Goal 2 – Assure members have access to care and a quality experience of care

<table>
<tr><td colspan="2">Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.</td></tr>
<tr><td>Confirm activity was conducted</td><td>Confirmed for the annual period 1/1/2021-12/31/2021, 1/1/2022-12/31/2022, and 1/1/2023-12/31/2023.

On an annual basis, the MCM Quality Program evaluates each MCO’s network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include:
• Annual member utilization of services provided by this provider type;
• Reasons for the unmet standards;
• MCO solution for deficiency;
• Progress on the solution if this was a previously requested exception; and
• Provider level detail.

Exceptions are reviewed by a cross-functional group of Department staff to approve the MCO’s requests for exceptions. Reasons for exception that are currently under consideration are:
• An insufficient number of qualified New Hampshire Medicaid and commercial providers or facilities are available to meet the geographic and timely access standards;
• The plan’s failure to develop a provider network that is sufficient in number and type of providers to meet all of the standards in the Medicaid Care Management Contract (due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons); and
• The required service can be obtained using telemedicine or telehealth from an in-network participating provider.</td></tr>
</table>

Current Results	In calendar year 2022, the most recent year results are available, of the 600 county and provider combinations that were evaluated, there were 62 instances, listed below, where at least one plan did not meet 90% of either the time or distance standards. In most instances the reason was a lack of the provider type in the county. In all instances the MCO had a plan for members in the county to access services. • Adult Medical Day Care (Coos) • Allergist (Coos) • Developmental Behavioral Health Pediatrician (Belknap, Carroll, Cheshire, Coos, Grafton, Merrimack, Stafford) • Hospital – Diagnostic Cardiac Catheterization (Cheshire, Coos) • Hospital – Therapeutic Radiation (Carroll, Coos, Grafton) • Licensed Renal Dialysis (Coos, Grafton) • Methadone Clinic (Carroll, Coos, Grafton) • Ophthalmologist (Coos) • Pediatric Specialist: Allergist/Immunologist, Audiologist, Ophthalmologist, Orthopedic Surgeon, Orthopedist, Otolaryngologist, Plastic Surgeon (All Counties) • Plastic Surgeon (Carroll, Coos, Grafton) • Short-Term Care Facility for Inpatient Psychiatric (Carroll, Cheshire, Coos, Grafton) • Short-Term Facility for Inpatient Medical Rehabilitation Services (Coos) • Thoracic Surgery (Coos, Grafton) Exception to network adequacy in 2022 are consistent with previous exceptions. All exceptions to network adequacy have MCO plans about how members will access services. The greatest number of exceptions are for providers in Carroll, Coos, and Grafton counties. Pediatric specialties represent the only provider type with statewide exceptions to network adequacy.

<table>
<tr><td>Progress on Objective</td><td>Met</td></tr>
<tr><td>Describe plan/provider-level corrective action (if any)</td><td>None at this time.</td></tr>
<tr><td>Describe system-level program changes made as a result of monitoring findings (if any)</td><td>DHHS will continue to monitor the MCOs networks on an annual basis and member access to care related to these services.</td></tr>
<tr><td>Revisions based on evaluation (if any)</td><td>None at this time.</td></tr>
<tr><td colspan="2">Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue</td></tr>
<tr><td>Confirm activity was conducted</td><td>Confirmed.

The MCO contract includes all requirements of 42 CFR 438.340 for assuring member access to care and availability of services. For monitoring member access to care and availability of services, the MCM Quality Program regularly reviews a selection of performance measures designed to evaluate beneficiary needs as well as service utilization. Measures include but are not limited to:
• Grievances and Appeals;
• Services utilization (i.e., emergency department, office/clinic visits);
• Emergency department visits for conditions treatable in primary care;
• Beneficiary requests for primary care and specialist;
• Member experience of care survey measures; and
• Network adequacy standards.

Annually, each MCO conducts a provider survey to determine compliance with the availability of services standards in the MCO contract. Survey results were reported to NH DHHS in August each year (2021, 2022, and 2023) for the prior calendar year's survey results. Corrective Action Plans are submitted for every provider category at the statewide or county level that is below any timely access</td></tr>
</table>

	standard threshold. Annually, the EQRO will conduct a secret shopper or revealed caller study for selected New Hampshire provider types. While each study will have a different focus, the core of the initiative will determine: • New Hampshire providers accepting Medicaid; • New Hampshire providers accepting Medicaid and accepting new patients; and • Projected wait times for new appointments. Reports completed: • State Fiscal Year 2021 Revealed Caller Survey of 5 types of Physical Health Specialty Providers Report • State Fiscal Year 2022 Revealed Provider Network Survey Report-PCPs, 8 types of Physical Health Specialty Providers, BH Providers (MH & SUD) • Sate Fiscal Year 2023 Revealed Provider Network Survey Report- Follow-up report of PCPs, 8 types of Physical Health Specialty Providers, BH Providers (MH & SUD)
Baseline Data	Percentage of MCO access performance measure reviews and annual EQRO secret shopper/revealed caller study that are conducted to identify potential access issues SFY 2021 baseline: 100%
Current Results	Percentage of monthly MCO access performance measure reviews that are conducted to identify potential access issues: • SFY 2022: 100% • SFY 2023: 100%
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	SFY 2022 & 2023 Revealed Provider Network Survey Reports: MCOs were provided a case-level data file that contained mismatched information between the MCO data and provider office responses and address each documented deficiency.

Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 2.3 – Ensure that MCOs and DO provide accurate information in their provider directories	
Confirm activity was conducted	The External Quality Review Organization (EQRO) for the NH MCM Quality Program evaluated MCO online provider directories annually and compared them with provider data submitted to the EQRO. See report *NH Secret Shopper Report 2021*: https://medicaidquality.nh.gov/sites/default/files/NH2021_Specialty%20Provider%20Survey_Report_F1.pdf See report *NH Network Validation Survey Report July 2022*: https://medicaidquality.nh.gov/sites/default/files/NH2022_Network%20Validation%20Survey_Report_F1.pdf See report *NH Network Validation Survey Report August 2023*: https://medicaidquality.nh.gov/sites/default/files/NH_SFY2023_Network%20Adequacy%20Validation%20Report_F1.pdf The DO provider analysis will be completed in SFY25.
Baseline Data	N/A
Current Results	The EQRO audited the MCO online provider directories compared to MCO supplied provider data files

	for exact matches. Exact match was defined as matching across the following seven indicators: provider name, provider address, provider city, provider state, provider ZIP Code, provider telephone number, and provider type/specialty. For SFY 2022 results: • Percentage of MCO audited primary care providers with exact matches* between MCO data and provider directory: 78.4% • Percentage of MCO audited behavioral health providers with exact matches* between MCO data and provider directory: 77.3% • Percentage of MCO audited specialist providers with exact matches between MCO data and provider directory: 78.1%
Progress on Objective	Met
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 2.4 - Ensure that by the end of State Fiscal Year 2025, annual member experience of care survey access to care rates are equal to or higher than the national average for Medicaid managed care health plans.	
Confirm activity was conducted	For CY2021 and CY2022 Adult and Child CAHPS experience of care survey results were compared to the national 50th percentile for the following managed care questions: • Adults CAHPS – Getting care quickly: Getting needed care right away – usually or always • Adults CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always • Adults CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed

	• Adults CAHPS – Getting needed care: Ease in getting care, tests, and treatment • Child CAHPS – Getting care quickly: Getting needed care right away – usually or always • Child CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always • Child CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed • Child CAHPS – Getting needed care: Ease in getting care, tests, and treatment
Baseline Data	• Adults CAHPS – Getting care quickly: Getting needed care right away – usually or always CY 2020 baseline: 84.9% • Adults CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always CY 2020 baseline: 85.2% • Adults CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed CY 2020 baseline: 85.5% • Adults CAHPS – Getting needed care: Ease in getting care, tests, and treatment CY 2020 baseline: 87.8% • Child CAHPS – Getting care quickly: Getting needed care right away – usually or always CY 2020 baseline: 95.1% • Child CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always CY 2020 baseline: 89.5% • Child CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed CY 2020 baseline: 82.6% • Child CAHPS – Getting needed care: Ease in getting care, tests, and treatment CY 2020 baseline: 89.5%

Current Results	• Adults CAHPS – Getting care quickly: Getting needed care right away – usually or always CY 2022 rate: 83.0% • Adults CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always CY 2022 rate: 78.5% • Adults CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed CY 2022 rate: 77.5% • Adults CAHPS – Getting needed care: Ease in getting care, tests, and treatment CY 2022 rate: 83.6% • Child CAHPS – Getting care quickly: Getting needed care right away – usually or always CY 2022 rate: 90.6% • Child CAHPS – Getting care quickly: Getting routine or check-up appointments as soon as they were needed – usually or always CY 2022 rate: 86.6% • Child CAHPS – Getting care quickly: Getting appointment with a specialist as soon as needed CY 2022 rate: 80.0% • Child CAHPS – Getting needed care: Ease in getting care, tests, and treatment CY 2022 rate: 90.7% See Appendix A for complete results.
Progress on Objective	Progress Made. Five of eight survey responses are above the National 50th percentile for CY 2022. The DO survey will be completed for the first time in CY 2024.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 2.5 - Ensure that annual member experience of care survey MCO and DO customer service quality rates are equal to or	

higher than the national average for Medicaid managed care health plans	
Confirm activity was conducted	For CY2021 and CY2022 Adult and Child CAHPS customer service survey results were compared to the national 50th percentile for the following managed care questions: • Adult CAHPS – Health plan customer service provided information or help – usually or always • Adult CAHPS – Health plan customer service treated member with courtesy and respect – usually or always • Child CAHPS – Health plan customer service provided information or help – usually or always • Child CAHPS – Health plan customer service treated caregiver with courtesy and respect – usually or always
Baseline Data	• Adult CAHPS – Health plan customer service provided information or help – usually or always CY 2020 baseline: 85.4% • Adult CAHPS – Health plan customer service treated member with courtesy and respect – usually or always CY 2020 baseline: 95.0% • Child CAHPS – Health plan customer service provided information or help – usually or always CY 2020 baseline: 82.2% • Child CAHPS – Health plan customer service treated caregiver with courtesy and respect – usually or always CY 2020 baseline: 97.8%
Current Results	• Adult CAHPS – Health plan customer service provided information or help – usually or always CY 2022 rate: 82.0% • Adult CAHPS – Health plan customer service treated member with courtesy and respect – usually or always CY 2022 rate: 96.2% • Child CAHPS – Health plan customer service provided information or help – usually or always CY 2022 rate: 87.0% • Child CAHPS – Health plan customer service treated caregiver with courtesy and respect – usually or always CY 2022 rate: 96.0%

	See Appendix A for complete results.
Progress on Objective	Progress made. Three of four survey response rates are above the National 50th percentile. The DO survey will be completed for the first time in CY 2024.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.

Goal 3 – Assure MCO and DO contract compliance

Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO and DO system wide performance measure evaluation.	
Confirm activity was conducted	The NH MCM Program includes a robust list of required quality reports. These data are presented both as individual measures and aggregated into measure sets and reports to demonstrate the impact of specific programs and overall MCO impact in all domains of administrative and clinical quality. On a monthly basis, the MCM Quality Program analyzes measures, plans, and reports for performance issues at the population and MCO level. The State reviews for: • Performance that is concerning relative to contract standards; • Continued trends over 3 measurement cycles; and • Notable increases and decrease from the prior reporting period. Performance issues are reviewed weekly by the State's contract managers. Others may be enlisted to discuss specific quality measures, reports, or plans as needed based on concerns identified during data review. State contract managers then share the results with the MCOs for potential corrective action and performance improvement.
Baseline Data	Percentage of months the Department completed the Medicaid Director's Remedy Report for the MCO SFY 2021 baseline: 100%

<table>
<tr><td>Current Results</td><td>From July 2021 – June 2024 the Department identified 225 issues of late, incorrect, or incomplete deliverables and an additional 181 instances where performance data indicated an MCO was out of compliance with a contract performance threshold. The most frequently cited performance indicators include:
• Health Risk Assessments
• MCO Contacts and Contact Attempts following ED Discharges for SUD
• Timely Provider Credentialing for Specialists
• Timely processing of all non-electronic provider claims within 30 days of receipt
For SFY 2023, the Medicaid Directors Remedy report was completed and acted upon for 12/12 months (100%).
DHHS tracked monthly DO performance issues beginning with deliverables that were due on or after April 1, 2023, corresponding with the program start date however, liquidated damages were not assessed for the first year of the program.</td></tr>
<tr><td>Progress on Objective</td><td>Met</td></tr>
<tr><td>Describe plan/provider-level corrective action (if any)</td><td>None at this time.</td></tr>
<tr><td>Describe system-level program changes made as a result of monitoring findings (if any)</td><td>The Department began exercising contractual authority to impose liquidated damages on April 1, 2021. Between June 1, 2021 and June 30, 2024 the Department has estimated $1,182,000 in liquidated damages to health plans that are out of compliance with specific provisions of the MCO contract.
It is expected that DHHS will begin exercising its contractual authority to impose liquidated damages on the DO for reporting items due on or after April 30, 2024.</td></tr>
<tr><td>Revisions based on evaluation (if any)</td><td>None at this time.</td></tr>
<tr><td colspan="2">Objective 3.2 – Ensure annual EQRO contract compliance audit results demonstrate MCO and DO contract standards are being met; and, for those standards that are not met, corrective action plans are approved.</td></tr>
</table>

Confirm activity was conducted	The EQRO conducted a compliance review at each MCO. See report 2023 New Hampshire External Quality Review Technical Report February 2024: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202023.pdf The EQRO conducts an annual compliance review at the offices of each MCO to ensure compliance with federal and State requirements including MCO contract requirements. After completing a comprehensive contract review in the first year of the MCM program, a new three-year cycle of reviewing one-third of all the elements contained in the compliance tool are implemented. For the review, a standard is created for each requirement. Requirements are reviewed to determine whether the standard has been: “Met,” “Partially Met,” or “Not Met”. Standards that are “Partially Met” or “Not Met” require the health plan to submit a corrective action plan that must be approved by the EQRO. All standards that result in corrective action plans are re-examined during the following year’s review. The DO contract compliance audit will be performed for the first time in SFY 2025.
Baseline Data	Percentage of MCO contract standards that are being met; and, for those standards that are not met, corrective action plans are approved SFY 2021 baseline: 100% The SFY 2021 overall compliance review scores were: • ACNH: initial score, 99.0%, final score 100%; • NHHF: initial score, 99.5%, final score 100%; and • WS: initial score 97.4%, final score 100%
Current Results	The SFY 2022 overall compliance review scores were: • ACNH: initial score, 99.2%, final score 100%; • NHHF: initial score, 99.6%, final score 100%; and • WS: initial score, 98.8%, final score 100%.

	The SFY 2023 overall compliance review scores are: • ACNH: initial score, 98.6%, final score 100%; • NHHF: initial score, 94.5%, final score 100%; and • WS: initial score, 97.7%, final score 100%. See Tables B-2 through B-4 for Standards and Scores Achieved for each MCO in the Compliance Reviews From SFY 2021–SFY 2023 located in the 2023 EQR Technical Report includes the initial results for all 18 standards and is available at: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202023.pdf. All MCO received a final score each year after completing a Corrective Action Plans (CAP) for all items initially scored as being partially met or not met.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time. Each MCO is required to complete an MCO-specific CAP for all items that are initially scored partially met or not met. The MCO-specific CAP remains open until the MCO is 100% compliant.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.

Goal 4 – Assure the quality and validity of MCO and DO data.

Objective 4.1 - Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO and DO performance measures.	
Confirm activity was conducted	The EQRO conducted a performance measure validation review for each MCO for SFY 2021, 2022, and 2023. Results are contained within the Annual EQRO Technical Reports. SFY 2021 – *See report 2021 New Hampshire External Quality Review Technical Report April 2022:* https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%2021_0.pdf SFY 2022 - See report *2022 New Hampshire External Quality Review Technical Report April 2023:* https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%2022.pdf SFY 2023 - See report *2023 New Hampshire External Quality Review Technical Report February 2024*: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%2023.pdf DO performance measure validation will be performed for the first time in SFY 2025.
Baseline Data	Percentage of MCO performance measures in the EQRO audit that are determined to be acceptable for reporting SFY 2021 baseline: 100% The SFY 2021 overall performance measure validation findings are: • Amerihealth Caritas: 100% • New Hampshire Healthy Families: 100% • Well Sense Health Plan: 92.8% (1/14 performance measure was not reportable due to data issue that could not be corrected in study data period. Reassessed in 2022 and received 100%)

Current Results	The SFY 2022 overall performance measure validation findings are: • Amerihealth Caritas: 100% • New Hampshire Healthy Families: 100% • Well Sense Health Plan: 100% The SFY 2023 overall performance measure validation findings are: • Amerihealth Caritas: 100% • New Hampshire Healthy Families: 100% • Well Sense Health Plan: 100%
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	2021: WS was unable to complete primary source verification for ACCESSREQ.05. The issue's root cause was under investigation and undetermined as of the completion of the SFY 2021 PMV. The PM was reassessed during the 2022 PMV. WS received a 100% compliance score.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 4.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO and DO contract compliance for timeliness and accuracy of encounter data.	
Confirm activity was conducted	The EQRO, in conjunction with DHHS, conducted encounter data validation review for each MCO for SFY 2021, 2022, and 2023. Results are contained within the Annual EQRO Technical Reports. SFY 2021 – *See report 2021 New Hampshire External Quality Review Technical Report April 2022:* https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202

021_0.pdf

SFY 2022 - See report *2022 New Hampshire External Quality Review Technical Report April 2023:* https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202022.pdf

SFY 2023 - See report *2023 New Hampshire External Quality Review Technical Report February 2024*: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202023.pdf

Baseline Data

- X12 EDI Compliance Edits (Professional and Institutional) SFY 2021 baseline: 100%
- Validity of Member Identification Number (Professional, Institutional, Pharmacy) SFY 2021 baseline: 100%
- Validity of Billing Provider Information (Professional, Institutional, Pharmacy) SFY 2021 baseline: 100%
- Validity of Servicing Provider Information (Professional, Institutional) SFY 2021 baseline: 100%
- Initial Submission Within 14 Days of Claim Payment (Professional, Institutional, Pharmacy) SFY 2021 baseline: 85.5%-100%

SFY 2021 encounter data validation findings:

Evaluation Area	Standard	MCO	837P Encounters		837I Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
X12 EDI Compliance Edits	98.0%	ACNH	100.0%		100.0%		NA	
		NHHF	100.0%		100.0%		NA	
		WS	100.0%		100.0%		NA	
Validity of Member Identification Number*	100.0%	ACNH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %
		NHHF	100.0%	99.8%	100.0%	100.0%	100.0%	99.9%
		WS	100.0%	99.7%	100.0%	99.6%	100.0%	100.0 %

Evaluation Area	Standard	MCO	837P % Present	837P %Valid	837I % Present	837I %Valid	Pharmacy % Present	Pharmacy %Valid
Validity of Billing Provider Information*	98.0%	ACNH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %
		NHHF	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %
		WS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %
Validity of Servicing Provider Information*	98.0%	ACNH	100.0%	100.0%	100.0%	100.0%	NA	
		NHHF	100.0%	100.0%	100.0%	100.0%	NA	
		WS	100.0%	100.0%	100.0%	100.0%	NA	
Initial Submission Within 14 Days of Claim Payment*	100.0%	ACNH	98.8%		99.1%		100.0%	
		NHHF	99.0%		99.6%		85.5%	
		WS	99.2%		100.0%		95.3%	

Current Results

SFY 2022 encounter data validation findings:

Evaluation Area	Standard	MCO	837P Encounters		837I Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
X12 EDI Compliance Edits	98.0%	ACNH	100%		100%		NA	
		NHHF	100%		100%		NA	
		WS	100%		100%		NA	
Validity of Member Identification Number	100%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	99.9%	100%	99.8%	100%	100%
Validity of Billing Provider Information	98.0%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	100%	100%	100%	100%	100%
Validity of Servicing Provider Information	98.0%	ACNH	100%	100%	100%	100%	NA	
		NHHF	100%	100%	100%	100%	NA	
		WS	100%	100%	100%	100%	NA	

Initial Submission Within 14 Days of Claim Payment	100%	ACNH	100%	100%	100%
		NHHF	82.8%	100%	99.8%
		WS	97.9%	99.8%	91.1%

SFY 2023 encounter data validation findings:

Evaluation Area	Standard	MCO	837P Encounters		837I Encounters		Pharmacy Encounters	
			% Present	%Valid	% Present	%Valid	% Present	%Valid
X12 EDI Compliance Edits	98.0%	ACNH	100%		100%		NA	
		NHHF	100%		100%		NA	
		WS	100%		100%		NA	
Validity of Member Identification Number	100%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	99.9%	100%	99.9%	100%	100%
Validity of Billing Provider Information	98.0%	ACNH	100%	100%	100%	100%	100%	100%
		NHHF	100%	100%	100%	100%	100%	100%
		WS	100%	100%	100%	100%	100%	100%
Validity of Servicing Provider Information	98.0%	ACNH	100%	100%	100%	100%	NA	
		NHHF	100%	100%	100%	100%	NA	
		WS	100%	100%	100%	100%	NA	
Initial Submission Within 14 Days of Claim Payment	100%	ACNH	99.9%		100%		100%	
		NHHF	97.0%		100%		99.7%	
		WS	94.5%		99.8%		99.7%	

	DO encounter data validation will be performed for the first time in SFY 2025.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	In addition to the standard EQRO EDV activity, high quality encounter data was added as a performance-based auto assignment method beginning in SFY 2022 to incentivize high performing MCOs on the quality of their encounter data.
Revisions based on evaluation (if any)	None at this time

Goal 5 – Maintain Quality Performance Improvement Initiatives

Objective 5.1 – Maintain MCO and DO performance improvement projects that are validated and align with DHHS Medicaid Quality priority areas.	
Confirm activity was conducted	The EQRO validated Performance Improvement Projects for each MCO. See report *2023 New Hampshire External Quality Review Technical Report February 2024*: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202023.pdf The DO will perform PIPs for the first time in SFY 2025.
Baseline Data	Percentage of MCO PIPs that are validated by the EQRO and align with DHHS goals and objectives SFY 2021 baseline: 100%
Current Results	In SFY 2023 the MCOs concluded the first of two required rapid-cycle PIPs. All PIPs aligned with DHHS priority areas.

	Validation results for each PIP include:
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.

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

MCO	**Confidence Level**		**Comments on Module 4**
	Modules 1-3	**Module 4**	
ACNH	High	Moderate	• ACNH achieved statistically significant improvement • ACNH did not conduct accurate data analysis • ACNH did not accurately interpret the PIP results
NHHF	High	Moderate	• NHHF did not achieve statistically significant improvement • NHHF did achieve significant programmatic improvement • NHHF did not achieve the SMART Aim goal
WS	High	Moderate	• WS did not achieve statistically significant improvement

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

MCO	**Confidence Level**		**Comments on Module 4**
	Modules 1-3	**Module 4**	
ACNH	High	Moderate	• ACNH did not achieve statistically significant improvement • ACNH did not achieve the SMART Aim goal
NHHF	High	Low	• NHHF did not achieve statistically significant improvement • NHHF could not reasonably link any of the interventions to the improvement
Continued Engagement of Opioid Abuse or Dependence Treatment			
WS	High	Low	• WS reported that all rolling 12-month measurements declined compared to the baseline • WS submitted incomplete forms for Module 4

Describe system-level program changes made as a result of monitoring findings (if any)	All four PIP modules for each MCO were validated as shown above. As a result of the low-moderate success of the PIPs demonstrating statistically significant improvement, the Bureau of Program Quality has recommended incentivizing MCOs based on the outcome of the selected PIPs. The incentive is proposed to be part of the Withhold and Incentive program beginning for SFY 2025.
Revisions based on evaluation (if any)	None at this time.
Objective 5.2 – Ensure MCOs and DOs have acted upon each EQR recommendation/finding in the Organization's annual QAPI report or the semi-annual EQRO.01 report.	
Confirm activity was conducted	For SFY 2023, all three MCOs submitted their QAPI and EQRO.01 reports as required.
Baseline	N/A
Current Results	• All three MCOs reported on 100% of the required items in the QAPI.02 (annual) and EQRO.01 semi-annual reports.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 5.3 – Maintain Quality Withhold and Incentive Program.	

Confirm activity was conducted	Starting in SFY 2021, the Department implemented an annual Medicaid Care Management Withhold and Incentive Program. The program includes specific performance measures that align with Departmental goals and objectives, including but not limited to measures outline in Objective 1.1 and 1.2. Withhold dollars that are not earned back by an MCO are used to fund an incentive pool that can award high performing MCOs.
Baseline	Percentage of withhold and incentive program stages that are completed SFY 2021 baseline: 100% • Amerihealth Caritas earned back 67% of their withhold amount and earned $0.00 for exceptional performance. • New Hampshire Healthy Families earned 79% of their withhold amount and earned $480,035.38 for exceptional performance. • Well Sense Health Plan earned back 46% of their withhold amount and earned back $0 for exceptional performance.
Current Results	Percentage of withhold and incentive program stages that are completed SFY 2022: 100%. • Amerihealth Caritas earned back 0% of their withheld amount and earned $0.00 for exceptional performance. • New Hampshire Healthy Families earned back 8.33% of their withheld amount and earned $0.00 for exceptional performance. • Well Sense Health Plan earned back 41.67% of their withheld amount and earned $0.00 for exceptional performance.
Progress on Objective	DHHS continues to maintain a Quality Withhold and Incentive Program designed around priority areas and related health outcome metrics.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as	DHHS will continue with a Quality Withhold and Incentive program however, some structural changes are under consideration for measurement periods beginning with CY 2025.

a result of monitoring findings (if any)	
Revisions based on evaluation (if any)	None at this time.
Objective 5.4 – Maintain Quality Performance Based Auto-Assignment (PBAA) Program.	
Confirm activity was conducted	The Department began administering an annual Performance Based Auto Assignment Program in SFY 2021 to incentivize MCO performance on a variety of Department priorities. The incentives resulting from the PBAA Program can result in preferential auto-assignment of members at time of enrollment to the highest performing MCO(s).
Baseline	SFY 2021 baseline: 100% of months had PBAA in effect.
Current Results	SFY 2022: 100% of months had PBAA in effect. SFY 2023: 100% of months had PBAA in effect.
Progress on Objective	DHHS continues to maintain a Quality Performance Based Auto-Assignment Program designed around priority areas and outcome metrics.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	DHHS will continue with a Quality Performance Based Auto-Assignment program. Beginning in SFY 2024, second place membership awards were removed in favor of larger first place membership awards in order to encourage continuous improvement for priority metrics.
Revisions based on evaluation (if any)	None at this time.
Objective 5.5 – Maintain liquidated damages program that includes sanctions that are compliant with 42 CFR 438 Subpart I.	
Confirm activity was conducted	MCO and DO performance is monitored for violations which may be subject to varying levels of financial penalty according to Exhibit N, Liquidated Damages Matrix, in the MCM and DO contracts.

	For SFY 2022 and SFY 2023, the Department monitored and assessed four tiered categories of liquidated damages based on violations or non-compliance to the Medicaid Care Management Services contract standards and Medicaid Care Management Dental Services contract.
Baseline	SFY 2021 baseline: 100% of months had liquidated damages program in effect that was compliant with 42 CFR 438 Subpart I.
Current Results	SFY 2022: 100% of months had liquidated damages program in effect that was compliant with 42 CFR 438 Subpart I. SFY 2023: 100% of months had liquidated damages program in effect that was compliant with 42 CFR 438 Subpart I.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	At least monthly, the MCOs and DO are issued an individual report detailing performance issues which are subject to financial penalties as well as request from DHHS for any corrective action for repeat performance violations.
Describe system-level program changes made as a result of monitoring findings (if any)	Some modifications to Exhibit N are in place for the next 5-year MCM contract, such as new financial penalties associated with NEMT performance violations, but overall DHHS will continue with a liquidated damages program as it has proven to be an effective tool for performance management.
Revisions based on evaluation (if any)	None at this time.
Objective 5.6 – Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators.	
Confirm activity was conducted	In SFY 2023 the Department held a quality forum to identify and prioritize the barriers and solutions to increase chlamydia screening among NH residents within the prioritized age group. See summary report: https://medicaidquality.nh.gov/sites/default/files/2023%20Medicaid%20Quality%20Meeting%20CHL%20Screening%20Summary.pdf.
Baseline	SFY 2021 baseline: DHHS conducts a multi-stakeholder quality forum that identifies barriers and solutions to improve the key performance indicator: Medicaid Member Follow-Up Appointments

	after Emergency Department Visits for Alcohol and Substance Abuse/Misuse. - 100%
Current Results	SFY 2023: Twenty-seven individuals representing hospitals, FQHCs, clinical providers, MCOs, community organizations, and DHH staff participated in the quality forum. Identified barriers fell into three top themes: education, comfort discussing sexually transmitted infections, and screening. Strategies to address the three categories of barriers were identified for providers, MCOs, and the NH DHHS. See summary report: https://medicaidquality.nh.gov/sites/default/files/2023%20Medicaid%20Quality%20Meeting%20CHL%20Screening%20Summary.pdf.
Progress on Objective	Met. DHHS, in collaboration with the EQRO, continues to host and plan multi-stakeholder forums for the MCOs, DHHS, and health care providers, to brainstorm barriers and solutions to improve key performance indicators.
Describe plan/provider-level corrective action (if any)	None at this time. The SFY 2024 Quality Forum topic scheduled for June 2024 will be Increasing Lead Level Testing Rates of 1- and 2-Year-olds.
Describe system-level program changes made as a result of monitoring findings (if any)	Each year nursing contact hour credit were offered for participation. SFY 2024, the Quality Forum will also offer CMEs in an effort to attract more physicians to the forum.
Revisions based on evaluation (if any)	None.

Goal 6 – Conduct Key Population Health Quality Activities

Objective 6.1 – Identify, evaluate and to the extent possible reduce health disparities. [42 CFR 438.340(b)(6)].	
Confirm activity was conducted	Partially confirmed. Calendar Year 2020 member level data for 11 HEDIS metrics were evaluated using multiple logistic regression modeling in an effort to identify health disparities based on age, race, ethnicity, gender, geography, and disability status. NH's health data has some systematic data

	collection limitations, specifically with race, ethnicity, and primary language, for which sophisticated statistical techniques (multiple imputation) must be applied, or for which analysis cannot be conducted. High level results are contained in NH's Comprehensive Medicaid Quality Strategy: https://medicaidquality.nh.gov/care-management-quality-strategy-0
Baseline	Percentage of tasks associated with the health disparity plan that were completed SFY 2021 baseline: 100%
Current Results	Preliminary calendar year 2020 results reported in NH's Comprehensive Medicaid Quality Strategy.
Progress on Objective	Progress made. During SFY 2022 and SFY 2023, member details on 47 HEDIS metrics were collected for calendar years 2021 and 2022 and are undergoing regression analysis. Results will be compiled and reported.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	Calendar year 2020 results reinforced the need for NH DHHS to inventory and evaluate collection of all demographic and social determinants of health data across all data and eligibility systems, including Medicaid. NH DHHS joined the National Academy of State Health Policy (NASHP) Learning Lab program to learn from other states who are leaders in this topic and has embarked on a multi-year project to enact system-level changes in data collection and management.
Revisions based on evaluation (if any)	None.
Objective 6.2 – Identify, evaluate, and to the extent possible reduce health disparities in the behavioral health population.	
Confirm activity was conducted	Partially confirmed. Calendar Year 2020 member level data for 11 HEDIS metrics were evaluated using multiple logistic regression modeling in an effort to identify health disparities based on the member being identified as a Community Mental Health Center client. High level results are contained in NH's Comprehensive Medicaid Quality Strategy:

	https://medicaidquality.nh.gov/care-management-quality-strategy-0
Baseline	Percentage of tasks associated with the health disparity plan that were completed SFY 2021 baseline: 100%
Current Results	Preliminary calendar year 2020 results reported in NH's Comprehensive Medicaid Quality Strategy.
Progress on Objective	Progress made. In SFY 2022 and SFY 2023 member details on 47 HEDIS metrics were collected for calendar years 2021 and 2022 and are undergoing regression analysis. Results will be compiled and reported.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 6.3 – Increase care coordination in the Managed Care Population.	
Confirm activity was conducted	Through SFY 2022 and SFY 2023 DHHS continued to monitor performance standards for enrollment in care management and health risk assessment completions through Exhibit O reporting.
Baseline	• Percentage of members enrolled in an MCO who are enrolled in care management SFY 2021 baseline: 1.9% • Percentage of members who annually complete a health risk assessment SFY 2021 baseline: 12.3%

	Dental risk assessment baseline is not expected until 5/31/2024.
Current Results	SFY 2022: • Percentage of members enrolled in an MCO who are enrolled in care management: 3.5% • Percentage of members who annually complete a health risk assessment: 19.3% SFY 2023: • Percentage of members enrolled in an MCO who are enrolled in care management: 3.6% • Percentage of members who annually complete a health risk assessment: 23.4%
Progress on Objective	Progress made. The MCOs made measurable improvement in both care management enrollment and health risk assessment completion. In SFY 2023 care management enrollment achieved the performance target (3%), but the health risk assessment performance target (25%) has not yet been achieved.
Describe plan/provider-level corrective action (if any)	Both measures are subject to liquidated damages for every reporting period an MCO does not achieve the contractually required performance standard for care management enrollment and health risk assessment completions.
Describe system-level program changes made as a result of monitoring findings (if any)	For the next 5-year MCM contract which begins on 9/1/2024, the approach to care management and health risk assessments will be changing. Care management will be based on the services the MCO provides to specific priority populations (inpatient behavioral health members, DCYF/juvenile justice involved youth, NAS babies, and community re-entry members leaving the State prison system). Health risk assessment will largely be shifted to an activity the primary care provider will perform, rather than the MCO.
Revisions based on evaluation (if any)	None at this time.

Goal 7 – Achieve State Directed Payment Goals

Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.	
Confirm activity was conducted	The most recent network adequacy reports show that in all counties, 90% of members in each MCO achieved the time or distance standard for DME (One (1) within sixty (60) minutes or forty-five (45) miles).
Baseline	Percent of counties where 90% of members meet time or distance standard for DME SFY 2021 baseline: 100%
Current Results	SFY 2023: • Percent of counties where 90% of members meet time or distance standards for DME: 100% SFY 2022: • Percent of counties where 90% of members meet time or distance standards for DME: 100%
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 7.2 – Ensure state meets goals of the Community Mental Health Program directed payment.	
Confirm activity was	DHHS continues to monitor five outcome-related metrics specific to the CMHC population. For CY

conducted	2022, data shows correct directionality in four out of five evaluation metrics compared to CY 2021.
Baseline	Calendar year 2019: • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 30 calendar days (lower performance desired): 6.4% • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 90 calendar days (lower performance desired): 15.5% • Follow-up after hospitalization for mental illness within 7 days of discharge: 56.1% • Follow-up after hospitalization for mental illness within 30 days of discharge: 74% • Emergency Department Visits for mental health conditions for adult members receiving CMHC services (lower performance desired): 19.3 visits per 1000 member months
Current Results	Calendar Year 2020: • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 30 calendar days (lower performance desired): 7.9% • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 90 calendar days (lower performance desired): 15.4% • Follow-up after hospitalization for mental illness within 7 days of discharge: 61.3% • Follow-up after hospitalization for mental illness within 30 days of discharge: 75.0% • Emergency Department Visits for mental health conditions for adult members receiving CMHC services (lower performance desired): 23.9 visits per 1000 member months Calendar Year 2021: • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 30 calendar days (lower performance desired): 7.9% • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 90 calendar days (lower performance desired): 13.8%

	• Follow-up after hospitalization for mental illness within 7 days of discharge: 64.2% • Follow-up after hospitalization for mental illness within 30 days of discharge: 77.0% • Emergency Department Visits for mental health conditions for adult members receiving CMHC services (lower performance desired): 18.1 visits per 1000 member months Calendar Year 2022: • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 30 calendar days (lower performance desired): 5.9% • Members receiving CMHC services who were discharged from NHH or a DRF and readmitted within 90 calendar days (lower performance desired): 11.9% • Follow-up after hospitalization for mental illness within 7 days of discharge: 71.5% • Follow-up after hospitalization for mental illness within 30 days of discharge: 88.2% • Emergency Department Visits for mental health conditions for adult members receiving CMHC services (lower performance desired): 13.6 visits per 1000 member months
Progress on Objective	Progress made. All metrics are showing correct directionality compared to baseline.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	NH DHHS will continue with a Directed Payment for the CMHCs in some form, however the focus under consideration may shift to outcomes related to timeliness to access and for services for children.
Revisions based on evaluation (if any)	None at this time.

Objective 7.3 – Ensure state meets goals of the Critical Access Hospital directed payment.	
Confirm activity was conducted	DHHS continues to monitor three outcome-related metrics specific to the CAH population.
Baseline	Calendar year 2020: • Admission rate for the following three measures: diabetes short-term complications; heart failure admission rates; chronic obstructive pulmonary disorder or asthma in older adults: 8.8 admissions per 100,000 member months • Follow-up after emergency department visit for alcohol and other drug abuse: 57% (30-day) • Follow-up after emergency department visit for mental illness: 76% (30-day)
Current Results	Calendar year 2021: • Admission rate for the following three measures: diabetes short-term complications; heart failure admission rates; chronic obstructive pulmonary disorder or asthma in older adults: 8.8 admissions per 100,000 member months • Follow-up after emergency department visit for alcohol and other drug abuse: 58% (30-day) • Follow-up after emergency department visit for mental illness: 73% (30-day) Calendar year 2022: • Admission rate for the following three measures: diabetes short-term complications; heart failure admission rates; chronic obstructive pulmonary disorder or asthma in older adults: 8.7 admissions per 100,000 member months • Follow-up after emergency department visit for alcohol and other drug abuse: 57% (7-day) • Follow-up after emergency department visit for mental illness: 71% (7-day)
Progress on Objective	Progress made.
Describe plan/provider-	None at this time.

level corrective action (if any)	
Describe system-level program changes made as a result of monitoring findings (if any)	NH DHHS is exploring the possibility of transforming the CAH directed payment into a value-based payment. Additionally, for CY 2022, the 7-day ED follow-up measure was utilized in place of the 30-day to align with other quality initiatives and to encourage CAHs to follow-up with BH members early following an ED visit.
Revisions based on evaluation (if any)	None at this time.

Appendix A: Outcome Goals and Objectives

Metric Name	Metric Specification	Baseline Performance (Year)	2021 Rates	Current 2022 Rates (Goal Met/Progress Made/Not Met)	Current National 50th Percentile (2022)	Current National 75th Percentile (2022)
Objective 1.1 – Ensure that by the end of State Fiscal Year 2025, annual preventive care measure rates are equal to or higher than 75th percentile of National Medicaid managed care health plan rates.						
Immunizations for Adolescents Combination 1 (IMA-CH)	HEDIS/Child Core Set	74.3% (CY2020)	72.2%	71.9% (Not Met)	80.5%	85.4%
Immunizations for Adolescents Combination 2 (IMA-CH)	HEDIS/Child Core Set	33.4% (CY2020)	29.7%	29.2% (Not Met)	34.3%	40.9%
Weight Assessment and Counseling in Adolescents/Children – BMI (WCC-CH)	HEDIS/Child Core Set	63.9% (CY2020)	70.6%	73.1% (Progress Made)	79.6%	85.0%
Chlamydia Screening in Women (CHL-CH) (CHL-AD)	HEDIS/Adult & Child Core Set	46.5% (CY2020)	48.3%	48.6% (Progress Made)	56.0%	62.9%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-AD)	HEDIS/Adult Core Set	77.1% (CY2020)	82.1%	81.9% (Not Met)	84.2%	88.3%
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	HEDIS/Adult Core Set	73.1% (CY2020)	79%	80.6% (Progress Made)	78.1%	82%
Objective 1.2 – Ensure that by the end of State Fiscal Year 2025 annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.						
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance (ADD-CH)	HEDIS/Child Core Set	53.6% (CY2020)	46.5%	48.9% (Not Met)	54.4%	59.8%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	HEDIS/Child Core Set	62.4% (CY2020)	65.5%	65.9% (Progress Made)	60.2%	66.3%
Comprehensive Diabetic Care Control <8% (HBD-AD, prior to 2022	HEDIS/Child Core Set	42.8% (CY2020)	45.7%	50.1% (Progress Made)	52.3%	57.2%

Metric Name	Metric Specification	Baseline Performance (Year)	2021 Rates	Current 2022 Rates (Goal Met/Progress Made/Not Met)	Current National 50th Percentile (2022)	Current National 75th Percentile (2022)
part of CDC-AD measure)						
Controlling High Blood Pressure – Total (CBP-AD)	HEDIS/Child Core Set	52.7% (CY2020)	57%	62.5% (Progress made)	61.3%	67.3%
Pharmacotherapy for Opioid Use Disorder (POD)	HEDIS	28.0% (CY2020)	30.1%	28.3% (Not Met)	28.5%	33.9%
Objective 2.4 – Ensure that by the end of State Fiscal Year 2025, annual member experience of care survey access to care rates are equal to or higher than the national average for Medicaid managed care health plans.						
Getting Needed Care Right Away (Usually + Always) - Adult	HEDIS/AHRQ/ CAHPS	84.9% (CY2020)	82.8%	83.0% (Met)	82.9%	84.9%
Getting Routine or Check-up Appointments as Soon as They Were Needed (Usually + Always) - Adult	HEDIS/AHRQ/ CAHPS	85.2% (CY2020)	82.2%	78.5% (Not Met)	80.0%	83.8%
Getting Appointment to See Specialist as Soon as Needed (Usually + Always) - Adult	HEDIS/AHRQ/ CAHPS	85.5% (CY2020)	83.3%	77.5% (Not Met)	78.9%	82.4%
Getting needed care: Ease in getting care, tests, and treatment - Adult	HEDIS/AHRQ/ CAHPS	87.8% (CY2020)	85%	83.6% (Not Met)	84.6%	87.4%
Getting Needed Care Right Away (Usually + Always) - Child	HEDIS/AHRQ/ CAHPS	95.1% (CY2020)	92.5%	90.6% (Met)	90.4%	93.0%
Getting Routine or Check-up Appointments as Soon as They Were Needed (Usually + Always) - Child	HEDIS/AHRQ/ CAHPS	89.5% (CY2020)	88.4%	86.6% (Met)	82.0%	86.0%
Getting Appointment to See Specialist as Soon as Needed (Usually + Always) - Child	HEDIS/AHRQ/ CAHPS	82.6% (CY2020)	85.5%	80.0% (Met)	77.3%	81.1%
Getting needed care: Ease in getting care, tests, and treatment - Child	HEDIS/AHRQ/ CAHPS	89.5% (CY2020)	92.9%	90.7% (Met)	88.9%	91.5%
Objective 2.5 - Ensure that annual member experience of care survey MCO and DO customer service quality rates are equal to or higher than the						

Metric Name	Metric Specification	Baseline Performance (Year)	2021 Rates	Current 2022 Rates (Goal Met/Progress Made/Not Met)	Current National 50th Percentile (2022)	Current National 75th Percentile (2022)
national average for Medicaid managed care health plans.						
Health plan customer service provided information or help – Usually or always - Adult	HEDIS/AHRQ/ CAHPS	85.4% (CY 2020)	83%	82.0% (Not Met)	83.8%	86.2%
Health plan customer service treated member with courtesy and respect – Usually or always - Adult	HEDIS/AHRQ/ CAHPS	95.0% (CY 2020)	95.8%	96.2% (Met)	95.4%	96.7%
Health plan customer service provided information or help – Usually or always - Child	HEDIS/AHRQ/ CAHPS	82.2% (CY 2020)	88%	87.0% (Met)	81.9%	87.2%
Health plan customer service treated caregiver with courtesy and respect – Usually or always - Child	HEDIS/AHRQ/ CAHPS	97.8% (CY 2020)	96.7%	96.0% (Met)	93.5%	95.2%
Objective 6.3 – Increase care coordination in the Managed Care Population.						
Percentage of members enrolled in an MCO who are enrolled in care management.	NH DHHS	1.9% (SFY 2021)	3.5% (SFY 2022)	3.6% (SFY 2023) (Met)	N/A	N/A
Percentage of members who annually complete a health risk assessment.	NH DHHS	12.3% (SFY 2021)	19.3% (SFY 2022)	23.4% (SFY 2023) (Progress Made)	N/A	N/A
Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.						
Percent of NH counties in which all MCO provider networks assure that 90% of members meet time or distance standards for DME providers.	NH DHHS	100% (SFY 2021)	100% (SFY 2022)	100% (SFY 2023) (Met)	N/A	N/A
Objective 7.2 – Ensure state meets goals of the Community Mental Health Program directed payment.						
Members receiving Community Mental Health Services who were discharged from New Hampshire	NH DHHS	6.4% (CY 2019)	7.9% (CY 2021)	5.9% (Progress Made)	N/A	N/A

Metric Name	Metric Specification	Baseline Performance (Year)	2021 Rates	Current 2022 Rates (Goal Met/Progress Made/Not Met)	Current National 50th Percentile (2022)	Current National 75th Percentile (2022)
Hospital or Designated Receiving Facility and readmitted within 30 calendar days						
Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital or Designated Receiving Facility and readmitted within 90 calendar days	NH DHHS	15.5% (CY 2019)	13.8% (CY 2021)	11.9% (Met)	N/A	N/A
Follow-up after hospitalization for mental illness: 7 Days of discharge	NH DHHS	56.1% (CY 2019)	64.2% (CY 2021)	71.5% (Met)	35.1%	44.3%
Follow-up after hospitalization for mental illness: 30 Days of discharge	NH DHHS	74% (CY 2019)	77.0% (CY 2021)	88.2% (Met)	57.7%	65.4%
Emergency Department Visits for Mental Health Conditions for Adult Members' receiving Community Mental Health Services.	NH DHHS	19.3 Visits (CY 2019)	18.1 Visits (CY 2021)	13.6 Visits (Met)	N/A	N/A
Objective 7.3 - Ensure state meets goals of the Critical Access Hospital directed payment						
Aggregated Rate: Diabetes Short-Term Complications Admission Rate; Heart Failure Admission Rate; Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	NH DHHS	8.8 admissions per 100,000 member months (CY 2021)	8.8 admissions per 100,000 member months	8.7 admissions per 100,000 member months (Progress Made)	N/A	N/A
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Increase Dependence	NH DHHS	57% (30-day) (CY 2020)	58% (30-day)	45% (7-day) (Measure changed)	N/A	N/A

Metric Name	Metric Specification	Baseline Performance (Year)	2021 Rates	Current 2022 Rates (Goal Met/Progress Made/Not Met)	Current National 50th Percentile (2022)	Current National 75th Percentile (2022)
Follow-Up After Emergency Department Visit for Mental Illness	NH DHHS	76% (30-day) (CY 2020)	73% (30-day)	58% (7-day) (Measure changed)		