State of New Hampshire
Department of Health and Human Services

2019 New Hampshire External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Conflict of Interest Statement

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

HSAG confirms that no one conducting 2019 EQRO activities had a conflict of interest with **New Hampshire Healthy Families** (**NHHF**) or **Well Sense Health Plan** (**Well Sense**) health plans.

1. Executive Summary

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 capitation managed care program. At the end of calendar year (CY) 2018, there were 133,788 New Hampshire Medicaid beneficiaries enrolled in the MCM Program.[1-1] Beneficiaries enrolled in the program received services through one of two managed care organizations (MCOs): **New Hampshire Healthy Families** (**NHHF**) or **Well Sense Health Plan** (**Well Sense**). Both health plans are responsible for coordinating and managing their members' care through dedicated staff and a network of qualified providers.

The Department evaluates the MCM Program through a comprehensive quality strategy which 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 assurance and performance improvement program.
- Participating in a program evaluation conducted by the external quality review organization (EQRO).

The state fiscal year (SFY) 2019 technical report is a summative account of a wide variety of activities conducted by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO. Activities conducted to evaluate individual MCOs included audits of each MCO's contract compliance, performance improvement projects (PIPs), performance measure validation (PMV), and encounter data validation (EDV). Further analysis was conducted of each MCO's health outcome and beneficiary experience of care data compared to national performance measures. In 2019, HSAG also conducted semi-structured member interviews at the MCM Program level and a specialty provider telephone survey.

In SFY 2019, the EQRO's activities revealed positive results as well as areas for improvement for the MCM Program. Rates declined a few points from the prior year in the compliance reviews, with both MCOs demonstrating the greatest opportunity for improvement in the Substance Use Disorder (SUD) standard. **NHHF** and **Well Sense** finalized their three PIPs that began with a baseline period of calendar year 2014, and HSAG completed the final validation in SFY 2019. The final validation results indicated that one **NHHF** PIP achieved statistically significant improvement in the first remeasurement period and sustained the improvement through the third remeasurement period. Rates for two remaining **NHHF**'s PIPs did not demonstrate a statistically significant improvement over the baseline measurement. **Well Sense** achieved statistically significant improvement for one of its PIPs at the second remeasurement; however, the improvement was not sustained during Remeasurement 3. The remaining two PIPs did not achieve statistically significant improvement over the baseline measurement.

[1-1] The data source for all enrollment data is the December 2, 2018, extract from the New Hampshire Medicaid Management Information System (MMIS).

PMV rates were successfully approved for reporting for both MCOs as they were in the prior year. New Hampshire uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).[1-2] For the CAHPS surveys in 2019, **NHHF** had more rates that were statistically significantly higher than the national averages for the adult measures than in the prior year (i.e., seven rates in 2019 versus one rate in 2018), and the same number of rates this year as last year that were statistically significantly higher than the national averages for the child measures (i.e., four rates). **Well Sense** had fewer rates that were statistically significantly higher than the national averages as compared to last year's rates for the adult measures (i.e., one rate in 2019 versus two rates in 2018) and for the child measures (i.e., three rates in 2019 versus four rates in 2018). **Well Sense** had one adult rate that was significantly below the national average in 2018; however, none of **Well Sense**'s rates in 2019 were statistically significantly below the national averages.

New Hampshire uses the Healthcare Effectiveness Data and Information Set (HEDIS®).[1-3] Regarding HEDIS, two rates fell below the national Medicaid 25th percentile for each MCO this year, the same number of rates that fell below the national Medicaid 25th percentile for each MCO last year.

Concerning the ongoing encounter data quality reports under EDV, both MCOs passed the compliance edits and the accuracy edits for servicing providers for the pharmacy encounters. **NHHF** and **Well Sense** did not meet the requirements for data accuracy related to member identification numbers or servicing provider information for institutional encounters or for timely encounter submissions. The MCOs need to ensure that all activities continue to improve the rates and results over the next year. For the information systems (IS) review, the MCOs' survey responses provided information demonstrating their capacity to collect, process, and transmit claims and encounter data to DHHS and their ability to promptly respond to quality issues identified by DHHS. **NHHF** and **Well Sense** should consider (1) investigating rejections caused by provider data to reduce rejection rates, (2) adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS, and (3) incorporating timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS. In addition, **Well Sense** should consider implementing a submission frequency assessment in its review of encounter files submitted by external service management vendors.

Because the corrective action plans (CAPs) remedied the areas of non-compliance for the compliance review, the areas that could be specifically targeted for improvement include the PIPs, the two HEDIS rates below the national Medicaid 25th percentile, and EDV. Also, both MCOs could focus on improving the CAHPS rates that declined from the prior year or remained neither statistically significantly above or below the national average. Many of the same activities will be conducted in SFY 2020, which will allow further evaluation of targeted opportunities for improvement identified in this report.

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

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

Table 1-1 contains a list of the opportunities for improvement for **NHHF** that includes all external quality review (EQR) tasks described in this SFY 2019 EQR Technical Report.

Table 1-1—Opportunities for Improvement for NHHF

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Audit*	Member Enrollment and Disenrollment	91.7%	100%
	Access	91.7%	100%
	Network Management	88.9%	100%
	Substance Use Disorder	64.3%	100%
Performance Improvement Projects (PIPs)	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*	No Statistically Significant Improvement	Statistically Significant Improvement
	Well-Child Visits for 3-to-6-Year-Olds	No Statistically Significant Improvement	Statistically Significant Improvement
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total	Below the 25th Percentile	Equal to or Higher than the National Average
Encounter Data Validation (EDV)	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.8%	100%
	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	99.8%	100%
	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	99.9%	100%
	837I: Validity of Servicing Provider Information—Percent Valid	82.8%	98.0%
	837P: Timeliness—Weekly Submissions	98.1%	100%
	837I: Timeliness—Weekly Submissions	98.1%	100%
	NCPDP: Timeliness—Weekly Submissions	88.5%	100%
	837P: Timeliness—Submission Within 30 Days of Claim Payment	82.6%	100%
	837I: Submission Within 30 Days of Claim Payment	97.5%	100%
	NCPDP: Submission Within 30 Days of Claim Payment	91.5%	100%

* Areas of non-compliance remedied through the CAP process.

Additional information about the tasks displayed in Table 1-1 is included in the Summary of Findings and Detailed Findings sections of this report.

Table 1-2 contains a list of the opportunities for improvement for **Well Sense** that includes all EQR tasks described in the SFY 2019 EQR Report.

Table 1-2—Opportunities for Improvement for Well Sense

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Audit*	Behavioral Health	91.7%	100%
	Network Management	88.9%	100%
	Utilization Management	92.9%	100%
	Substance Use Disorder	71.4%	100%
PIPs	*Reducing Hospital Readmissions-60 Days of Discharge*	No Statistically Significant Improvement	Statistically Significant Improvement
	Well-Child Visits for 3-to-6-Year-Olds	No Statistically Significant Improvement	Statistically Significant Improvement
HEDIS	*Chlamydia Screening in Women (CHL)—Total*	Below the 25th Percentile	Equal to or Higher than the National Average
	Prenatal and Postpartum Care (PPC)—Postpartum Care	Below the 25th Percentile	Equal to or Higher than the National Average
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	99.2%	100%
	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	99.0%	100%
	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	99.9%	100%
	837P: Validity of Servicing Provider Information—Percent Valid	96.4%	98.0%
	837I: Validity of Servicing Provider Information—Percent Valid	80.8%	98.0%
	837P: Timeliness—Weekly Submissions	98.1%	100%
	837I: Timeliness—Weekly Submissions	98.1%	100%
	NCPDP: Timeliness—Weekly Submissions	98.1%	100%
	837P: Timeliness—Submission Within 30 Days of Claim Payment	66.2%	100%
	837I: Submission Within 30 Days of Claim Payment	66.8%	100%
	NCPDP: Submission Within 30 Days of Claim Payment	64.1%	100%

* Areas of non-compliance remedied through the CAP process.

Additional information about the tasks displayed in Table 1-2 is included in the Summary of Findings and Detailed Findings sections of this report.

2. Overview of the MCM Program

Program Overview

The New Hampshire statewide Medicaid Care Management Program is the primary method of service delivery covering over 99 percent[2-1] of the NH Medicaid population. The following populations are enrolled in the MCM program.

- Aid to the Needy Blind Recipients;
- Aid to the Permanently and Totally Disabled Recipients;
- American Indians and Alaskan Natives;
- Auto Eligible and Assigned Newborns;
- Breast and Cervical Cancer Program Recipients;
- Children Enrolled in Special Medical Services/Partners in Health;
- Children with Supplemental Security Income;
- Foster Care/Adoption Subsidy Recipients;
- Granite Advantage (Medicaid Expansion Adults);
- Home Care for Children with Severe Disabilities (Katie Beckett);
- Medicaid Children Funded through the Children's Health Insurance Program;
- Medicaid for Employed Adults with Disabilities;
- Medicare Duals;
- Poverty Level Adults (Including Pregnant Women);
- Poverty Level Children; and
- Old Age Assistance Recipients.

The following eligibility groups are exempted from the MCM program and receive their benefits from the NH fee-for-service 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); and
- Veterans Affairs Benefit Recipients.

[2-1] Figure is based on Medicaid Eligibility Data as of June 1, 2019.

The MCM program covers all NH Medicaid services with the exception of the following services that are covered by the Medicaid fee-for-service program:

- Dental Benefits;
- Division for Children, Youth and Families Services (i.e. Non-EPSDT [Early and Periodic Screening, Diagnostic, and Treatment] Child Health Support Services, Crisis Intervention, Home Based Therapy, Intensive Home and Community-Based Services, Placement Services, Private Non-Medical Institution for Children);
- Early Supports and Services;
- Glencliff Home Services;
- Home and Community Based Care Waiver Services (i.e. Acquired Brain Disorder Waiver, Choices for Independence Waiver, In Home Support Waiver; Developmental Disabilities Waiver);
- Medicaid to Schools Services; and
- Nursing Facility Services.

New Hampshire has contracted with the following MCOs to provide statewide coverage for the NH MCM program:

- **AmeriHealth Caritas New Hampshire** (beginning on September 1, 2019);
- **New Hampshire Healthy Families**; and
- **Well Sense Health Plan**.

With the onset of the MCM Program, the Department implemented a comprehensive quality strategy approved by CMS to evaluate the MCM Program. The strategy included:

- Monitoring over 200 performance measures.
- Requiring health plan accreditation by NCQA.
- Reporting validated measures to the public via medicaidquality.nh.gov.
- Requiring each health plan to implement a quality assurance and performance improvement program.
- Participating in a program evaluation conducted by the EQRO.

3. Summary of Findings

Overview

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

The SFY 2019 New Hampshire EQR Technical Report for the New Hampshire MCM Program complies with the Code of Federal Regulations (CFR) 42 §438.364 which requires the EQRO to produce "an annual detailed technical report that summarizes findings on access and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity."[3-2] This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information of any beneficiary. The current report contains findings from the activities conducted during SFY 2019.

Additionally, the report presents and compares the rates of the two New Hampshire Medicaid health plans, **NHHF** and **Well Sense**, and offers nationally recognized comparisons, when appropriate. The report also offers recommendations for improving the quality, timeliness of care, and access to health care services provided by each health plan and includes statements from the MCOs concerning their follow-up to the SFY 2018 EQR Technical Report recommendations for improvement. Appendices to this report include a list of abbreviations and acronyms; the methodology for conducting contractual compliance, PIPs, and PMV activities; and demographics of the New Hampshire MCM Program.

[3-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Sept 6, 2019.

[3-2] U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Sept 6, 2019.

External Quality Review Activities, Conclusions, and Recommendations

Managed Care Organization (MCO) Contractual Compliance

Each year HSAG conducts an on-site compliance review at **NHHF** and **Well Sense** to ensure compliance with federal and State requirements. Subsequent to the comprehensive contract review in SFY 2014, the SFY 2015 review initiated a three-year cycle of reviewing one-third of the elements contained in the comprehensive compliance tool. The SFY 2019 review was part of the second round of the three-year cycle of evaluating one-third of the compliance requirements.

Findings

Table 3-1 illustrates the overall score for the SFY 2019 Compliance Review for **NHHF** and **Well Sense**.

Table 3-1—Summary of the SFY 2019 Compliance Review Scores for NHHF and Well Sense

Overall Rates for the SFY 2019 Compliance Review	NHHF	Well Sense
Overall Score	95.7%	96.2%

The 2019 compliance review included 12 standards. **NHHF** achieved 95.7 percent and **Well Sense** achieved 96.2 percent on the 105 elements reviewed. The activity also included file reviews for grievances, appeals, and denials and checklist reviews for access, provider directory, member handbook, website, and member rights. The overall scores for the file reviews and checklists are shown in Table 3-2.

Table 3-2—Summary of the SFY 2019 File Reviews and Checklists Reviews for NHHF and Well Sense

Overall Scores for the SFY 2019 File Reviews and Checklist Reviews	NHHF	Well Sense
File Review Score	99.1%	97.2%
Checklist Score	98.6%	98.6%

Conclusions and Recommendations for MCO Contractual Compliance

NHHF

NHHF achieved a comprehensive score of 95.7 percent on the SFY 2019 review of standards. The file review score was 99.1 percent, and the checklist review score was 98.6 percent. The review included an examination of 12 standards, with 98 **NHHF** elements *Met* (93.3 percent), five elements *Partially Met* (4.8 percent), and two elements *Not Met* (1.9 percent).

HSAG offers the following recommendations for **NHHF** from the review of standards. **NHHF** must ensure that:

- NHHF must complete training for new providers within 30 calendar days of the provider entering into a contract with the health plan.

- Plan documents include complete information concerning:
  - Reasons members may request disenrollment without cause.
  - Situations when abortion can be provided.
  - The anti-gag clause provisions for providers.
  - SUD requirements:
    - Initial eligibility screenings for SUD services.
    - Admission requirements for pregnant women diagnosed with SUD.
    - Assessment requirements for members who have screened positive for SUD.

Concerning recommendations from the review of the appeals files, Provider Directory Checklist, and MCO Website Checklist, **NHHF** must:

- Obtain written confirmation of a member's oral request for a standard appeal.
- Ensure that the provider directory and the MCO website indicates whether a provider has completed cultural competence training.

NHHF successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the current SFY 2019 compliance review.

Well Sense

Well Sense achieved a comprehensive score of 96.2 percent on the SFY 2019 compliance reviews. The review included an examination of 12 standards, with 98 **Well Sense** elements *Met* (93.3 percent),six elements *Partially Met* (5.7 percent), and one element *Not Met* (1.0 percent).

HSAG offers the following recommendations for **Well Sense**. **Well Sense** must ensure that:

- Provider training is completed within 30 calendar days of entering a contract and that the training addresses information pertaining to the grievance and appeals system, including State fair hearings.
- Written utilization management (UM) policies, procedures, and criteria are available upon request to DHHS, members, and providers.
- Annual submissions of policies governing the coordination of care with primary care providers (PCPs) and community mental health programs are submitted as required to DHHS.
- SUD documents include comprehensive requirements for:
  - Conducting an initial eligibility screening for services by SUD providers.
  - Completing a timely American Society for Addiction Medicine (ASAM) level of care (LOC) assessment and clinical evaluations for members who have screened positive for SUD services.
  - Initiating timely services for members with a SUD diagnosis identified for withdrawal management, outpatient, or intensive outpatient services.
  - Assisting, admitting, and treating pregnant women with a SUD diagnosis.

HSAG offers the following recommendations for **Well Sense** from the review of the appeal files, the Provider Directory Checklist, and the MCO Website Checklist. **Well Sense** must ensure that:

- An acknowledgement letter is sent to the member upon receipt of an appeal.
- The provider directory and MCO website indicates whether a provider has completed cultural competence training.

Well Sense successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the current SFY 2019 compliance review.

For additional information concerning the compliance activities, see Section 4 Detailed Findings, page 4-1.

For additional information concerning HSAG's methodology for conducting an MCO contractual compliance review, see Appendix B Methodologies for Conducting EQR Activities, page B-1.

Evaluation of Programs and Projects: Performance Improvement Projects (PIPs)

The purpose of a PIP, as defined by 42 CFR §438.330(d),[3-3] is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. To ensure that such projects achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

Findings

The SFY 2019 HSAG validation involved the Design, Implementation, and Outcomes stages of the three PIP topics selected by **NHHF** and the three PIP topics selected by **Well Sense**, as shown in Table 3-3. One of the three PIP topics conducted by each MCO focused on behavioral health, as required by DHHS.

Table 3-3—Performance Improvement Project Topics Selected by NHHF and Well Sense

NHHF PIP Topics	Well Sense PIP Topics
Comprehensive Diabetes Screening—Vision Screening	*Chlamydia Screening*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	*Reducing Hospital Readmissions**
Well-Child Visits for 3-to-6-Year-Olds	*Well-Child Visits for 3-to-6-Year-Olds*

* The **Well Sense** *Reducing Hospital Readmissions* PIP focused on reducing readmissions to New Hampshire Hospital, which provides inpatient mental health care.

For each MCO, Table 3-4 shows the aggregate number of applicable evaluation elements that were scored *Met* for each PIP stage and the combined overall percentage of evaluation elements *Met* for the three PIPs. The Design stage establishes the methodological framework for the PIP. The Implementation stage includes data analysis and interpretation, as well as development and implementation of interventions and improvement strategies. In the Outcomes stage, the PIPs are assessed for statistically significant improvement in study indicator outcomes (i.e., rates compared to the baseline).

[3-3] U. S. Government Printing Office. (n.d.). *Quality Assessment and Performance Improvement Program.* Available at: https://www.govregs.com/regulations/title42_chapterIV_part438_subpartE_section438.330. Accessed on: Nov 26, 2018.

Table 3-4—2018 PIP Validation Results Comparison by MCO for Topics Selected by NHHF and Well Sense

Stage	Activities	Percentage of Applicable Elements Scored *Met*	
		NHHF (Number [N]=3 PIPs)	Well Sense (N=3 PIPs)
Design	Activities I–VI	100% (45/45)	100% (39/39)
Implementation	Activities VII–VIII	100% (38/38)	100% (37/37)
Outcomes	Activities IX–X	64% (7/11)	55% (6/11)
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**96%**	**94%**

Both MCOs met 100 percent of the requirements for all activities in the Design stage across all three PIPs. The MCOs designed and implemented scientifically sound PIPs supported by key research principles and quality improvement (QI) methods. The MCOs demonstrated solid performance in the Implementation stage, receiving a *Met* score for 100 percent of evaluation elements across all three PIPs. For SFY 2019, the MCOs reported Remeasurement 3 (1/1/17–12/31/17) study indicator results for each PIP and described QI activities that occurred during this remeasurement period. With the reporting of Remeasurement 3 results, both MCOs progressed through at least Activity IX of the Outcomes stage (i.e., assessing for real improvement) for each PIP, with **NHHF** progressing to Activity X (i.e., assessing for sustained improvement) for one PIP, *Comprehensive Diabetes Care—Vision Screening*, with successfully demonstrating sustained improvement. Both **NHHF** and **Well Sense** have opportunities for improvement in the Outcomes stage, receiving *Met* scores for 64 percent and 55 percent, respectively, across the three PIPs.

Table 3-5 displays the study indicator outcomes for the three **NHHF** PIPs.

Table 3-5—Study Indicators for NHHF

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)	HEDIS 2018 Rate*
Comprehensive Diabetes Care—Vision Screening					
The percentage of members aged 18 to 75 years with diabetes (type 1 or type 2) who had an eye exam (retinal) performed.	59.8%	65.6%↑*	70.4%↑**	68.1%↑**	69.6%↑**

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)	HEDIS 2018 Rate*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members ages 18 to 64 years with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening in the measurement year.	77.6%	78.7% ⇔	78.5% ⇔	83.6% ⇔	79.2% ⇔
Well-Child Visits for 3-to-6-Year-Olds					
The percentage of members ages 3 to 6 years who had at least one well-child visit with a primary care physician (PCP) in the measurement year.	79.3%	78.9% ⇔	82.0% ⇔	76.9 ⇔	78.1% ⇔

* The final HEDIS 2018 rate was generated after the close of the PIPs.

↑* Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).

↑** The remeasurement rate demonstrated sustained improvement over the baseline rate.

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (*p* value >= 0.05).

Table 3-6 displays the study indicator outcomes for the three **Well Sense** PIPs.

Table 3-6—Study Indicators for Well Sense

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)	HEDIS® 2018 Rate*
Chlamydia Screening					
The percentage of women 16 to 24 years of age who were identified as sexually active and had had at least one chlamydia test performed in the measurement year.	43.5%	42.7% ⇔	46.9% ↑	46.3% ⇔	47.4% ↑**
Reducing Hospital Readmissions (to New Hampshire Hospital)					
The percentage of eligible members readmitted to New Hampshire Hospital within 30 days of discharge.	12.7%	9.8% ⇔	12.8% ⇔	7.8 ⇔	NA
The percentage of eligible members readmitted to New Hampshire Hospital within 60 days of discharge.	18.2%	14.0% ⇔	17.8% ⇔	13.2% ⇔	NA
The percentage of eligible members readmitted to New Hampshire Hospital within 90 days of discharge.	19.2%	17.3% ⇔	20.9% ⇔	16.7% ⇔	NA
Well-Child Visits for 3-to-6-Year-Olds					
The percentage of members ages 3 to 6 years who had at least one well-child visit with a PCP in the measurement year.	77.5%	79.8% ⇔	78.7% ⇔	76.0% ⇔	80.7% ⇔

* The final HEDIS® 2018 rate was generated after the close of the PIPs.

↑ Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).

↑** The remeasurement rate demonstrated sustained improvement over the baseline rate.

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (*p* value >= 0.05).

Not Applicable (NA) designates that HEDIS® rate was not applicable to the study indicators.

Conclusions and Recommendations

NHHF and Well Sense

NHHF and **Well Sense** designed scientifically sound projects supported by key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. The MCOs used methodologically sound approaches to data analysis and QI activities. Both MCOs have opportunities for improvement in the Outcomes stage. One **NHHF** PIP (i.e., *Comprehensive Diabetes Screening—Vision Screening*), demonstrated statistically significant improvement at Remeasurement 1 (1/1/15–12/31/15) and sustained the improvement through Remeasurement 3 (1/1/17–12/31/17). One **Well Sense** PIP (*Chlamydia Screening*) demonstrated statistically significant improvement over the baseline for the first time at Remeasurement 2; however, it was not able to sustain its improvement at Remeasurement 3. The remaining two PIPs for both MCOs have yet to achieve statistically significant improvement over the baseline. **NHHF** and **Well Sense** should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement and achieve the desired outcomes. For the final HEDIS rates that were generated after the close of the PIPs, **NHHF**'s *Comprehensive Diabetes Screening—Vision Screening* maintained statistically significant and sustained improvement over the baseline performance as did **Well Sense**'s *Chlamydia Screening* PIP.

HSAG offered the following recommendations for both MCOs to strengthen and improve future PIP performance:

- Review the progress, achievements, challenges, and lessons learned for each PIP and use the knowledge gained to drive further improvement.
- For those PIPs that have not yet achieved statistically significant improvement in the study indicator results, the MCOs should identify and document new or revised barriers that have prevented improvement in outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement.
- Consider using different QI tools or processes to gain a fresh perspective on the factors impacting outcomes. For example, the MCOs may want to develop one or more process map(s) for each PIP to illustrate the current processes involved in achieving the desired outcomes for each project. By graphically illustrating the steps involved, a process map can help improvement teams identify gaps and/or opportunities for improvement within the process that, when addressed, can facilitate improved outcomes.
- The MCO should ensure it revisits its causal/barrier analysis throughout the year instead of annually.
- Continue to evaluate the effectiveness of each individual intervention. The MCOs should make data-driven decisions, based on evaluation results, when revising, continuing, or discontinuing interventions.

HSAG offers the following recommendation for DHHS:

- For MCOs that achieve statistically significant improvement and have identified effective interventions and quality improvement processes, DHHS may consider requiring the MCOs to continually monitor and measure study indicator rates beyond the end of the PIP. DHHS may also consider having the MCOs provide DHHS with a written plan for sustaining improvement achieved. This process could be applicable to PIPs, as well as HEDIS and performance measures.

For additional information concerning the PIP activities, see Section 4 Detailed Findings, page 4-6.

For additional information concerning HSAG's methodology for validating PIPs, see Appendix B Methodologies for Conducting EQR Activities, page B-7.

Performance Measure Validation (PMV)

As required by 42 CFR §438.358(b)(ii),[3-4] HSAG completed the validation of MCO performance measures for SFY 2019, and this section provides a summary of the findings, conclusions, and recommendations from the PMV activities.

Findings

Table 3-7 provides an overview of the findings generated by the HSAG team for the audit elements reviewed for the 15 state-specific measures validated during the SFY 2019 PMV audit.

Table 3-7—SFY 2019 PMV Findings

Audit Element	SFY 2019	
	NHHF	Well Sense
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable
Appropriate provider data systems and processing	Acceptable	Acceptable
Appeals data System and Process Findings	Acceptable	Acceptable
Prior Authorization and Case Management Data System and Process findings	Acceptable	Acceptable
Performance Measure Production and Reporting Findings	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable

[3-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Oct 25, 2019.

Conclusions and Recommendations

NHHF

As part of the PMV process, HSAG evaluated **NHHF**'s data systems for processing each data type used for reporting DHHS performance measure rates, including claims, membership and enrollment, appeals, prior authorization, and case management. HSAG did not identify any issues with **NHHF**'s data systems or data processing. Additionally, HSAG reviewed and approved the source code used by **NHHF** to produce the measures. During the on-site audit, HSAG conducted primary source verification for each measure under review. The primary source review relied on **NHHF**'s system demonstrations and individual record verification to validate compliance with the measure's specifications. HSAG also benchmarked the reported rates by comparing them to its peers and to the prior year's reported rates.

At the conclusion of the PMV process, HSAG did not have any concerns, nor did it find any outliers compared to its peers, based on population stratifications. HSAG determined that **NHHF** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **NHHF** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production for any measure under review this year.

Well Sense

As part of the PMV process, HSAG evaluated **Well Sense**'s data systems for processing each data type used for reporting DHHS performance measure rates, including claims, membership and enrollment, appeals, prior authorization, and case management. HSAG did not identify any issues with **Well Sense**'s data systems or data processing. Additionally, HSAG reviewed and approved the source code used by **Well Sense** to produce the measures. During the on-site audit, HSAG conducted primary source verification for each measure under review. The primary source review relied on **Well Sense**'s system demonstrations and individual record verification to validate compliance with the measure's specifications. HSAG also benchmarked the reported rates by comparing them to its peers and to the prior year's reported rates.

At the conclusion of the PMV process, HSAG did not have any concerns, nor did it find any outliers compared to its peers, based on population stratifications. HSAG determined that **Well Sense** produced the measures in accordance with the specifications and benchmarked appropriately based on its population/sub-populations. **Well Sense** demonstrated proficiency in its measure production and passed primary source verification without issue. HSAG had no concerns with the measure production for any measure under review this year.

For additional information concerning the validation of the MCO performance measures, see Section 4 Detailed Findings, page 4-18.

For additional information concerning HSAG's methodology for validating MCO performance measures, see Appendix B Methodologies for Conducting EQR Activities, page B-9.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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. **NHHF** and **Well Sense** were responsible for obtaining a CAHPS vendor to administer the survey to adult members and parents or caretakers of child members. Adult members and parents or caretakers of child members completed the surveys in 2019, following NCQA's data collection protocol.

Findings

The CAHPS 5.0H Surveys include a set of standardized items including four global ratings and five composite scores.[3-5] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. 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, the percentage of respondents who chose a positive satisfaction rating on a scale of 0 to 10 was calculated. A positive response for the global ratings was defined as a value of 8, 9, or 10. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive response for the composites was defined as a response of "Usually/Always" or "Yes."

Each measure rate was compared to the NCQA national average, and a statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted in Table 3-8 and Table 3-9 with arrows. An upward green arrow (↑) is denoted if the lower limit of the confidence interval was higher than the national average. However, if the upper limit of the confidence interval was lower than the national average, then a downward red arrow (↓) is denoted. If the national average was within the confidence interval, then there was no significant difference, which is denoted with a dash (—).

[3-5] For this report, the 2019 Adult and Child Medicaid CAHPS results presented for **NHHF** and **Well Sense** are limited to the four CAHPS global ratings and five CAHPS composite measures evaluated through the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys (i.e., CAHPS results are not presented for the two individual item measures or five Children with Chronic Conditions [CCC] composite scores/items).

Table 3-8 contains the results from the 2019 Adult Medicaid CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to the NCQA national averages.[3-6]

Table 3-8—NHHF and Well Sense Adult Medicaid CAHPS Results

CAHPS Measure	2019 Adult Medicaid Positive Rates	2018 National Average Comparison*	2019 Adult Medicaid Positive Rates	2018 National Average Comparison*
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**81.3%**	↑	**75.4%**	—
Rating of All Health Care	**77.5%**	—	**74.9%**	—
Rating of Personal Doctor	**83.4%**	—	**79.1%**	—
Rating of Specialist Seen Most Often	**87.0%**	↑	**82.6%**	—
Composite Measures	**NHHF**		**Well Sense**	
Getting Needed Care	**86.5%**	↑	**83.3%**	—
Getting Care Quickly	**88.9%**	↑	**84.0%**	—
How Well Doctors Communicate	**94.3%**	↑	**93.9%**	—
Customer Service	**91.8%**	↑	**84.1%**+	—
Shared Decision Making	**84.1%**	↑	**85.6%**	↑

* The 2018 NCQA national averages are the most current benchmarks available.

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

↑ Indicates the measure rate is statistically significantly higher than the national average.

↓ Indicates the measure rate is statistically significantly below than the national average.

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

3-6 The 2019 Adult Medicaid CAHPS Results presented in Table 3-8 for **NHHF** and **Well Sense** are based on the responses of adult Medicaid beneficiaries that returned a completed CAHPS survey. **NHHF** surveyed a total of 2,160 adult Medicaid members, of which 423 completed surveys were returned. **Well Sense** surveyed a total of 1,485 adult Medicaid members, of which 290 completed surveys were returned. After ineligible members were excluded, the response rates were computed. In 2018, the adult Medicaid **NHHF** and **Well Sense** response rates were lower than the average NCQA response rate, which was 21.8 percent for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

Table 3-9 contains the results from the 2019 General Child CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to NCQA national averages.[3-7]

Table 3-9—NHHF and Well Sense Child Medicaid CAHPS Results

CAHPS Measure	2019 Child Medicaid Positive Rates	2018 National Average Comparison*	2019 Child Medicaid Positive Rates	2018 National Average Comparison*
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**87.2%**	—	**85.9%**	—
Rating of All Health Care	**92.2%**	↑	**86.8%**	—
Rating of Personal Doctor	**90.3%**	—	**87.2%**	—
Rating of Specialist Seen Most Often	**86.5%**	—	**81.0%+**	—
Composite Measures	**NHHF**		**Well Sense**	
Getting Needed Care	**87.9%**	—	**86.7%**	—
Getting Care Quickly	**93.6%**	↑	**93.3%**	↑
How Well Doctors Communicate	**96.7%**	↑	**95.7%**	↑
Customer Service	**89.4%**	—	**88.4%+**	—
Shared Decision Making	**85.3%**	↑	**84.5%+**	↑

* The 2018 NCQA national averages are the most current benchmarks available.
\+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the measure rate is statistically significantly higher than the national average.
↓ Indicates the measure rate is statistically significantly below than the national average.
— Indicates the measure rate is neither statistically significantly higher nor lower than the national average.

Conclusions and Recommendations

NHHF

NHHF's adult Medicaid population rates were statistically significantly higher than NCQA's 2018 Medicaid national averages for *Rating of Health Plan, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service*, and *Shared*

[3-7] The 2019 Child Medicaid CAHPS Results presented in Table 3-9 for **NHHF** and **Well Sense** are based on the responses of parents/caretakers of child Medicaid beneficiaries, selected as part of the general child sample only, that returned a completed CAHPS survey (i.e., based on the results of the general child population only). A total of 2,640 **NHHF** general child Medicaid members were selected for surveying, of which 485 completed surveys were returned. A total of 2,013 **Well Sense** general child Medicaid members were selected for surveying, of which 355 completed surveys were returned. In 2019, the child Medicaid **NHHF** and **Well Sense** response rates were lower than the average NCQA response rate, which was 22.3 percent for the CAHPS 5.0H Child Medicaid Health Plan Survey.

Decision Making. The remaining measure rates, *Rating of All Health Care* and *Rating of Personal Doctor*, were neither statistically significantly higher nor lower than the national averages.

NHHF's child Medicaid population rates were statistically significantly higher than NCQA's 2018 Medicaid national averages for *Rating of All Health Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. The remaining measure rates, *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*, were neither statistically significantly higher nor lower than the national averages.

HSAG recommends that **NHHF**:

- Focus QI efforts on enhancing members' experiences with *Rating of Personal Doctor* for the adult and child populations; *Rating of All Health Care* for the adult population; and *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* for the child population.

Well Sense

Well Sense's adult Medicaid population rate for *Shared Decision Making* was statistically significantly higher than NCQA's 2018 Medicaid national average, while *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* rates were neither statistically significantly higher nor lower than the national averages.

Well Sense's general child Medicaid population rates were statistically significantly higher than NCQA's 2018 Medicaid national averages, with the exception of *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*, which were neither statistically significantly higher nor lower than the national averages.

HSAG recommends that **Well Sense**:

- Focus QI efforts on enhancing members' experiences with *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* for the adult and child populations and *Getting Care Quickly* and *How Well Doctors Communicate* for the adult population.

For additional information concerning the CAHPS Survey, see Section 4 Detailed Findings, page 4-19.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a standardized set of nationally recognized indicators that are used in measuring performance of managed care plans. According to NCQA, HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[3-8] **NHHF** and **Well Sense** were responsible for generating HEDIS rates for the indicators prescribed by DHHS and contracting with independent certified HEDIS compliance auditors (CHCAs) to validate and confirm the rates generated by the respective MCO. DHHS requires MCOs to report NCQA HEDIS measures annually. To compile the information for the HEDIS section of this report, both MCOs provided their final audit reports (FARs), information system compliance tools, and the interactive data submission system (IDSS) files approved by an NCQA-licensed organization (LO).

Findings

The auditors found both MCOs to be fully compliant with all applicable information system assessment standards. HSAG compared the CY 2018 rates achieved by the MCOs on 45 of 48 measures to percentiles for HEDIS 2018. HSAG displayed the results for each measure in figures that contain the rates achieved by **NHHF** and **Well Sense**, along with the national benchmarks, when applicable. For three rates, comparisons to percentiles were not made due to changes in the technical specifications (*Controlling High Blood Pressure*) or because lower or higher rates are not indicative of better or worse performance (*Identification of Alcohol and Other Drug Services* and *Mental Health Utilization*).

To evaluate the performance of **NHHF** and **Well Sense**, 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

Table 3-10 and Table 3-11 display the rates achieved by the MCOs according to the comparison of their rates to the national benchmarks.

[3-8] National Committee for Quality Assurance. (n.d.). *HEDIS & Quality Measurement*. Available at: http://store.ncqa.org/index.php/performance-measurement.html?___SID=U. Accessed on: Aug 30, 2019.

Table 3-10—Summary of Scores for CY 2018 HEDIS Measures With National Comparative Rates for NHHF

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	3	7	6	2	1	19
Acute and Chronic Care	2	5	5	1	0	13
Behavioral Health	6	0	4	2	1	13
All Domains	11	12	15	5	2	45
Percentage	24.44%	26.67%	33.33%	11.11%	4.44%	100.0%

NHHF's rates ranked at or above the 50th percentile for 38 measures (84.44 percent), with 11 of these measures (24.44 percent) meeting or exceeding the 90th percentile. The rates for two measures (4.44 percent) fell below the 25th percentile.

Table 3-11—Summary of Scores for CY 2018 HEDIS Measures With National Comparative Rates for Well Sense

Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below 90th Percentile	Met 50th Percentile and Below 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	2	6	5	4	2	19
Acute and Chronic Care	2	4	3	4	0	13
Behavioral Health	2	3	4	4	0	13
All Domains	6	13	12	12	2	45
Percentage	13.33%	28.89%	26.67%	26.67%	4.44%	100.0%

Well Sense's rates ranked at or above the 50th percentile for 31 measures (68.89 percent), with six of these measures (13.33 percent) meeting or exceeding the 90th percentile. The rates for two measures (4.44 percent) fell below the 25th percentile.

Conclusions and Recommendations

NHHF

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

- Three Prevention measure rates: *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total*, *Adolescent Well-Care Visits (AWC)*, and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Two Acute and Chronic Care measure rates: *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation (PCE)—Systemic Corticosteroid* and *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
- Six Behavioral Health measure rates: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*, *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total*, and *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

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

- One Prevention measure rate: *Chlamydia Screening in Women (CHL)—Total*
- One Behavioral Health measure rate: *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*

Well Sense

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

- Two Prevention measure rates: *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total* and *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*
- Two Acute and Chronic Care measure rates: *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid* and *Bronchodilator*
- Two Behavioral Health measure rates: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)* and *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total*

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

- Two Prevention measure rates: *Chlamydia Screening in Women (CHL)—Total* and *Prenatal and Postpartum Care (PPC)—Postpartum Care*

For additional information concerning the HEDIS measures, see Section 4 on page 4-30 in the Detailed Findings.

Encounter Data Validation (EDV)

During SFY 2019, HSAG conducted the following two EDV activities:

- Continued to use an Encounter Data Quality Reporting System (EDQRS) to evaluate the quality of encounter data files submitted by the MCOs.
- Completed an IS review to assess DHHS' and the MCOs' information systems/processes.

For the first EDV activity, HSAG continued to use the EDQRS to evaluate the quality of encounter data files submitted by **NHHF** and **Well Sense**. The EDQRS was designed to import, store, and review incoming encounter data and generate automated weekly/monthly/quarterly reports for DHHS. Participating MCOs prepare and submit 837 P/I and NCPDP pharmacy files to HSAG daily/weekly. HSAG then processes the files and evaluates the encounter data in four areas: (1) weekly reports for encounter submission accuracy and completeness, (2) monthly reports for encounter data completeness, (3) monthly reports for encounter data accuracy, and (4) quarterly reports for encounter data timeliness.

Findings From EDQRS

For encounters received from MCOs between July 1, 2018, and June 30, 2019, this section presents the aggregate rates for five standards within Exhibit A—Amendment #12 of the MCM Contract.[3-9] These standards include:

- Passing X12 electronic data interchange (EDI) compliance edits (Standard 25.2.24.2.1).
- Accuracy and validity of member identification numbers (Standard 25.2.24.2.3).
- Accuracy and validity of servicing provider information (Standard 25.2.24.2.4).
- Encounter data shall be submitted weekly (Standard 25.2.24.3.1).
- Encounter data shall be submitted within 30 calendar days of claim payment (Standard 25.2.24.3.1).

Table 3-12 displays aggregate compliance rates for each MCO in relation to the standards. Values in green font indicate rates meeting the corresponding standards, and values in red font indicate rates falling below the corresponding standards by more than 10 percentage points. Black font indicates that the rate did not meet the required standard, however, the rate *did not* fall below the corresponding standard by more than 10 percentage points.

[3-9] New Hampshire Department of Health and Human Services. (2016). *Medicaid Managed Care Organization Contract Amendment #12.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: Sept 27, 2019.

Table 3-12—Aggregate Rates for Encounter Data Submission and Quality Standards

Evaluation Area	Standard	837P (Professional) Encounters		837I (Institutional) Encounters		NCPDP (Pharmacy) Encounters	
		NHHF	Well Sense	NHHF	Well Sense	NHHF	Well Sense
X12 EDI Compliance Edits	98.0%	100.0%	100.0%	100.0%	100.0%	NA	NA
Validity of Member Identification Number*							
Percent Present	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		99.8%	99.2%	99.8%	99.0%	99.9%	99.9%
Validity of Servicing Provider Information*							
Percent Present	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		99.3%	96.4%	82.8%	80.8%	100.0%	99.5%
Timeliness*							
Weekly Submission	100.0%	98.1%	98.1%	98.1%	98.1%	88.5%	98.1%
Submission Within 30 Days of Claim Payment	100.0%	82.6%	66.2%	97.5%	66.8%	91.5%	64.1%

* Refer to Table 4-13 through Table 4-17 for more details regarding these items.

The list below shows the findings for each standard:

- X12 EDI Compliance Edits: **NHHF** and **Well Sense** met submission standards 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 NCPDP encounters.
- Member Identification Number: **NHHF** and **Well Sense** populated all submitted encounters with member identification numbers for all three encounter types. However, when these values were assessed, both MCOs fell slightly below the percent accurate standard of 100 percent by no more than 1.0 percentage point.
- Servicing Provider Information: **NHHF** and **Well Sense** populated all submitted encounters with servicing provider information for all three encounter types. While both **NHHF** and **Well Sense** met the percent accurate standard for their NCPDP encounters, neither of them met the percent accurate standard for their 837I encounters. For the 837P encounters, **NHHF** met the standard and **Well Sense** fell slightly below the standard by 1.6 percentage points.
- Weekly Submission: Neither **NHHF** nor **Well Sense** met the weekly submission standard by submitting all three encounter types to DHHS for 100 percent of the weeks in SFY 2019, which was below the standard of 100 percent.
- Submission Within 30 Days of Claim Payment: The percentage of encounters submitted to DHHS within 30 calendar days of claim payment dates were below the standard of 100 percent for both **NHHF** and **Well Sense** for all three encounter types. **NHHF** submitted more than 91.0 percent of its 837I and NCPDP encounters within 30 days of claim payment, though the percentage for its 837P encounters was 82.6 percent. The percentage of 837P/I and NCPDP encounters submitted to DHHS

within 30 days of claim payment by **Well Sense** was less than 67.0 percent, which was considerably below the standard of 100 percent.

Conclusions and Recommendations from EDQRS

NHHF

Based on aggregate compliance rates for the five contract standards assessed, **NHHF**'s submitted encounters met the following standards:

- X12 EDI compliance edits
- Accuracy for servicing providers in the 837P and NCPDP encounters

HSAG recommends that **NHHF** focus on the following:

- Data accuracy related to member identification numbers for all three encounter types
- Data accuracy related to servicing provider information for the 837I encounters
- Weekly encounter submissions to DHHS; and submissions to DHHS within 30 days of the claim payment date for all three encounter types

Well Sense

Based on aggregate compliance rates for the five contract standards assessed, **Well Sense**'s submitted encounters met the following standards:

- X12 EDI compliance edits
- Accuracy for servicing providers in the NCPDP encounters

HSAG recommends that **Well Sense** focus on the following:

- Data accuracy related to member identification numbers for all three encounter types
- Data accuracy related to servicing provider information for the 837P and 837I encounters
- Weekly encounter submissions to DHHS; and submissions to DHHS within 30 days of the claim payment date for all three encounter types

Findings From the IS Review

HSAG conducted a second EDV activity, an IS review, with the goal of examining the extent to which DHHS and the MCOs have appropriate system documentation and infrastructure to produce, process, and monitor encounter data. 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 interviews with key staff members.

Based on the questionnaire responses, the MCOs provided information demonstrating their capacity to collect, process, and transmit to DHHS claims and encounter data meeting established quality specifications. Though each MCO employed different strategies to facilitate accurate and timely encounter data submission, each MCO described the centrality of its encounter data systems and data warehouse to its ability to develop adaptable data review processes that can promptly respond to quality issues identified by DHHS. Both MCOs described the role of internal personnel and departments, software systems, and/or external vendors employed for activities, such as claims adjudication, provider and member information verification, and management of third-party liability (TPL) information. When necessary, the MCOs described the systems/vendor oversight and data remediation activities that they have in place to ensure the completeness and accuracy of data submitted to them or processed on their behalf.

While DHHS offers the MCOs substantial autonomy regarding the development and management of their encounter data systems, it requires MCOs to submit complete and accurate encounter data in a timely manner. The Medicaid Management Information System (MMIS) was designed to review encounter transmissions for noncompliance with American National Standards Institute (ANSI) X12 standard guidelines and DHHS' data element-specific completeness and accuracy specifications. However, the MMIS has limited ability to review other aspects of data quality. For example, the DHHS team described challenges associated with verifying provider data from submitted encounters due to reliance on fee-for-service (FFS) provider enrollment data, which may not comprehensively represent all providers contracted with the MCOs. Additionally, differences between the MCOs' claims systems and DHHS' MMIS do not permit direct verification of provider information.

Prompt detection and remediation of inconsistencies with adjudicated encounters represents a data quality review limitation within DHHS' MMIS. Though the MCOs are directed to follow specific processes for the submission of adjusted, denied, and voided encounters, questionnaire responses did not indicate that either MCO follows DHHS' specifications. Because the MMIS does not currently include "scrubs" or "edits" that reject submissions that are noncompliant with specifications, precise identification of voided and denied encounters is limited. For example, DHHS' specifications require that voided and denied encounters be submitted separately from other encounters. However, questionnaire responses from both MCOs indicated that encounters of all statuses are included in batch submissions.

Conclusions and Recommendations From the IS Review

NHHF

While **NHHF**'s survey responses provided information demonstrating its capacity to collect, process, and transmit to DHHS claims and encounter data, as well as its ability to promptly respond to quality issues identified by DHHS, HSAG recommends that **NHHF** focus on the following for future improvement:

- Investigate rejections caused by provider data to reduce rejection rate.

- Add more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS.
- Incorporate timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS.

Well Sense

While **Well Sense**'s survey responses provided information demonstrating its capacity to collect, process, and transmit to DHHS claims and encounter data, as well as its ability to promptly respond to quality issues identified by DHHS, HSAG recommends that **Well Sense** focus on the following for future improvement:

- Investigate rejections caused by provider data to reduce rejection rate.
- Add more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS.
- Incorporate timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS.
- Implement a submission frequency assessment in its review of encounter files submitted by external service management vendors.

For additional information concerning EDV, see Section 4 Detailed Findings, page 4-84.

Other External Quality Review (EQR) Activities

Specialty Provider Survey

In November 2019, HSAG completed a revealed caller (non-secret) telephone survey among physical health specialty providers contracted with one or both Medicaid MCOs. The goal of the survey was to evaluate New Hampshire's Medicaid managed care network for 13 types of physical health specialty providers. Specific survey objectives included the following:

- Determine whether providers accept patients enrolled with a Medicaid MCO.
- Determine whether providers accept new patients.
- Determine appointment availability with the sampled providers for urgent and non-urgent services.

NHHF and **Well Sense** submitted provider data files to DHHS for HSAG's use, reflecting providers who were actively enrolled in the New Hampshire MCM program between February 21, 2019, and March 8, 2019. To include a comparison of the MCM Program results to a commercial insurance plan, HSAG assessed appointment availability using the Anthem State Health Employee Plan (Anthem).

HSAG's interviewers used a DHHS-approved survey script to complete survey calls to all sampled provider locations during August and September 2019. HSAG attempted to contact 4,419 provider locations ("cases"), with a 58.6 percent response rate. Due to the revealed caller nature of the study, providers' offices may have ended the caller's conversation for a survey case without offering responses for all survey elements.

Results

More than 95.0 percent of applicable survey respondents indicated that the provider location was accepting new patients and these results were similar for all three health plans (i.e., **NHHF**, **Well Sense**, and Anthem). Additionally, more than 50.0 percent of respondents indicated that they only served adult members. Table 3-13 displays a summary of the overall median appointment wait times in calendar days for each MCO.

Table 3-13—Summary of Median Appointment Wait Times in Calendar Days by MCO

MCO	New Patient Routine Visit	New Patient Urgent Issue	Existing Patient Routine Visit	Existing Patient Urgent Issue
NHHF	33.0	20.0	31.0	14.0
Well Sense	40.0	25.5	33.5	15.0
Anthem	35.0	22.0	32.0	14.0

Recommendations

Based on the survey findings, HSAG offers the following recommendations:

- HSAG was unable to reach more than 41 percent of the sampled cases and the key non-response reason was that the survey respondent indicated that the provider location did not offer the physical health specialty noted in the data files. DHHS should consider forwarding the data files with incorrect provider information to the MCOs for investigation and to ensure that the MCOs' provider directories include accurate data.
- Because the overall survey results for average and median appointment wait times exceeded the MCOs' contractual agreement, DHHS should request that each MCO supply copies of its documentation regarding the MCO's processes for monitoring and evaluating members' ability to access care in a timely manner, including both geographic access and timely access to care.
- Future studies could include an audit of the MCOs' provider directories to verify that the MCOs' publicly available provider data accurately represent the provider data supplied to members.

For additional information concerning the Specialty Provider Survey, see Section 4 Detailed Findings, page 4-93.

Summary of Strengths and Opportunities for Improvement Concerning Quality, Timeliness of Care, and Access to Care Furnished by MCOs

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

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[3-10]

- ***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."[3-11] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. 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). [3-12]

[3-10] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Oct 25, 2019.

[3-11] NCQA. *2017 Standards and Guidelines for the Accreditation of Health Plans.* Washington, DC: The NCQA; 2017: UM5.

[3-12] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Oct 25, 2019.

New Hampshire Healthy Families

Compliance

NHHF demonstrated strength in complying with federal and State standards by obtaining an overall score of 95.7 percent in the SFY 2019 compliance review. Of the 12 standard areas reviewed, **NHHF** achieved *100 percent compliance* on eight standards, demonstrating complete adherence to all requirements in these standards. **NHHF** also scored 90.0 percent or higher on two standards, demonstrating a high degree of adherence to the elements contained in those standards. The scores for one standard was 88.9 percent, demonstrating a moderate degree of adherence to the elements. The SUD standard, with a score of 64.3 percent, represented the greatest opportunity for improvement. Of the 105 elements reviewed for **NHHF**, 98 (i.e., 93.3 percent) received a *Met* score representing strengths in compliance with federal and State requirements for ***quality, timeliness of care, and access to care*** for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **NHHF** in the items that partially met or did not meet the requirements included in this year's review of compliance with federal and State requirements. **NHHF** must ensure timely training for new providers on the network. Plan documents must include all requirements concerning disenrolling without cause, when abortions can be provided with Medicaid funds, and the anti-gag clause provisions for providers. **NHHF** also needs to document and implement all contractual requirements for members with SUD to ensure that members receive the required services in a timely manner. The elements that need to be revised represent measures that could affect ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries.

After finalization of the SFY 2019 Compliance Review Report in March 2019, **NHHF** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be partially met or not met during the compliance review. **NHHF** successfully submitted CAPs for all the recommendations noted above and created documents to rectify the deficiencies identified during the SFY 2019 compliance review. HSAG will include a review of the SFY 2019 Compliance Review CAP items during the on-site SFY 2020 compliance audit.

PIPs

During SFY 2019, HSAG validated the design, implementation, and outcomes stages for **NHHF**'s three PIPs. All three PIPs are related to ***quality of care***, and one of the three PIPs is also related to both ***access to care*** and ***timeliness of care***. One of the PIPs, related to ***quality of care***, demonstrated strength by achieving statistically significant improvement over the baseline (1/1/14–12/31/14) at Remeasurement 1 (1/1/15–12/31/15) and sustained the significant improvement through Remeasurement 3 (1/1/17–12-31/17). As of Remeasurement 3, the other two PIPs had not achieved statistically significant improvement over the baseline. **NHHF** should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement of study indicator outcomes for the two PIPs that have not demonstrated statistically significant improvement in the Outcomes stage.

PMV

HSAG's PMV activities found all 15 performance measures, representing ***quality of care***, ***access to care***, and ***timeliness of care***, acceptable for reporting, and the auditors suggested that **NHHF**:

- Back up all reported data as a static dataset database so that the rates can be reproduced at any time. The data should include claim identifiers, member identifiers, and any relevant information that would allow **NHHF** to reproduce the measure details in the future, if required.
- **NHHF**'s quality management staff should continue to communicate regularly with the measure producing staff to ensure any changes to measure specifications are captured for accurate reporting.
- Conduct internal audits of its reported measures through primary source verification, to ensure ongoing quality of reported rates.

CAHPS

Seven positive rates for **NHHF**'s adult Medicaid population and four positive rates for the child Medicaid population in 2019 were statistically significantly higher than the 2018 NCQA adult and child Medicaid national averages. These measures represent responses related to ***access to care***, ***timeliness of care***, and ***quality of care***. The remaining two 2019 adult measure rates and five child measure rates for **NHHF**, representing both ***access to care*** and ***quality of care*** domains, were neither statistically significantly higher nor lower than the 2018 NCQA adult and child Medicaid national averages.

To improve CAHPS rates, **NHHF** could consider involving MCO staff members at every level to assist in improving *Getting Needed Care* and *Customer Service* rates. MCOs should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: 1) it reduces delays in patient care; 2) it increases continuity of care; and 3) it decreases wait times and the number of no-shows, resulting in cost savings. An evaluation of current MCO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. MCOs should further promote the use of existing after-hours customer service to improve customer service results. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

The rates for *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 newsletters and providing periodic reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO's members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for

understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions. MCOs can encourage providers to share members' medical record information and encourage discussions about members' health care. Access to this information allows members to better understand their condition and treatment plan, feel more in control of their health, and identify and correct inaccurate information. Also, using simple, inexpensive tools, such as patient question lists, to help members communicate effectively could lead to higher experience of care ratings. Members could create a list of questions they want to ask their provider during the office visit to ensure that all questions are answered during the health care encounter.

HEDIS

NHHF demonstrated strength for measures related to ***quality of care***, exceeding the 50th percentile for 31 of 38 (81.58 percent) measures related to ***quality***. The following measures related to ***quality*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits*
- *Adolescent Well-Care Visits (AWC)**
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total*
- *Childhood Immunization Status (CIS)—Combinations 2* and *10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing*, *HbA1c Poor Control (>9.0%)**, and *HbA1c Control (<8.0%)*
- *Asthma Medication Ratio (AMR)—Total*
- *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**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase**

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)*
- *Chlamydia Screening in Women (CHL)—Total*†

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total†*

NHHF demonstrated strength in measures related to ***timeliness of care***, exceeding the 50th percentile for nine of the 12 (75.00 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):

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase**

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total†*

NHHF demonstrated strength in measures related to ***access to care***, exceeding the 50th percentile for 12 of the 15 (80.00 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**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase** and *Continuation and Maintenance Phase**

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

- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*†

Encounter Data Validation

NHHF met the standard for X12 EDI compliance edits and data accuracy for servicing provider information in 837P and NCPDP encounters. **NHHF** should continue improving its data accuracy for the member identification number and servicing provider information for outstanding encounter types, and timely data submissions to DHHS so that **NHHF** can meet the corresponding standards. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. **NHHF** also may work with DHHS on example cases with inaccurate member identification numbers and/or servicing provider information to determine the root cause. Lastly, appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the ***timeliness*** issues. Determining ***access to care*** and health outcomes that represent ***quality of care*** could be difficult if **NHHF** does not submit accurate and timely encounter data to DHHS.

Based on **NHHF**'s IS Review questionnaire responses, the MCO provided information demonstrating its capacity to collect, process, and transmit to DHHS claims and encounter data meeting established quality specifications. **NHHF** described the centrality of its encounter data systems and data warehouse and its ability to develop adaptable data review processes that can promptly respond to quality issues identified by DHHS. **NHHF** should consider (1) investigating rejections caused by provider data to reduce rejection rates, (2) adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS, and (3) incorporating timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS.

Well Sense Health Plan

Compliance

Well Sense demonstrated strength in complying with federal and State standards by obtaining an overall score of 96.2 percent in the SFY 2019 compliance review. Of the 12 standard areas reviewed, **Well Sense** achieved *100 percent compliance* on eight standards, demonstrating total adherence to all requirements in these standards. **Well Sense** also scored greater than 90.0 percent on two standards, demonstrating a high degree of adherence to the elements contained in those standards. The score for one standard was 88.9 percent, demonstrating a moderate degree of adherence to the elements. The SUD standard, with a score of 71.4 percent, represents the greatest opportunity for improvement. Of the 105 elements reviewed for **Well Sense**, 98 elements that received a *Met* score represented strengths in the requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries.

Opportunities for improvement exist for **Well Sense** in the items that partially met or did not meet the requirements included in this year's review of compliance with federal and State requirements. **Well Sense** must ensure timely training for new providers on the network. UM policies, procedures, and criteria must be available upon request, and documents governing the coordination of care with PCPs and community mental health centers (CMHCs) must be submitted as required to DHHS for review and approval. **Well Sense** also needs to document and implement all contractual requirements for members with SUD to ensure that members receive the required services in a timely manner. The elements that need to be revised represent measures that could affect ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries.

After finalization of the SFY 2019 Compliance Review Report in March 2019, **Well Sense** completed a CAP that required the MCO to resubmit documents related to processes, policies, procedures, and workflows demonstrating full compliance with the elements found to be partially met or not met during the compliance review. **Well Sense** successfully submitted CAPs for all the recommendations noted above and created documents to rectify the deficiencies identified during the SFY 2019 compliance review. HSAG will include a review of the SFY 2019 Compliance Review CAP items during the on-site SFY 2020 compliance audit.

PIPs

During SFY 2019, HSAG validated the design, implementation, and outcomes stages for **Well Sense**'s three PIPs. The three PIPs are related to ***quality of care***, two PIPs are also related to ***access to care***, and one PIP is also related to ***timeliness of care***. One of the PIPs, related to both ***quality of care*** and ***access to care***, demonstrated strength by achieving statistically significant improvement over baseline (1/1/14–12/31/14) at Remeasurement 2 (1/1/16–12/31/16); however, it was not able to sustain that improvement at Remeasurement 3 (1/1/17–12/31/17). **Well Sense** should review study indicator performance, causal/barrier analyses, and intervention evaluation results for each PIP to facilitate improvement of study indicator outcomes for the two PIPs that have not demonstrated statistically significant or sustained improvement over baseline through the third remeasurement.

PMV

HSAG's PMV activities found all 15 performance measures, representing ***quality of care***, ***access to care***, and ***timeliness of care***, acceptable for reporting, and the auditors suggested that **Well Sense**:

- Create a vendor oversight project to monitor monthly submissions of data. Part of this monitoring should include additional primary source verification to determine compliance with the measure reporting. From discussions during the on-site audit, this process has started but has not been completely implemented.
- Back up all reported data to a database so that the rates can be reproduced at any time. The data should include claim identifiers, member identifiers, and any relevant information that would allow **Well Sense** to reproduce the measure details in the future, if required.
- Continue to communicate regularly with vendors to ensure they are capturing all data elements required to produce the measures. For example, **Well Sense** should continue to work with Envision to ensure the data elements required to capture PHARMQI.09 are met for future reporting periods.
- Conduct internal audits of its reported measures through primary source verification, to ensure ongoing quality of reported rates.

CAHPS

One positive rate for **Well Sense**'s adult Medicaid population and three positive rates for the child Medicaid population in 2019 were statistically significantly higher than the 2018 NCQA adult and child Medicaid national averages. These measures represent responses related to ***timeliness of care*** and ***quality of care***. The remaining eight 2019 adult measure rates and six 2019 child measure rates for **Well Sense**, representing ***access to care***, ***timeliness of care***, and ***quality of care*** domains, were neither statistically significantly higher nor lower than the 2018 NCQA adult and child Medicaid national averages.

To improve CAHPS rates, **Well Sense** could consider involving MCO staff members at every level to assist in improving *Getting Needed Care* and *Customer Service* rates. MCOs should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: 1) it reduces delays in patient care; 2) it increases continuity of care; and 3) it decreases wait times and the number of no-shows, resulting in cost savings. An evaluation of current MCO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. MCOs should further promote the use of existing after-hours customer service to improve customer service results. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

The rates for *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 newsletters and providing periodic reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions. MCOs can encourage providers to share member's medical records to share information and encourage discussions about members' health care. Access to this information allows members to better understand their condition and treatment plan, feel more in control of their health, and identify and correct inaccurate information. Also, using simple, inexpensive tools, such as patient question lists, to help members communicate effectively could lead to higher experience of care ratings. Members could create a list of questions they want to ask their provider during the office visit to ensure that all questions are answered during the health care encounter.

HEDIS

Well Sense demonstrated strength for measures related to ***quality of care***, exceeding the 50th percentile for 24 of 38 (63.16 percent) measures related to ***quality***. The following measures related to ***quality*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**
- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid** and *Bronchodilator**
- *Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**
- *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*

Well Sense has opportunities for improvement related to ***quality of care***, with **Well Sense**'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)—Body Mass Index (BMI) Percentile Documentation—Total* and *Counseling for Nutrition—Total*
- *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)*
- *Chlamydia Screening in Women (CHL)—Total*†
- *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*†
- *Annual Monitoring for Patients on Persistent Medications (MPM)—Total*
- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*
- *Use of Imaging Studies for Low Back Pain (LBP)*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

Well Sense demonstrated strength in measures related to ***timeliness of care***, exceeding the 50th percentile for six of the 12 (50.00 percent) measures related to ***timeliness***. The following measures related to ***timeliness*** met or exceeded the 75th percentile (an asterisk * indicates the measure met or exceeded the 90th percentile):

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid** and *Bronchodilator**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*

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

- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

Well Sense demonstrated strength in measures related to ***access to care***, exceeding the 50th percentile for nine of the 15 (60.00 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**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total** and *30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*

Well Sense has opportunities for improvement related to ***access to care***, with **Well Sense**'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*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*†
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase* and *Continuation and Maintenance Phase*

Encounter Data Validation

Well Sense met the standard for X12 EDI compliance edits and data accuracy for servicing provider information in NCPDP encounters. **Well Sense** should continue improving its data accuracy for the member identification number and servicing provider information for the outstanding encounter types and timely data submissions to DHHS so that **Well Sense** can meet the corresponding standards. Developing system edits to flag incorrect information prior to data submission may be helpful in eliminating data accuracy errors. **Well Sense** also may work with DHHS on example cases containing inaccurate member identification numbers and/or servicing provider information to determine the root cause. Lastly, appointing a specific team member to be responsible for more stringent oversight of the due dates for data submission may correct the ***timeliness*** issues. Determining ***access to care*** and health outcomes that represent ***quality of care*** could be difficult if **Well Sense** does not submit accurate and timely encounter data to DHHS.

Based on **Well Sense**'s IS Review questionnaire responses, the MCO provided information demonstrating its capacity to collect, process, and transmit to DHHS claims and encounter data meeting established quality specifications. **Well Sense** described the centrality of its encounter data systems and data warehouse and its ability to develop adaptable data review processes that can promptly respond to quality issues identified by DHHS. **Well Sense** should consider (1) investigating rejections caused by provider data to reduce rejection rates, (2) adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS, (3) incorporating timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS, and (4) implementing a submission frequency assessment in its review of encounter files submitted by external service management vendors.

Health Plan Comparisons and Health Plan-Specific Conclusions and Recommendations

MCO Contractual Compliance

The SFY 2014 compliance activities consisted of reviewing 14 standards containing 294 applicable elements for **NHHF** and 295 applicable elements for **Well Sense**. HSAG included the requirements found in 42 CFR §438 Subparts A–F of the BBA and the State contractual requirements in the New Hampshire MCM Contract[4-1] in the comprehensive compliance tool. The review of compliance conducted in SFY 2015 began a three-year cycle of reviewing one-third of the elements contained in the comprehensive compliance tool. The current review in SFY 2019 included 12 standards with 105 applicable elements for **NHHF** and **Well Sense**. HSAG also included the CAP elements from the SFY 2018 compliance review in the SFY 2019 on-site review to ensure that the information submitted for the CAP was operationalized correctly by the MCO.

HSAG conducted a pre-on-site desk review of documents submitted by the MCOs and an on-site review that consisted of a review of additional documentation and staff interviews. The complete description of the methodology HSAG uses to conduct compliance reviews is included in Appendix B.

Results of the SFY 2019 Compliance Review

Table 4-1 includes the findings from the SFY 2019 compliance reviews for **NHHF** and **Well Sense**.

Table 4-1—Comparison of MCO Scores for the SFY 2019 Compliance Review

Standard	Standard Name	NHHF	Well Sense
I.	Delegation and Subcontracting*	NA	NA
II.	Plans Required by the Contract	100%	100%
III.	Emergency and Post-Stabilization Care*	NA	NA
IV.	Care Management/Care Coordination	100%	100%
V.	Wellness and Prevention*	NA	NA
VI.	Behavioral Health	100%	91.7%
VII.	Member Enrollment and Disenrollment	91.7%	100%
VIII.	Member Services	100%	100%
IX.	Cultural Considerations	100%	100%

[4-1] New Hampshire Department of Health and Human Services. (2014). *Medicaid Managed Care Organization Contract and Amendments.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: Oct 25, 2019.

Standard	Standard Name	NHHF	Well Sense
X.	Grievances and Appeals	100%	100%
XI.	Access	91.7%	100%
XII.	Network Management	88.9%	88.9%
XIII.	Utilization Management	100%	92.9%
XIV.	Quality Management	100%	100%
XV.	Substance Use Disorder	64.3%	71.4%
Overall Score		**95.7%**	**96.2%**

* This standard was not included in the SFY 2019 compliance review.

Of the 12 standards included in the SFY 2019 compliance review, **NHHF** achieved 100 percent compliance for 8 standards, 90–99 percent compliance for two standards, 88.9 percent compliance for one standard, and 64.3 percent compliance for one standard. **Well Sense** achieved 100 percent compliance for 8 standards, 90–99 percent compliance in two standards, 88.9 percent compliance in one standard, and 71.4 percent compliance for one standard.

The SFY 2019 compliance review also included file reviews and checklist reviews, as shown in Table 4-2.

Table 4-2—Summary of the SFY 2019 File Reviews and Checklists Reviews for NHHF and Well Sense

Overall Rate for the File and Checklist Reviews	NHHF	Well Sense
File Reviews		
Grievances	100%	100%
Appeals	97.8%	91.7%
Denials	100%	100%
File Review Score	**99.1%**	**97.2%**
Checklist Reviews		
Access Standards	100%	100%
Provider Directory	95.7%	95.7%
Member Handbook	100%	100%
MCO Website	97.3%	97.4%
Member Rights	100%	100%
Checklist Score	**98.6%**	**98.6%**

NHHF Conclusions and Recommendations for the Compliance Review

During **NHHF**'s SFY 2019 compliance review, 93.3 percent of the 105 elements were found to be compliant with federal and State regulations. HSAG also validated through a review of policies, procedures, and staff interviews that the MCO corrected the deficiencies identified during the prior year's audit.

NHHF received 100 percent compliance on eight standards. Two standards each scored 91.7 percent: Access and Member Enrollment and Disenrollment. Network Management scored 88.9 percent, and the standard representing the greatest opportunity for improvement was SUD, which scored 64.3 percent.

HSAG offers the following recommendations for **NHHF**:

- **NHHF** must include the required statements concerning the reasons members may request disenrollment without cause in plan documents.
- **NHHF** must include a list of the situations when abortions can be provided in plan documents concerning abortions.
- **NHHF** must complete network provider training within 30 calendar days of entering into a contract with a provider.
- **NHHF** must include in plan documents the statement that health care professionals acting within the lawful scope of practice are not prohibited or otherwise restricted from advising or advocating on behalf of a member who is his or her patient for the member's right to express preferences about future treatment decisions.
- Pregnant women diagnosed with SUD must be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment.
- Initial eligibility screening for SUD services should be conducted as soon as possible, ideally at the time of first contact (by in person or electronic face-to-face communication or by telephone conversation) with the member or referring agency, but no later than two business days following the date of first contact.
- Members who have screened positive for SUD services should receive an ASAM LOC Assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three days after admission.

HSAG offers the following recommendations for **NHHF** from the review of the appeal files, the Provider Directory Checklist, and the MCO Website Checklist:

- When a member request for appeal is submitted orally, **NHHF** must obtain written confirmation of the member's oral request for appeal.
- **NHHF** must ensure that the provider directory and the MCO website indicates whether a provider has completed cultural competence training.

NHHF successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the SFY 2019 compliance review. HSAG will include a review of the SFY 2019 Compliance Review CAP items during the on-site SFY 2020 compliance audit.

Well Sense Conclusions and Recommendations for the SFY 2019 Compliance Review

During **Well Sense**'s SFY 2019 compliance review, 93.3 percent of the 105 elements were found to be compliant with federal and State regulations.

Well Sense received 100 percent compliance on eight standards. Two standards received a score of 92.9 percent and 91.7 percent, respectively: UM and Behavioral Health. Network Management scored 88.9 percent, and one standard, SUD, represented the greatest opportunity for improvement with a score of 71.4 percent.

HSAG offers the following recommendations for **Well Sense**:

- **Well Sense** must complete provider training within 30 calendar days of entering a contract and ensure that the training addresses information pertaining to the grievance and appeals system, including State fair hearings.
- **Well Sense** must furnish written UM policies, procedures, and criteria upon request to DHHS, members, and providers.
- **Well Sense** must submit policies governing the coordination of care with PCPs and community mental health programs to DHHS for review and approval 90 calendar days prior to the beginning of each Agreement year.
- SUD providers must conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (by in person or electronic face-to-face communication or by telephone conversation) with the member or referring agency, but no later than two business days following the date of first contact.
- Members who have screened positive for SUD services must receive an ASAM LOC Assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three days after admission.
- Members with a SUD diagnosis identified for withdrawal management, outpatient, or intensive outpatient services must start receiving services within seven business days from the date the ASAM LOC assessment was completed.
- Pregnant women with a SUD diagnosis will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor:
  a. Assists the pregnant woman with identifying alternative providers and accessing services with these providers. This assistance includes actively reaching out to identify providers on behalf of the client.
  b. Provides interim services until the appropriate LOC becomes available at either the contractor agency or an alternative provider. Interim services include:
     i. At least one 60-minute individual or group outpatient session per week.
     ii. Recovery support services as needed by the client.
     iii. Daily calls to the client to assess and respond to any emergent needs.

HSAG offers the following recommendations for **Well Sense** from the review of the appeal files, the Provider Directory Checklist, and the MCO Website Checklist:

- **Well Sense** must ensure that an acknowledgement letter is sent to the member upon receipt of an appeal.
- **Well Sense** must ensure that the provider directory and the MCO website indicates whether a provider has completed cultural competence training.

Well Sense successfully submitted CAPs for all the recommendations noted above and created policies, procedures, and processes to rectify the deficiencies identified during the SFY 2019 compliance review. HSAG will include a review of the SFY 2019 Compliance Review CAP items during the on-site SFY 2020 compliance audit.

Trending

Table 4-3 displays the compliance scores achieved by **NHHF** and **Well Sense** during the six years that HSAG conducted compliance reviews.

Table 4-3—Compliance Scores for NHHF and Well Sense from 2014–2019

Fiscal Year	Standards Reviewed	Elements Reviewed	NHHF	Well Sense
2014	14	294	95.1%	93.4%
2015	14	82	99.5%	99.5%
2016	13	130	92.7%	88.8%
2017	14	110	97.3%	98.6%
2018	14	128	98.0%	98.8%
2019	12	105	95.7%	96.2%

The scores for **NHHF** ranged from 92.7 percent in 2016 to 99.5 percent in 2015. The scores for **Well Sense** ranged from 88.8 percent in 2016 to 99.5 percent in 2015. As previously mentioned, the SFY 2014 compliance activities consisted of reviewing all 14 standards containing 294 applicable elements. Since that time, HSAG has reviewed one-third of the elements.

Since 2015, the compliance tool has contained different elements for each year of the review. The MCOs scored the lowest scores in 2016 and the highest scores in 2015. The review in 2016 included a new standard because DHHS requested that HSAG include the SUD requirements in that review. The MCOs scored under 50 percent for the SUD standard; however, **NHHF** and **Well Sense** submitted CAPs to correct the deficiencies noted in the review. The 2019 compliance review also included the SUD requirements, and the SUD standard once again represented the lowest standard score achieved by both MCOs.

PIPs

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. The PIP process allows MCOs the opportunity to identify areas of concern affecting their membership and strategize ways to improve care. For such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. A complete description of the methodology HSAG uses to validate PIPs is included in Appendix B.

During the first half of SFY 2019, HSAG validated three PIP topics selected by **NHHF** and three PIP topics selected by **Well Sense** as shown in Table 4-4. The contract between DHHS and the MCOs requires that one of the three PIP topics be focused on behavioral health.

Table 4-4—Performance Improvement Project Topics Selected by NHHF and Well Sense

NHHF PIP Topics	Well Sense PIP Topics
Comprehensive Diabetes Screening—Vision Screening	*Chlamydia Screening*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	*Reducing Hospital Readmissions**
Well-Child Visits for 3-to-6-Year-Olds	*Well-Child Visits for 3-to-6-Year-Olds*

* The **Well Sense** *Reducing Hospital Readmissions* PIP focused on reducing readmissions to New Hampshire Hospital, which provides inpatient mental health care.

Validation Results

For each MCO, Table 4-5 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for the three PIPs. This table illustrates **NHHF**'s and **Well Sense**'s overall application of the PIP process and the degree to which the MCOs achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score satisfied the necessary technical requirements for a specific element. The validation results presented in Table 4-5 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and the overall score across all three stages.

Table 4-5—2018 PIP Validation Results Comparison by MCO for Topics Selected by NHHF and Well Sense

Stage	Activities	Percentage of Applicable Elements* Scored *Met*	
		NHHF (N=3 PIPs)	Well Sense (N=3 PIPs)
Design	Activities I–VI	100% (45/45)	100% (39/39)
Implementation	Activities VII–VIII	100% (38/38)	100% (37/37)
Outcomes	Activities IX–X	64% (7/11)	55% (6/11)
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**96%**	**94%**

* The number of evaluation elements in each activity and each stage is based on the evaluation criteria outlined in the CMS *EQR Protocol 3: Validating Performance Improvement Projects: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[4-2]

For all PIPs, the Design stage establishes the methodological framework. The activities in this stage include development of the study topic, study question, study indicators, study population, sampling methodology, if applicable, and data collection process. To implement successful improvement strategies, a strong study design is necessary. The validation for SFY 2019 indicated that both MCOs met 100 percent of the requirements for all activities in the Design stage of each PIP.

The Implementation stage includes data analysis and interpretation of results, as well as development and implementation of improvement strategies and interventions. For the SFY 2019 validation, the MCOs reported results for the third remeasurement (1/1/17–12/31/17) for each PIP and described improvement strategies and interventions that occurred during the third remeasurement period. The MCOs demonstrated solid performance in the Implementation stage, both receiving a *Met* score for 100 percent of the evaluation elements, respectively, across all PIPs.

In the Outcomes stage, PIPs are assessed for statistically significant improvement in the study indicator outcomes. Both MCOs progressed through Activity IX of the Outcomes stage for each of the PIPs, reporting results of the third remeasurement and evaluating study indicator outcomes for improvement. Additionally, **NHHF** progressed through Activity X for one PIP. In Activity X, **NHHF** sustained the significant improvement achieved at Remeasurement 1 (1/1/15–12/31/15). **Well Sense** achieved statistically significant improvement over baseline at Remeasurement 2 for one of the PIPs; however, the MCO was not able to sustain the improvement at Remeasurement 3. The remaining two PIPs for both MCOs have not yet achieved statistically significant improvement over the baseline through Remeasurement 3. The PIPs are not evaluated for sustained improvement until statistically significant

[4-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 25, 2019.

improvement has been demonstrated across all study indicators and results from a subsequent measurement period have been reported. **NHHF** and **Well Sense** could improve performance in the Outcomes stage, with 64 percent and 55 percent of the evaluation elements receiving a *Met* score, respectively. HSAG included recommendations to improve PIP outcomes in the following sections that evaluate the individual PIPs for each MCO.

PIP-Specific Outcomes

NHHF

Table 4-6 displays the baseline through Remeasurement 3 study indicator results for the *Comprehensive Diabetes Care—Vision Screening* PIP.

Table 4-6—NHHF's Performance Improvement Project Outcomes for *Comprehensive Diabetes Care—Vision Screening*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
The percentage of members aged 18 to 75 years with diabetes (type 1 or type 2) who had an eye exam (retinal) performed.	59.8%	65.6%↑*	70.4%↑**	68.1% ↑**

↑* Designates statistically significant improvement over the baseline measurement period (p value < 0.05).

↑** The remeasurement rate demonstrated sustained improvement over the baseline rate.

For the *Comprehensive Diabetes Care—Vision Screening* PIP, **NHHF** reported a baseline study indicator rate of 59.8 percent. At Remeasurement 1, the MCO reported a rate of 65.6 percent. The Remeasurement 1 rate was a statistically significant ($p = 0.0442$) improvement of 5.8 percentage points over the baseline rate. The Remeasurement 1 rate also exceeded the MCO's goal of 65.5 percent. At Remeasurement 2, the MCO reported a rate of 70.4 percent. The Remeasurement 2 rate demonstrated a statistically significant ($p < 0.0001$) improvement of 10.6 percentage points over the baseline rate but did not meet the MCO's goal of 71.4 percent. The Remeasurement 3 rate demonstrated a statistically significant ($p < 0.0001$) improvement of 8.3 percentage points over the baseline rate; however, this rate did not meet the goal of 71.4 percent. **NHHF** was able to sustain the statistically significant improvement that was achieved at Remeasurement 1 for the subsequent measurement period.

Lessons Learned

NHHF reported the following lessons learned for the *Comprehensive Diabetes Care—Vision Screening* PIP:

- The Envolve Vision provider and member outreach was a consistently strong intervention and continues to account for year-over-year improvement.

- Having a combined approach targeting eye care providers and members with consistent, timely follow-up yielded positive results.
- Having a collaborative relationship with the broader provider network was key for overcoming barriers to eye care services.
- Consistent outreach to in-network PCP groups to share population health details and missing services in the form of monthly care gap reporting was impactful only if the provider group was staffed to meet the required level of member outreach.
- Collaborative outreach with the federally qualified health centers and having an embedded eye care provider or eye care clinic on-site yielded high compliance rates.
- When PCPs receive diabetic retinal eye exam results from an eye care specialist, the provider faces challenges with manually inputting the eye exam results into their electronic medical record (EMR) system for reporting purposes. EMR interoperability is needed between health care providers.
- The bundling of the measure incentive award made it difficult for members to achieve all three services (HbA1c testing, medical attention for nephropathy, and diabetic retinal eye exam). Going forward, the MCO will remove the screening for nephropathy to raise an opportunity for members to earn the incentive award for HbA1c testing and the diabetic retinal eye exam. Bundling of these two components of the measure will reinforce to the member the importance of managing their chronic condition.
- Member incentives are not a turnkey approach to rate improvement. Incentives must be kept simple and straightforward.

Table 4-7 displays the baseline through Remeasurement 3 study indicator results for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP.

Table 4-7—NHHF's Performance Improvement Project Outcomes for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
The percentage of members ages 18 to 64 years with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening in the measurement year.	77.6%	78.7% ⇔	78.5% ⇔	83.6% ⇔

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP, **NHHF** recalculated the baseline study indicator rate using updated HEDIS specifications so that the baseline and Remeasurement 1 rates would be comparable. HSAG

recommended a baseline rate recalculation because the NCQA changed the denominator definition in the HEDIS specifications after the baseline measurement period. The specification changes impacted the comparability of rates. Using the updated specifications, the MCO reported a baseline study indicator rate of 77.6 percent and a Remeasurement 1 rate of 78.7 percent. The increase of 1.1 percentage points from baseline to Remeasurement 1 was not statistically significant ($p = 0.7784$). The Remeasurement 1 rate did not meet the MCO's goal of 89.0 percent. At Remeasurement 2, the MCO reported a rate of 78.5 percent. The 0.9 percentage point increase from baseline to Remeasurement 2 was not statistically significant ($p = 0.8425$). The Remeasurement 2 rate did not meet the MCO's goal of 85.4 percent. For Remeasurement 3, the MCO reported a rate of 83.6 percent. The increase of 6 percentage points from baseline to Remeasurement 3 was not statistically significant ($p = 0.0634$). The Remeasurement 3 rate did not meet the goal of 85.4 percent.

Lessons Learned

NHHF reported the following lessons learned for the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP:

- Narrowing the number of required lab reports to only those members in the denominator, rather than all members prescribed an antipsychotic medication, increases provider impact and efficiency and reduces administrative burden on the providers.
- Year-round management and understanding of the HEDIS measure are necessary with prescribers and PCPs for consistent care-gap sharing.
- Having a collaborative relationship with the broader provider network is key to overcoming barriers.
- Consistent outreach to in-network PCP groups to share population health details and missing services in the form of monthly or quarterly care gap reporting was impactful only if the provider group was staffed to meet the required level of member outreach.
- **NHHF** needs to have accountability related to knowing who prescribed the medication and who should order the lab when meeting with CMHCs.
- Not having a point of care (POC) identified at CMHCs is an obstacle.
- There needs to be consistent attention to documentation in the EMR for labs ordered, labs executed, and lab reports received for all types of provider sites.

Table 4-8 displays the baseline through Remeasurement 3 study indicator results for the *Well-Child Visits for 3-to-6-Year-Olds* PIP.

Table 4-8—NHHF's Performance Improvement Project Outcomes for *Well-Child Visits for 3-to-6-Year-Olds*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
The percentage of members ages 3 to 6 years who had at least one well-child visit with a PCP in the measurement year.	79.3%	78.9% ⇔	82.0% ⇔	76.9% ⇔

⇔ Designates an improvement or a decline over the baseline measurement period that was not statistically significant (*p* value >= 0.05).

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **NHHF** reported a baseline study indicator rate of 79.3 percent. At Remeasurement 1, the MCO reported a rate of 78.9 percent. The decline of 0.4 percentage point from baseline to Remeasurement 1 was not statistically significant ($p = 0.9323$). The Remeasurement 1 rate of 78.9 percent did not meet the MCO's goal of 84.5 percent. At Remeasurement 2, the MCO reported a rate of 82.0 percent. The increase of 2.7 percent points over the baseline rate was not statistically significant ($p = 0.3369$). The Remeasurement 2 rate of 82.0 percent did not meet the MCO's goal of 84.5 percent. For Remeasurement 3, the MCO reported a rate of 76.9 percent. The decline of 2.4 percentage points over the baseline rate was not statistically significant ($p = 0.4503$). The Remeasurement 3 rate of 76.9 percent did not meet the goal of 84.5 percent.

Lessons Learned

NHHF reported the following lessons learned for the *Well-Child Visits for 3-to-6-Year-Olds* PIP:

- Bringing the HEDIS medical record review abstraction project in-house was successful beyond increasing the HEDIS rates.
- Early planning of interventions is necessary to stagger the interventions and keep them on track.
- Encouraging providers to use the EMR submission process promotes efficiency for both the providers and the MCO.

Well Sense

Table 4-9 displays the baseline through Remeasurement 3 study indicator results for the *Chlamydia Screening* PIP.

Table 4-9—Well Sense's Performance Improvement Project Outcomes for *Chlamydia Screening*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
The percentage of women 16 to 24 years of age who were identified as sexually active and had had at least one chlamydia test performed in the measurement year.	43.5%	42.7% ⇔	46.9% ↑	46.3% ⇔

⇔ Designates a decline over the baseline measurement period that was not statistically significant (*p* value >= 0.05).
↑ Designates statistically significant improvement over the baseline measurement period (*p* value >= 0.05).

For the *Chlamydia Screening* PIP, **Well Sense** reported a baseline study indicator rate of 43.5 percent. At Remeasurement 1, the MCO reported a rate of 42.7 percent. The decline of 0.8 percentage point in the study indicator rate from baseline to Remeasurement 1 was not statistically significant ($p = 0.6164$). The Remeasurement 1 rate did not meet the MCO's goal of 47.5 percent. At Remeasurement 2, the MCO reported a rate of 46.9 percent. The Remeasurement 2 rate demonstrated a statistically significant improvement of 3.4 percentage points over the baseline rate ($p = 0.0438$); however, this rate fell short of the Remeasurement 2 goal of 47.5 percent by 0.6 percentage point. At Remeasurement 3, the MCO reported a rate of 46.3 percent. The increase of 2.8 percentage points over the baseline rate was not statistically significant ($p = 0.0977$) and did not meet the Remeasurement 3 goal of 47.5 percent. In addition, the MCO did not maintain the improvement from the Remeasurement 2 rate to Remeasurement 3.

Lessons Learned

Well Sense reported the following lessons learned for the *Chlamydia Screening* PIP:

- Barrier analyses and discussions with providers show that the younger members, particularly those who still live with a parent or guardian, may avoid screenings due to concerns about parents becoming aware they are sexually active. These members may also be more likely to take advantage of free screenings at Title X facilities, where they are able to remain anonymous, while members of the older cohort may be more comfortable being screened by their PCP.
- While direct member interventions show positive results, these results have not translated into a significant change in overall chlamydia screening rates. This may be due to the stigma attached to sexually transmitted infections and screenings, privacy concerns, or discomfort with discussing sexual activity with providers.

- Provider interventions, including chlamydia screenings in the MCO's Quality Incentive Program, have not shown to significantly improve rates of chlamydia screenings among participating providers.
- Provider interventions, such as distribution of the Chlamydia Screening Care Gap Report and the New Hampshire Sexually Transmitted Diseases/Human Immunodeficiency Virus (STD/HIV) Surveillance Program 5 Year Data Summary Report, have a potentially greater impact on the overall chlamydia screening rates by educating providers on the number of care gaps among their members and on the prevalence of chlamydia in New Hampshire, particularly in the State's most populated areas.
- The MCO's quality team has been successful in encouraging at least one large provider group to test mandatory "in the door" urine, screening chlamydia for female members in the appropriate age range.

Table 4-10 displays the baseline through Remeasurement 3 study indicator results for the *Reducing Hospital Readmissions* PIP.

Table 4-10—Well Sense's Performance Improvement Project Outcomes for *Reducing Hospital Readmissions*

Study Indicators*	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
1. The percentage of eligible members readmitted to New Hampshire Hospital within 30 days of discharge.	12.7%	9.8% ⇔	12.8% ⇔	7.8% ⇔
2. The percentage of eligible members readmitted to New Hampshire Hospital within 60 days of discharge.	18.2%	14.0% ⇔	17.8% ⇔	13.2% ⇔
3. The percentage of eligible members readmitted to New Hampshire Hospital within 90 days of discharge.	19.2%	17.3% ⇔	20.9% ⇔	16.7% ⇔

***** The PIP's study indicators are inverse indicators, where ***a lower rate is better***.

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

Well Sense used three inverse study indicators for the *Reducing Hospital Readmissions* PIP, ***where a lower rate represents better performance***. Prior to the Remeasurement 2 PIP submission, the MCO revised the baseline and Remeasurement 1 study indicator data after identifying and resolving some data calculation errors in the PIP. **Well Sense** reported the following revised baseline rates for Study Indicators 1 (30-day readmission rate), 2 (60-day readmission rate), and 3 (90-day readmission rate), respectively: 12.7 percent, 18.2 percent, and 19.2 percent. For Remeasurement 1, the MCO reported a revised rate of 9.8 percent for Study Indicator 1 (30-day readmission rate). The Remeasurement 1 rate for Study Indicator 1 was not a statistically significant improvement from the baseline rate ($p = 0.2355$). For Study Indicator 2 (60-day readmission rate), the MCO reported a revised Remeasurement 1 rate of

14.0 percent, which was not a statistically significant improvement from baseline ($p = 0.1292$). For Study Indicator 3 (90-day readmission rate), the MCO reported a revised Remeasurement 1 rate of 17.3 percent, which was not a statistically significant improvement from the baseline rate ($p = 0.5310$).

For the Remeasurement 2 study indicator outcomes, **Well Sense** reported a Study Indicator 1 rate of 12.8 percent, which reflected an increase in the 30-day readmission rate of 0.1 percentage point over baseline; the difference was not statistically significant ($p = 0.9550$). The Study Indicator 1 goal of less than or equal to 7.8 percent was not met. The Remeasurement 2 rate for Study Indicator 2 was 17.8 percent, which was not a statistically significant improvement over the baseline 60-day readmission rate ($p = 0.9041$). The Study Indicator 2 goal of less than or equal to 12.3 percent was not met. The Remeasurement 2 rate for Study Indicator 3 of 20.9 percent represented an increase in the 90-day readmission rate of 1.7 percentage points over the baseline rate, but the difference was not statistically significant ($p = 0.5773$). The Study Indicator 3 goal of less than or equal to 13.3 percent was not met. Overall, there have been no statistically significant changes in the three study indicator rates from baseline to Remeasurement 2. Additionally, none of the Remeasurement 2 goals were met.

For the Remeasurement 3 study indicator outcomes, **Well Sense** reported a Study Indicator 1 rate of 7.8 percent, which reflected a decrease in the 30-day readmission rate of 4.9 percentage points over the baseline; the difference was not statistically significant ($p = 0.0589$). The Study Indicator 1 goal of less than or equal to 7.8 percent was met. The Study Indicator 2 rate was 13.2 percent, reflecting a decrease in the 60-day readmission rate of 5.0 percentage points over the baseline; the difference was not statistically significant ($p = 0.1092$). The Study Indicator 2 goal of less than or equal to 12.3 percent was not met. The Study Indicator 3 rate was 16.7 percent, reflecting a decrease in the 90-day readmission rate of 2.5 percentage points over the baseline; the difference was not statistically significant ($p = 0.4556$). The Study Indicator 3 goal of less than or equal to 13.3 percent was not met. Overall, there have been no statistically significant changes in the three study indicator rates from baseline to Remeasurement 3.

Lessons Learned

Well Sense reported the following lessons learned for the *Reducing Hospital Readmissions* PIP:

- Case rounds are effective and resulted in a significant lower rate of readmissions for members who were rounded between Beacon and the CMHCs compared to the overall population.
- Using written educational materials on the day of discharge did not yield measurable results. Going forward, Beacon and the MCO will consider disseminating written education materials at a time when the member is fully attentive and ready to learn the information.
- Attempts to promote care management engagement provided timely crisis intervention and avert hospitalization with Beacon and CMHCs.
- Telephonic outreach to members was not effective.
- Incorporating data and data analysis into a Plan-Do-Study-Act (PDSA) informs all aspects of a performance improvement project, such as variances, benchmarks, economics, and targeted interventions. Once implemented, the PDSA kept the project on task and continuously moving

forward, ensuring small tests of change were measured and mid-course corrections were made to refine interventions.

- Comparing outcomes when Beacon was contracted with the CMHCs versus not contracted and partnership and direct collaboration with providers yielded more robust interventions and better-quality outcomes.
- Chart audits and the value-based purchasing (VBP) program ensured documentation standards and performance incentive metrics were tracked; however, the MCO was unable to determine a direct impact or make a correlation to readmission rates for this intervention through the course of this project.

Table 4-11 displays the baseline through Remeasurement 3 study indicator results for the *Well-Child Visits for 3-to-6-Year-Olds* PIP.

Table 4-11—Well Sense's Performance Improvement Project Outcomes Results for *Well-Child Visits for 3-to-6-Year-Olds*

Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Remeasurement 3 (1/1/2017–12/31/2017)
1. The percentage of members 3 to 6 years of age who had at least one well-child visit with a PCP in the measurement year.	77.5%	79.8% ⇔	78.7% ⇔	76.0% ⇔

⇔ Designates an improvement or decline over the baseline measurement period that was not statistically significant (*p* value >= 0.05).

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **Well Sense** reported a baseline study indicator rate of 77.5 percent. At Remeasurement 1, the MCO reported a rate of 79.8 percent. The increase of 2.3 percentage points from baseline to Remeasurement 1 was not statistically significant ($p = 0.4683$). The Remeasurement 1 rate did not meet the MCO's goal of 83.1 percent. At Remeasurement 2, the MCO reported a rate of 78.7 percent, which was 1.2 percentage points above the baseline rate. The rate improvement from baseline to Remeasurement 2 was not statistically significant ($p = 0.7104$), and the Remeasurement 2 goal of 83.1 percent was not met. At Remeasurement 3, the MCO reported a rate of 76.0 percent. The rate of 76.0 percent was a non-statistically significant ($p = 0.6494$) decrease of 1.5 percentage points from the baseline rate. The Remeasurement 3 rate did not meet the MCO's goal of 83.1 percent.

Lessons Learned

Well Sense reported the following lessons learned for the *Well-Child Visits for 3-to-6-Year-Olds* PIP:

- Member interventions in the form of parent/guardian reminders (mailings during birthday months) or phone/text outreach proved popular with members and were successful in generating results among

members receiving the interventions. However, as parents receive outreach from multiple sources, including providers and agencies, it was difficult to determine the extent to which any individual intervention contributed to study indicator outcomes.

- Barriers to members 3 to 6 years of age attending well-visits varied. Among other issues, parents/guardians of members may have difficulty due to work schedules, inability to find childcare for other children in the home during a well-visit, or inability to find transportation to a well-visit. Parents/guardians may also lack awareness of the MCO's transportation benefit or of the importance of a yearly check-up even if their child is feeling well. Parents/guardians of severely ill children or children with developmental or behavioral health issues may not prioritize well-visits since their children are already seeing specialists or providers on a regular basis. Food or housing insecurity may also contribute to parents/guardians being unable to access the well-visit benefit for their children. Because barriers vary greatly, multiple interventions are required to significantly improve the well-visit rate.
- Provider interventions, such as the quality incentive program and care gap list (the All-in-One Care Gap report and EPSDT report), were well-received by providers. Over time, and in consultation with the providers, the MCO moved from delivering hard copy reports via mail, to providing electronic reports on the MCO's provider portal, and finally to providing electronic reports to providers via secure email. This has made provider care gap lists more effective, as providers may easily import the electronic reports into their EMR systems.

Conclusions and Recommendations

NHHF

NHHF designed scientifically sound projects supported by key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. A sound study design created the foundation for the MCO to progress to subsequent PIP stages—implementing active interventions that have the potential to impact study indicator outcomes. In the Implementation stage, **NHHF** conducted a casual/barrier analysis, prioritized barriers, and evaluated the effectiveness of each intervention to determine the status of the intervention. **NHHF** has opportunities for improvement in the Outcomes stage. Only one of the MCO's PIPs demonstrated statistically significant improvement at Remeasurement 1 and sustained that improvement through Remeasurement 3. The remaining two PIPs have not achieved statistically significant improvement over the baseline.

HSAG offered the following recommendations to strengthen the **NHHF** PIPs and support improvement in outcomes:

- **NHHF** should review the progress, achievements, challenges, and lessons learned for each PIP and use the knowledge gained to drive further improvement.
- **NHHF** should identify and document new or revised barriers that have prevented improvement in study indicator outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement. To evaluate barriers, the MCO may want to

consider using different QI tools and/or processes to gain a fresh perspective on the factors impacting outcomes.

- **NHHF** should evaluate the effectiveness of individual interventions and apply evaluation results to further refine improvement strategies. Process data should be used to assess the timing and reach of each intervention to determine if enough members were reached in a timely manner to impact study indicator outcomes. Process data can also demonstrate whether each intervention was implemented as planned and, if not, identify areas of implementation that can be improved.
- **NHHF** should consider if any improvement strategies, processes, or lessons learned from one of the PIPs can be applied to the other two PIPs that did not achieve statistically significant improvement. Although each PIP is addressing a different topic and member population, the MCO may identify lessons or strategies that can be translated to drive improvement in other areas.

Well Sense

Well Sense designed scientifically sound projects supported by key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. The MCO designed methodologically sound projects, used appropriate QI tools for causal/barrier analyses, and thoroughly evaluated interventions for effectiveness. **Well Sense** has opportunities for improvement in the Outcomes stage. Only one of the PIPs, has achieved statistically significant improvement over the baseline. The remaining two PIPs have not achieved statistically significant improvement over the baseline.

HSAG offered the following recommendations to strengthen the **Well Sense** PIPs and support improvement in PIP outcomes:

- **Well Sense** should review the progress, achievements, challenges, and lessons learned for each PIP and use the knowledge gained to drive further improvement.
- **Well Sense** should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement. To evaluate barriers, the MCO may want to use different QI tools and/or processes to gain a fresh perspective on the factors impacting outcomes.
- **Well Sense** should evaluate the effectiveness of individual interventions and apply evaluation results to further refine improvement strategies. Process data should be used to assess the timing and reach of each intervention to determine if enough members were reached in a timely manner to impact study indicator outcomes. Process data can also demonstrate whether each intervention was implemented as planned and, if not, identify areas of implementation that can be improved.
- **Well Sense** should consider if any improvement strategies, processes, or lessons learned from one of the PIPs can be applied to the other PIPs that have not demonstrated statistically significant improvement. Although each PIP is addressing a different topic and member population, the MCO may identify lessons or strategies that can be translated to drive improvement in other areas.

PMV

The following section of the report describes the results of HSAG's SFY 2019 EQR activities specific to validation of performance measures. This section provides conclusions as to the strengths and areas of opportunity related to the quality, timeliness of care, and access to care provided by the New Hampshire Medicaid MCOs. During SFY 2019, each MCO submitted rates for 15 state-specific measures that were validated during PMV. Recommendations are offered to each MCO to facilitate continued QI in the Medicaid program. The measures reviewed in SFY 2019 and a complete description of the audit methodology used to conduct the review of performance measures are included in Appendix B.

Results for SFY 2019

Table 4-12 provides an overview of the findings of the HSAG performance validation review for SFY 2019.

Table 4-12—SFY 2019 PMV Findings

Audit Element	NHHF	Well Sense
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable
Appropriate provider data systems and processing	Acceptable	Acceptable
Appeals data System and Process Findings	Acceptable	Acceptable
Prior Authorization and Case Management Data System and Process findings	Acceptable	Acceptable
Performance Measure Production and Reporting Findings	Acceptable	Acceptable
Required measures received a "Reportable" designation	Acceptable	Acceptable

Conclusions and Recommendations for Improvement

NHHF

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

NHHF should back up all reported data as a static dataset database so that the rates can be reproduced at any time. The data should include claim identifiers, member identifiers, and any relevant information that would allow **NHHF** to reproduce the measure details in the future, if required. **NHHF**'s Quality Management staff should continue to communicate regularly with the measure producing staff to ensure

any changes to the measures are captured and reported accurately. **NHHF** should also conduct internal audits of its reported measures through primary source verification, to ensure ongoing quality of reported rates.

Well Sense

Well Sense used a variety of methods for producing the measure under review. The measures underwent source code review by HSAG to ensure eligible populations, numerators, and denominators were accounted for accurately. HSAG had no concerns with the measure production for any measure reviewed this year.

Well Sense should create a vendor oversight project to monitor monthly submissions of data. Part of this monitoring should include additional primary source verification to determine compliance with the measure reporting. From discussions during the on-site audit, this process has started but has not been completely implemented. **Well Sense** should back up all reported data to a database so that the rates can be reproduced at any time. The data should include claim identifiers, member identifiers, and any relevant information that would allow **Well Sense** to reproduce the measure details in the future, if required. **Well Sense** continues to communicate regularly with vendors to ensure they are capturing all data elements required to produce the measures. **Well Sense** conducts internal audits of its reported measures through primary source verification to ensure ongoing quality of reported rates.

CAHPS

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. 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. **NHHF** and **Well Sense** were responsible for obtaining a CAHPS vendor to conduct CAHPS surveys of its adult and child Medicaid populations. Morpace, Inc., an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2019 CAHPS surveys for **NHHF**. Symphony Performance Health Analytics (SPHA), an NCQA-certified HEDIS/CAHPS survey vendor, administered the 2019 CAHPS surveys for **Well Sense**.

Technical Methods of Data Collection

For both **NHHF** and **Well Sense**, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. Both **NHHF** and **Well Sense** used a mixed-mode methodology for data

collection for the adult and child Medicaid populations.[4-3] Adult members and parents or caretakers of child members completed the surveys in 2019, following NCQA's data collection protocol.

The CAHPS 5.0H Surveys include a set of standardized items (53 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 83 items for the CAHPS 5.0H Child Medicaid Health Plan Survey with CCC measurement set) that assess patient perspectives on care. The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores.[4-4] The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all health care. 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, the percentage of respondents who chose the top experience ratings (a response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (i.e., positive response). For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of positive responses is referred to as a global proportion for the composite measures. The positive rates presented in this report for **NHHF** and **Well Sense** 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 purposes of this report, results are reported 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. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, for purposes of this report, the adult and general child Medicaid populations' survey findings were compared to 2018 NCQA CAHPS adult and general child Medicaid national averages, where applicable.[4-5] Each measure rate was compared to the NCQA national average, and a statistically significant difference was identified by using the confidence interval for each measure rate. The measure rates, confidence intervals, and the NCQA national average are displayed in the figures below. Statistically significant differences between each measure rate's lower and upper confidence intervals and the NCQA national average are discussed below the figures.

4-3 For the adult and child Medicaid populations, **NHHF** used an enhanced mixed-mode (i.e., mail, telephone, and Internet protocol with pre-notification postcard) survey methodology pre-approved by NCQA. **Well Sense** used a mixed-mode (i.e., mail, telephone, and Internet protocol) survey methodology pre-approved by NCQA.

4-4 For this report, the 2019 Child Medicaid CAHPS results presented for **NHHF** and **Well Sense** 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.

4-5 National data were obtained from the 2018 Quality Compass. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Results

NHHF

A total of 2,160 **NHHF** adult Medicaid members were surveyed in 2019, of which 423 completed surveys were returned. After ineligible members were excluded, the response rate was 19.8 percent. In 2019 the **NHHF** adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey, which was 21.8 percent. Figure 4-1 and Figure 4-2 show the 2019 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2018 national averages for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s adult Medicaid population.

Figure 4-1—NHHF Adult Medicaid CAHPS Results: Global Ratings

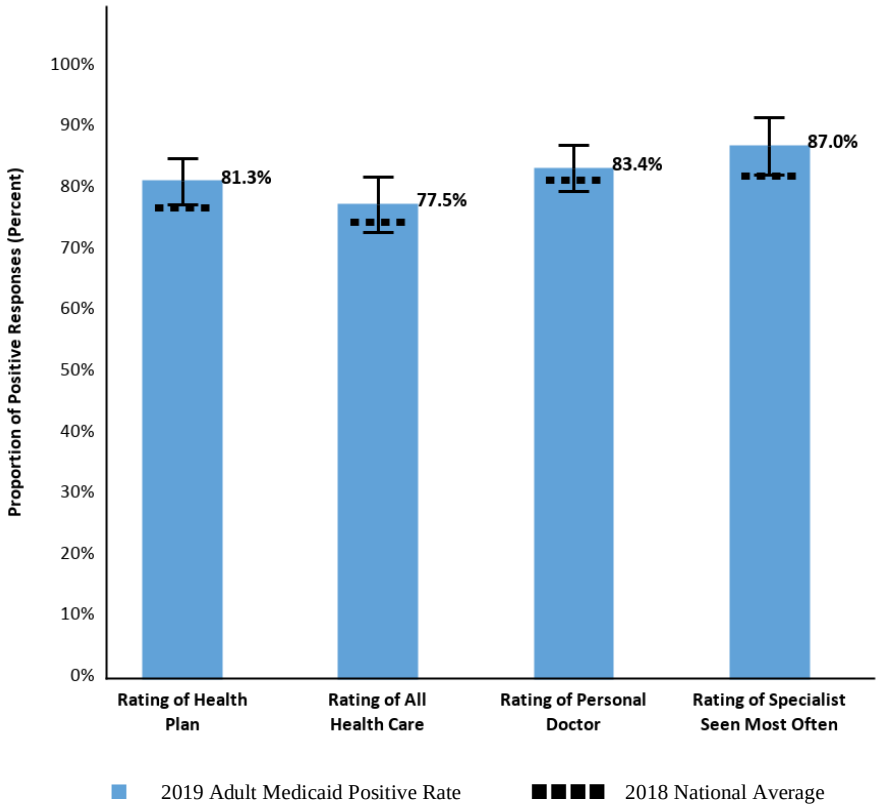
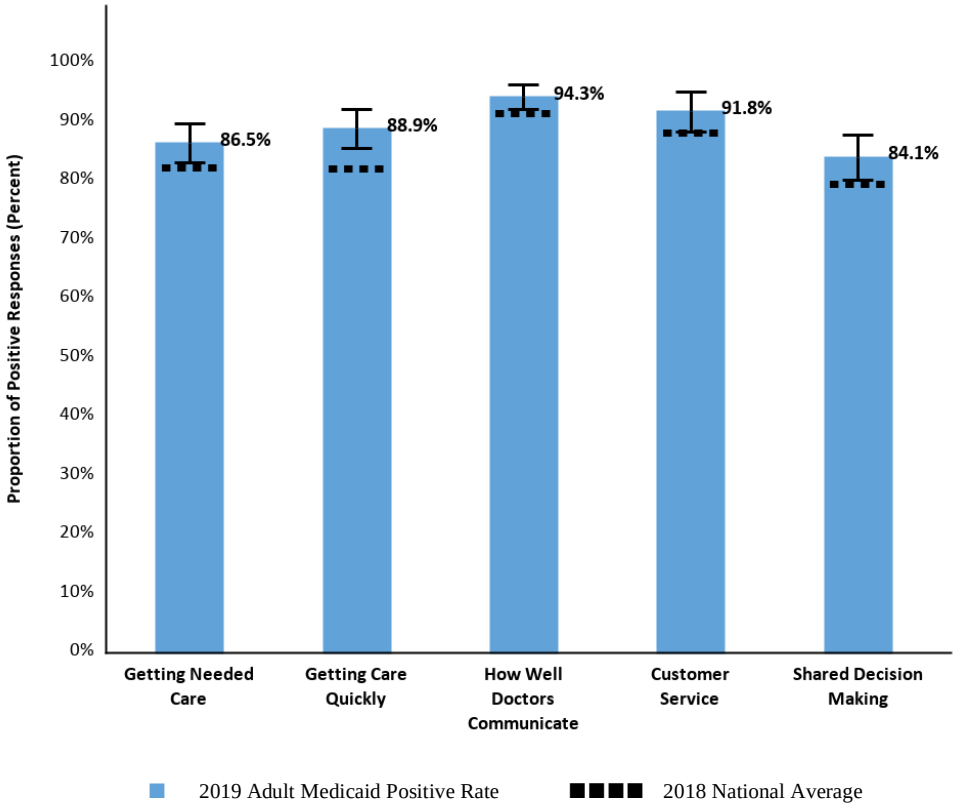


Figure 4-2—NHHF Adult Medicaid CAHPS Results: Composite Measures



For **NHHF**'s adult Medicaid population, all rates were higher than NCQA's 2018 Medicaid national averages. In addition, all rates were statistically significantly higher than NCQA's 2018 Medicaid national averages, except for *Rating of All Health Care* and *Rating of Personal Doctor*, which were neither statistically significantly higher nor lower than the national averages.

A total of 2,640 **NHHF** general child Medicaid members were surveyed in 2019, of which 485 completed surveys were returned on behalf of these members. After ineligible members were excluded, the response rate for the general child population was 18.4 percent.[4-6] In 2019, the **NHHF** general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set, which was 20.8 percent. Figure 4-3 and Figure 4-4 show the 2019 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2018 national averages for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s general child Medicaid population.[4-7]

[4-6] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid beneficiaries in the general child sample only (i.e., they do not include survey responses from the CCC supplemental sample).

[4-7] The 2019 child Medicaid CAHPS results presented in Figure 4-3 and Figure 4-4 for **NHHF** are based on results of the general child population only.

Figure 4-3—NHHF Child Medicaid CAHPS Results: Global Ratings

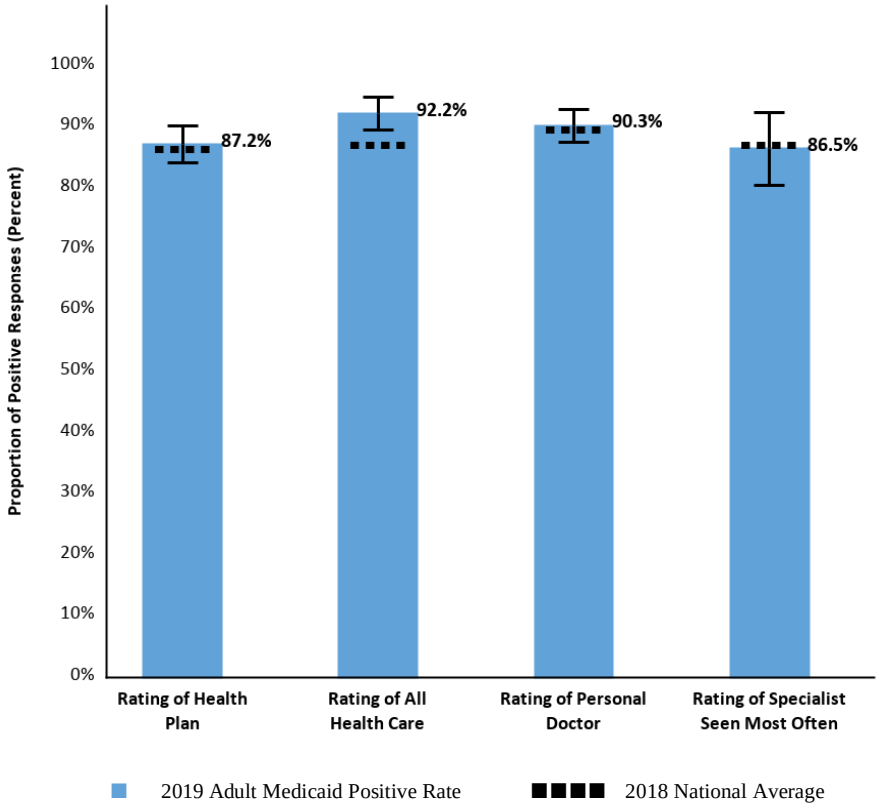
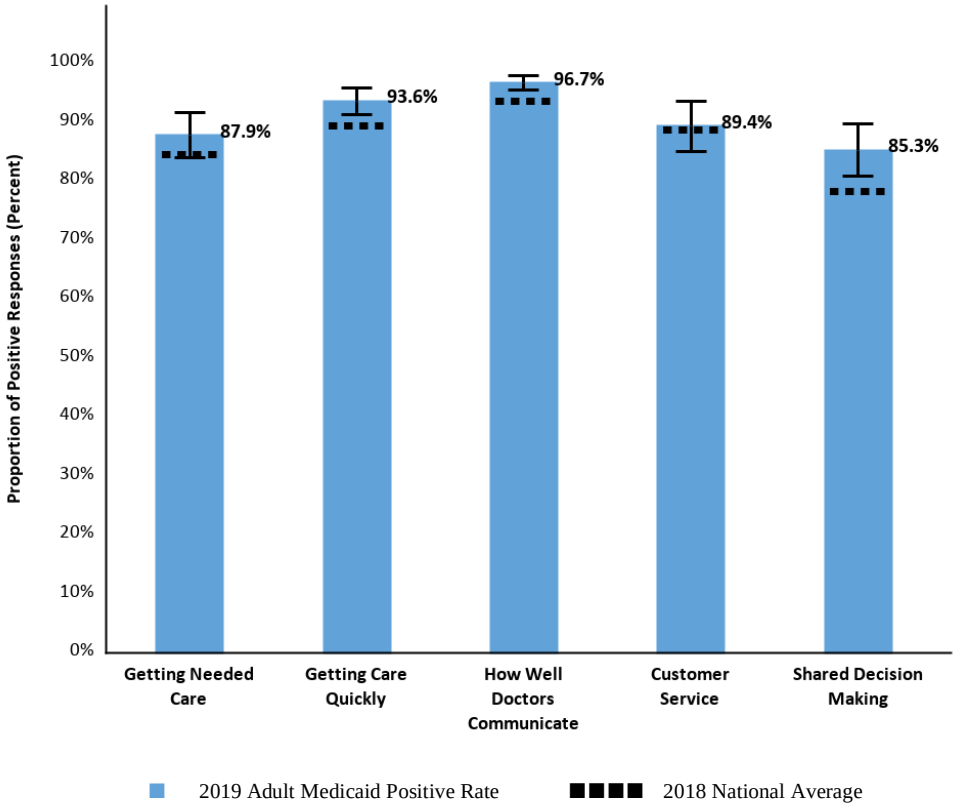


Figure 4-4—NHHF Child Medicaid CAHPS Results: Composite Measures



For **NHHF**'s general child Medicaid population, all rates were higher than NCQA's 2018 Medicaid national averages, except for *Rating of Specialist Seen Most Often.* Four rates, *Rating of All Health Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, were statistically significantly higher than NCQA's 2018 Medicaid national average, while the remaining five rates were neither statistically significantly higher nor lower than the national averages.

Well Sense

A total of 1,485 **Well Sense** adult Medicaid members were surveyed in 2019, and 290 completed surveys were returned. After ineligible members were excluded, the response rate was 19.9 percent. In 2019, the **Well Sense** adult Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey, which was 21.8 percent. Figure 4-5 and Figure 4-6 show the 2019 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2018 national averages for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s adult Medicaid population.

Figure 4-5—Well Sense Adult Medicaid CAHPS Results: Global Ratings

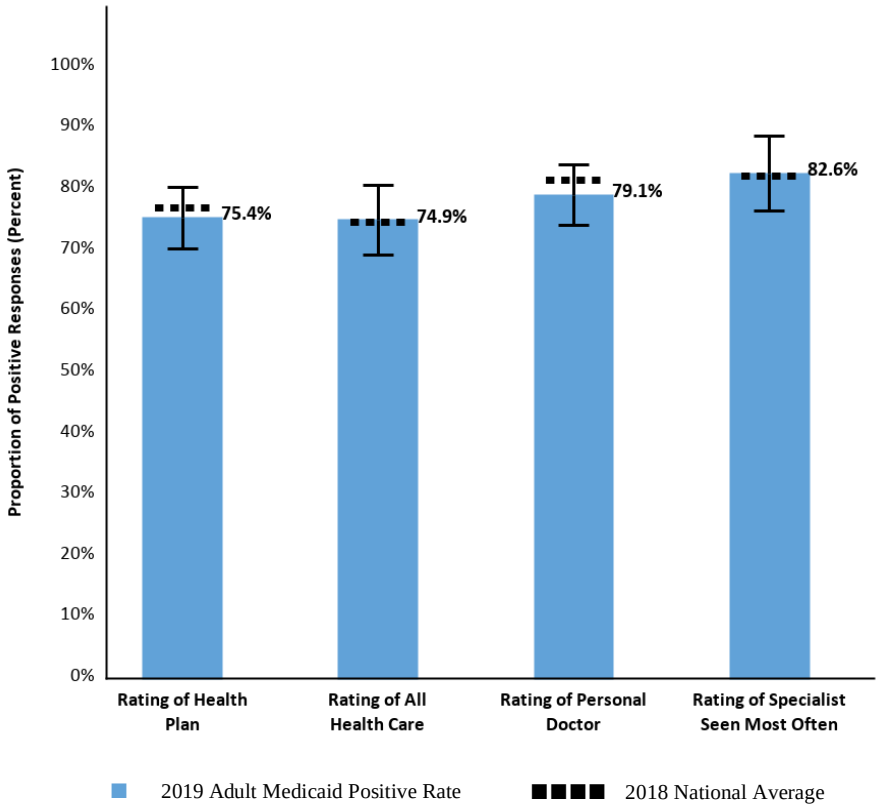
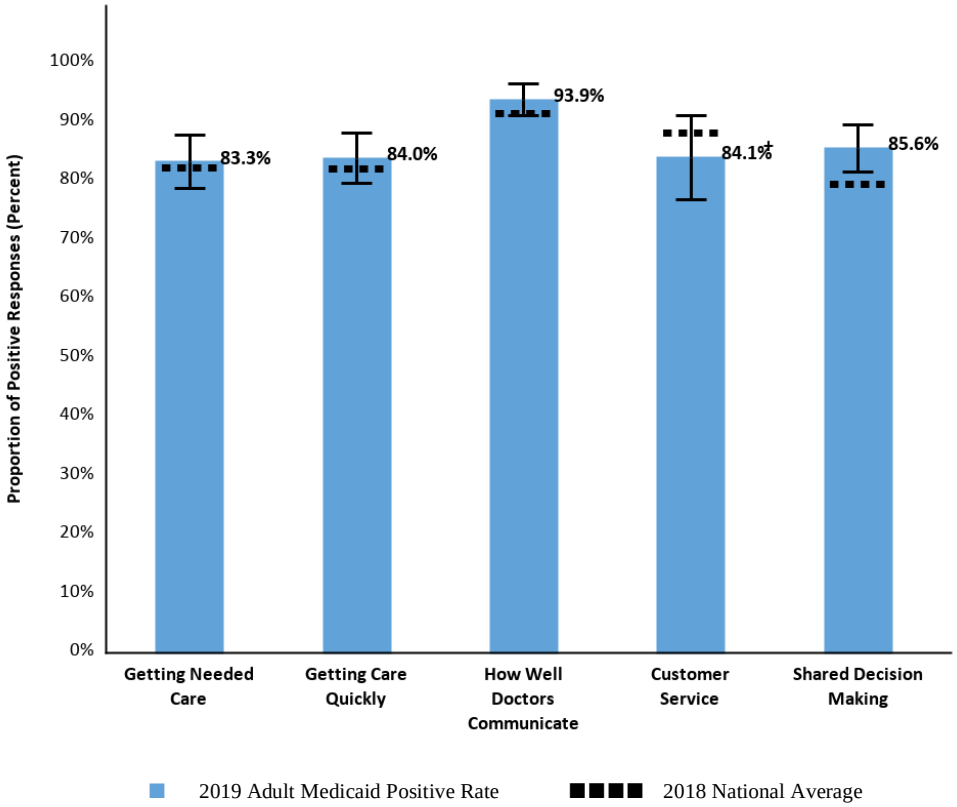


Figure 4-6—Well Sense Adult Medicaid CAHPS Results: Composite Measures



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

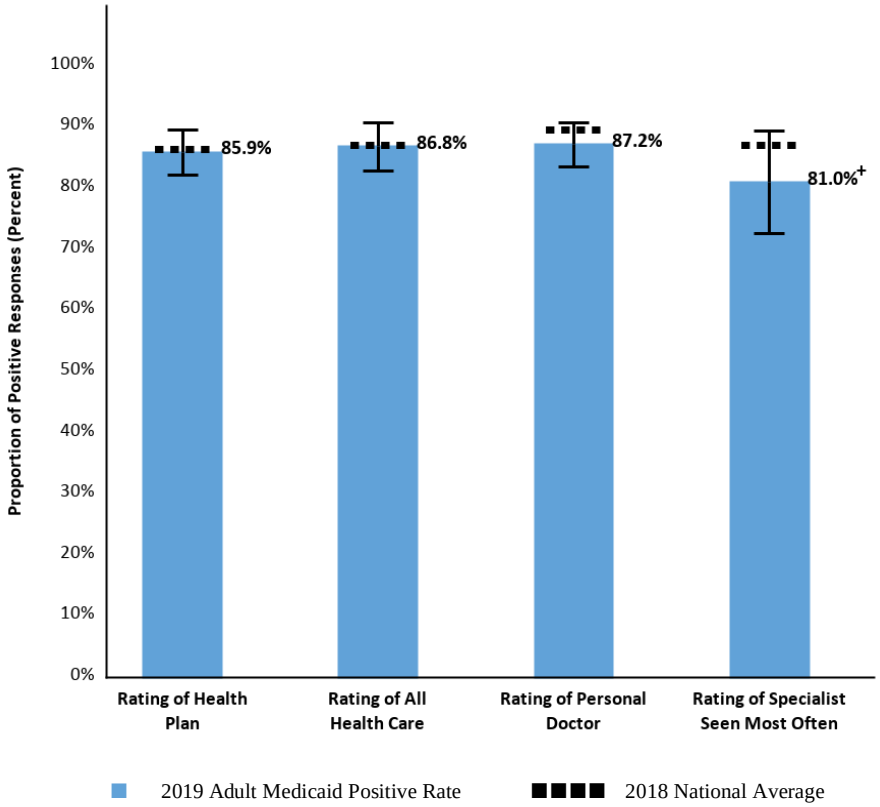
For **Well Sense**'s adult Medicaid population, all rates were higher than NCQA's 2018 Medicaid national averages, expect for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service*. One rate, *Shared Decision Making*, was statistically significantly higher than NCQA's 2018 Medicaid national average. The remaining eight rates were neither statistically significantly higher nor lower than the national averages.

In 2019, a total of 2,013 **Well Sense** general child Medicaid members were surveyed, of which 355 completed surveys were returned on behalf of these members. After ineligible members were excluded, the response rate for the general child population was 17.8 percent.[4-8] In 2019, the **Well Sense** general child Medicaid response rate was lower than the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set, which was 20.8 percent. Figure 4-7 and Figure 4-8 show the 2019 positive rates, and comparisons of the lower and upper confidence intervals to the NCQA 2018 national averages for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s general child Medicaid population.[4-9]

[4-8] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid beneficiaries in the general child sample only (i.e., do not include survey responses from the CCC supplemental sample).

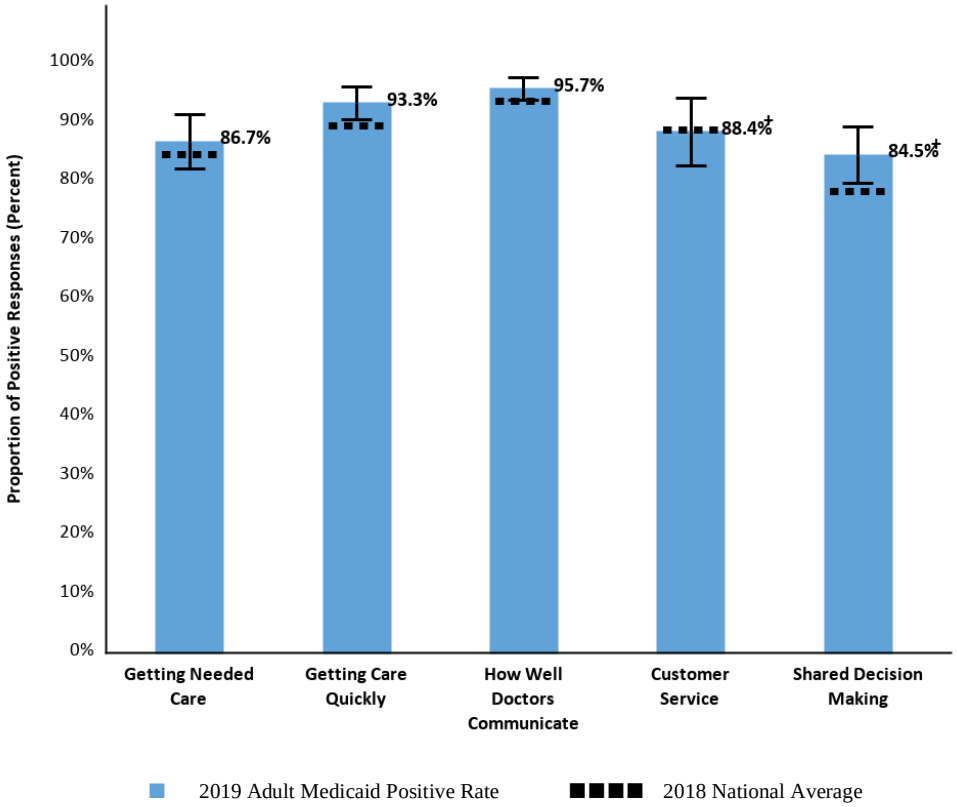
[4-9] The 2019 child Medicaid CAHPS results presented in Table 4-8 and Table 4-9 for **Well Sense** are based on results of the general child population only.

Figure 4-7—Well Sense Child Medicaid CAHPS Results: Global Ratings



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

Figure 4-8—Well Sense Child Medicaid CAHPS Results: Composite Measures



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

For **Well Sense**'s general child Medicaid population, all rates were higher than NCQA's 2017 Medicaid national average, except for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*. Three rates, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, were statistically significantly higher than NCQA's 2018 Medicaid national averages, while the remaining six rates were neither statistically significantly higher nor lower than the national averages.

Conclusions and Recommendations for Improvement

NHHF

HSAG compared the adult and child Medicaid populations' 2019 CAHPS survey results to the 2018 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2019 positive rates for the adult or child Medicaid populations were statistically significantly lower than the 2018 NCQA Medicaid national averages, HSAG recommends that **NHHF** focus QI efforts on the *Rating of Specialist Seen Most Often* measure as its rate fell below the national average for the child population.

The rate for *Rating of Specialist Seen Most Often* could be improved by including information about the ratings from the CAHPS survey in provider communications during the year. **NHHF** could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. 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.

Well Sense

HSAG performed a comparison of the adult and child Medicaid populations' 2019 CAHPS survey results to the 2018 NCQA CAHPS adult and general child Medicaid national averages, respectively, to determine potential areas for improvement. Since none of the 2019 positive rates for the adult or child Medicaid populations were statistically significantly lower than the 2018 NCQA Medicaid national averages, HSAG recommends that **Well Sense** focus its QI efforts on the *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service* measures, as those rates fell below the national averages for both the adult and child populations.

To improve CAHPS rates, **Well Sense** could consider involving MCO staff members at every level to assist in improving the *Rating of Health Plan* rate. Methods for achieving improvement could include ensuring that QI goals align with the mission and goals of the MCO, establishing MCO-level performance measures, clearly defining and communicating measures that require improvement, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, the progress of QI initiatives could be monitored by cross-departmental teams and reported internally to assess the effectiveness of improvement efforts. Engaging employees in departmental meetings, quarterly employee forums, annual staff meetings to discuss outcomes for the measures, topic-specific improvement teams, leadership development courses, and employee awards could instill ownership in the improvement process.

The rates for *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. **Well Sense** could include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MCO members. Patient-centered communication could have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives.

The rates for *Customer Service* could be improved by conducting an evaluation of current MCO call center hours and practices to determine if the hours and resources meet members' needs. MCOs could further promote the use of existing after-hours customer service to improve customer service results. The MCO's Member Advisory Board could be used to better understand what constitutes high quality services from the perspective of its members. MCOs could appoint work groups from call center staff members to develop service standards that clearly inform staff members what is expected of them during their interactions with members. Additionally, asking members to complete a short survey at the end of each call could assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

HEDIS

This section reports results of the 2019 NCQA HEDIS Compliance Audits™ for the health plans.[4-10] NCQA's IS standards are the guidelines used by CHCA to assess a health plan's ability to report HEDIS rates accurately and reliably.[4-11] Compliance with the guidelines also helps an auditor to understand a health plan's HEDIS reporting capabilities. For HEDIS 2019, health plans were assessed on seven IS standards. To assess an MCO's adherence to the IS standards, HSAG reviewed several documents for the New Hampshire MCOs. These included the MCOs' FARs, IS compliance tools, and the IDSS files approved by the CHCA.

Both MCOs contracted with an NCQA LO to have their measure rates reviewed by a CHCA. Both MCOs contracted with an external software vendor for HEDIS measure production and rate calculation. HSAG reviewed the MCOs' FARs and ensured that these software vendors participated and passed NCQA's Measure Certification process. MCOs either purchased the software with certified measures and generated HEDIS measure results internally or provided all data to the software vendor who generated HEDIS measures for them.

[4-10] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[4-11] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.* Washington D.C.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used, and all characters are captured.
- Principal codes are identified, and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.
- Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure the accurate entry and processing of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting, and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of data have checking procedures to ensure accuracy.
- Data entry processes are timely, accurate, and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.
- Data approved for Electronic Clinical Data System reporting met reporting requirements.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.
- Data transfers to HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting is suitable for measures and enable required programming efforts.
- Report production is managed effectively, and operators perform appropriately.
- The organization regularly monitors vendor performance against expected performance standards.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Data transfers to HEDIS repository from transaction files are accurate.
- Report production is managed effectively, and operators perform appropriately.
- Measure reporting software is managed properly with regard to development, methodology, documentation, version control, and testing.
- The organization regularly monitors vendor performance against expected performance standards.

IS Review Results

NHHF and **Well Sense** were found to be fully compliant with all applicable IS assessment standards. The HEDIS audits confirmed that the MCOs 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. The MCOs demonstrated the accuracy and completeness of its primary databases, which contained claims and encounters, membership and enrollment, and provider credentialing data. The MCOs also demonstrated the ability to appropriately store data used for HEDIS reporting.

HEDIS Measures Results

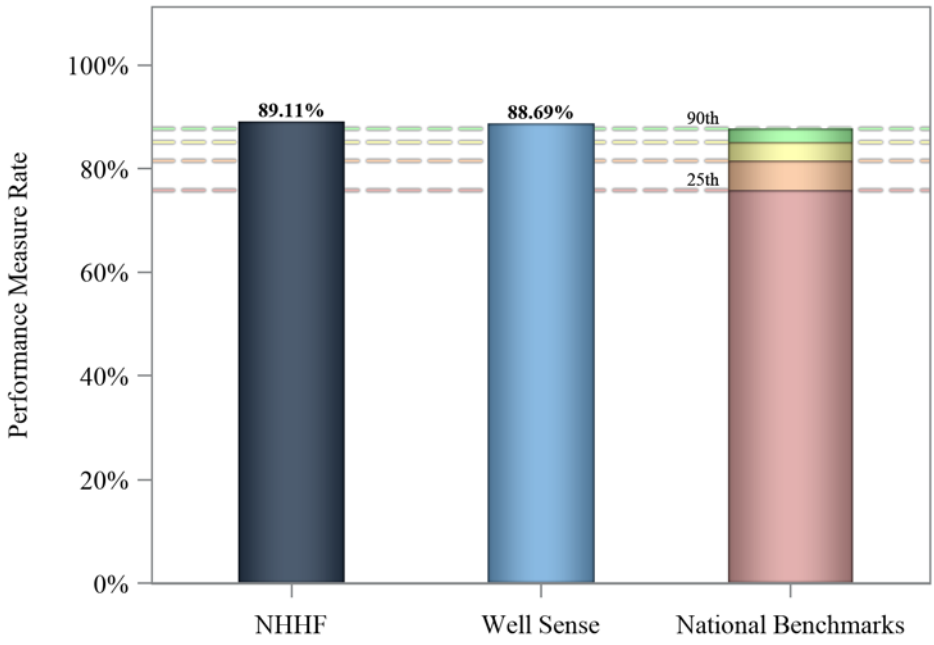
HSAG organized, aggregated, and analyzed the validated performance measure data to draw conclusions about **NHHF**'s and **Well Sense**'s performance in providing quality, accessible, and timely care to its members. The following performance measure results reflect all three domains of care—quality, access, and timeliness. Each figure contains HEDIS 2019 (CY 2018) performance measure rates for **NHHF** (i.e., the bar shaded dark blue) and **Well Sense** (i.e., the bar shaded light blue), along with national benchmarks (i.e., the bar shaded light red, orange, yellow, and green), when applicable. The national benchmarks stacked bar is shaded to indicate percentiles (i.e., light red represents the 25th percentile, orange represents the 50th percentile, yellow represents the 75th percentile, and green represents the 90th percentile). National benchmarks are based on NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018. Additionally, due to specification changes in HEDIS 2019 (CY 2018), comparisons to percentiles are not appropriate for the *Controlling High Blood Pressure* measure.

Prevention

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total

AAP—Total measures the percentage of members 20 years and older who had an ambulatory or preventive care visit during 2018. **NHHF**'s and **Well Sense**'s *AAP—Total* measure results are shown in Figure 4-9.

Figure 4-9—CY 2018 *AAP—Total* Measure Results



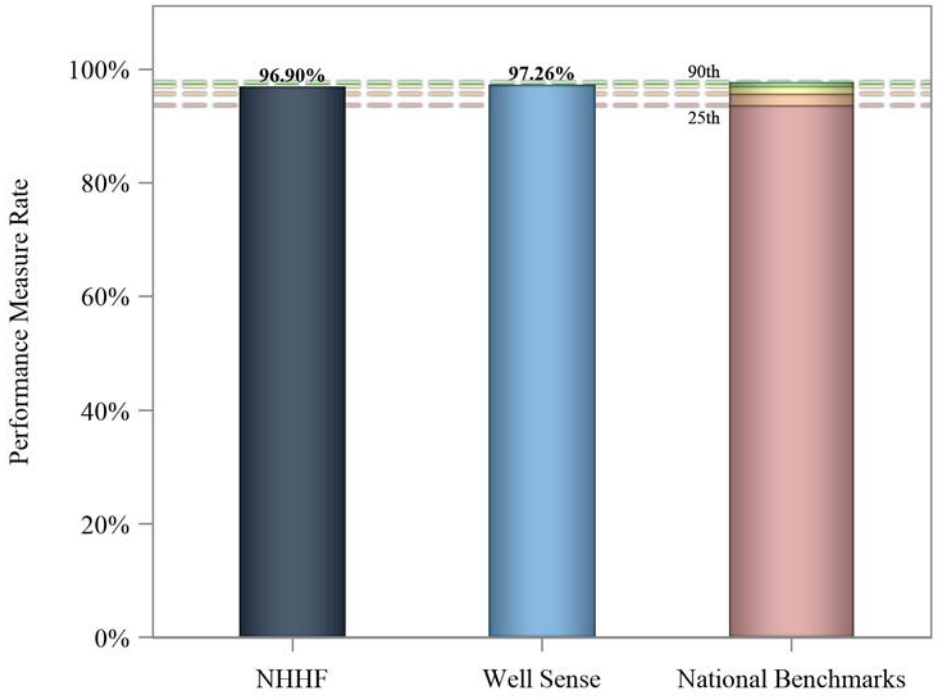
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's and **Well Sense**'s reported rates exceeded the 90th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months

CAP—12–24 Months measures the percentage of members ages 12–24 months who had a visit with a PCP during 2018. **NHHF**'s and **Well Sense**'s *CAP—12–24 Months* measure results are shown in Figure 4-10.

Figure 4-10—CY 2018 *CAP—12–24 Months* Measure Results

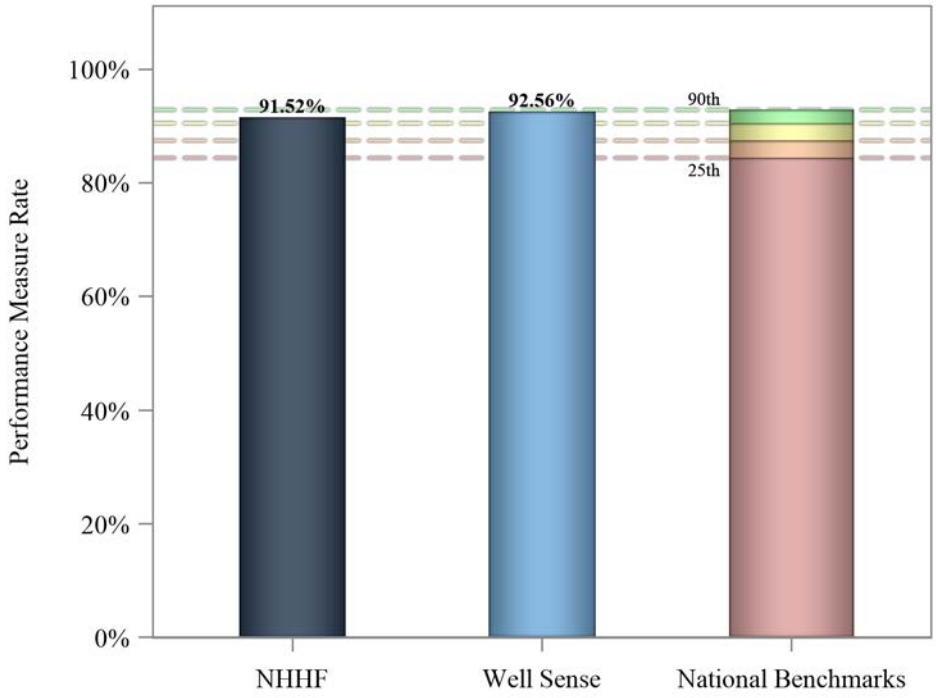


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years

CAP—25 Months–6 Years measures the percentage of members ages 25 months to 6 years who had a visit with a PCP during 2018. **NHHF**'s and **Well Sense**'s *CAP—25 Months–6 Years* measure results are shown in Figure 4-11.

Figure 4-11—CY 2018 *CAP—25 Months–6 Years* Measure Results

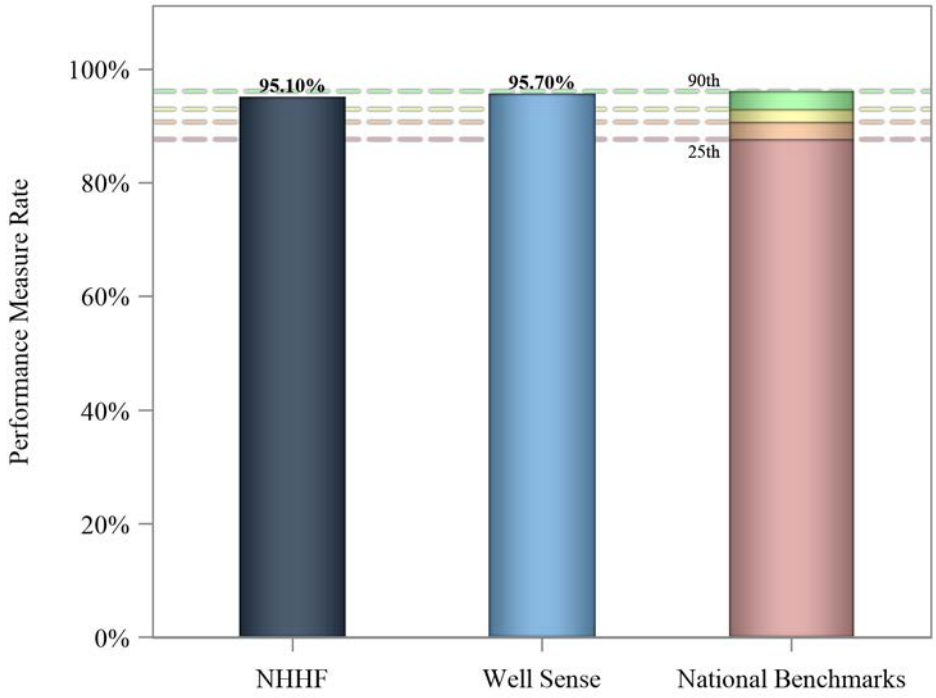


NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years

CAP—7–11 Years measures the percentage of members ages 7 to 11 years who had a visit with a PCP during 2017 or 2018. **NHHF**'s and **Well Sense**'s *CAP—7–11 Years* measure results are shown in Figure 4-12.

Figure 4-12—CY 2018 *CAP—7–11 Years* Measure Results

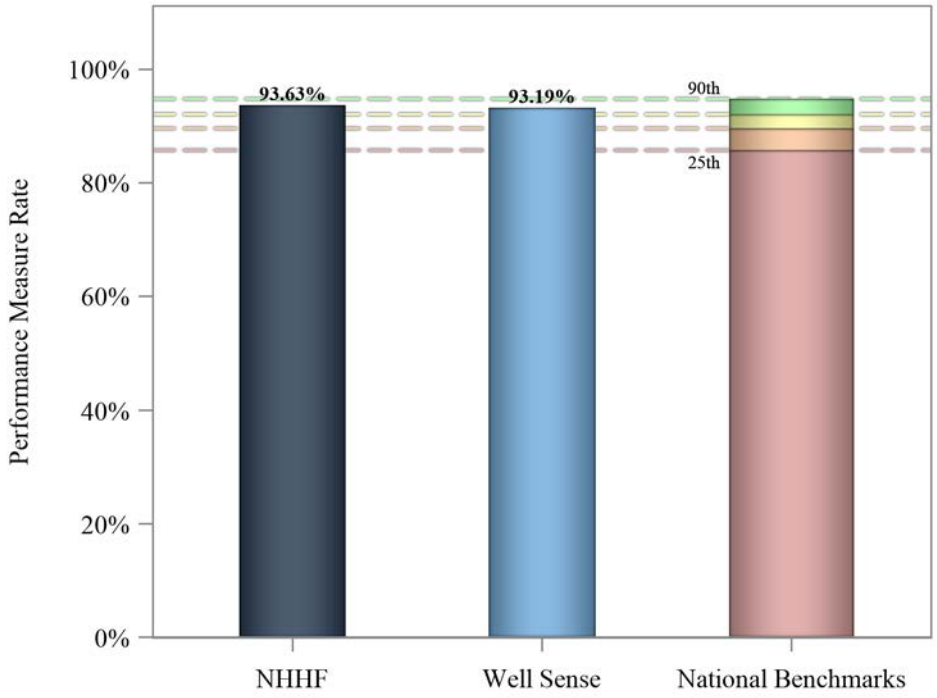


NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years

CAP—12–19 Years measures the percentage of members ages 12 to 19 years who had a visit with a PCP during 2017 or 2018. **NHHF**'s and **Well Sense**'s *CAP—12–19 Years* measure results are shown in Figure 4-13.

Figure 4-13—CY 2018 *CAP—12–19 Years* Measure Results

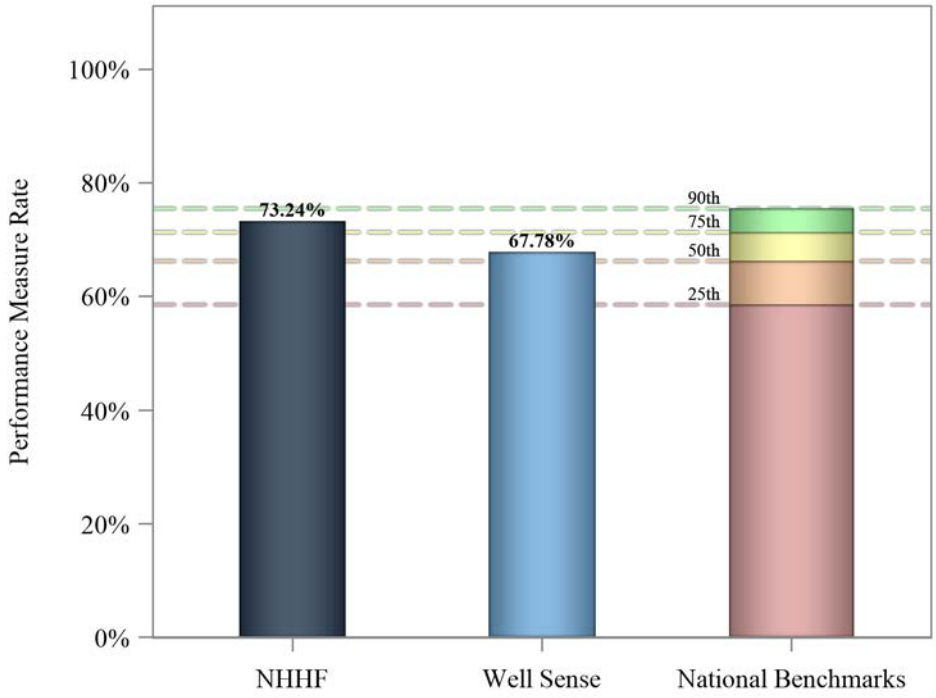


NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits

W15—Six or More Visits measures the percentage of members who turned 15 months old during 2018 and who received six or more well-child visits with a PCP during their first 15 months of life. **NHHF**'s and **Well Sense**'s *W15—Six or More Visits* measure results are shown in Figure 4-14.

Figure 4-14—CY 2018 *W15—Six or More Visits* Measure Results

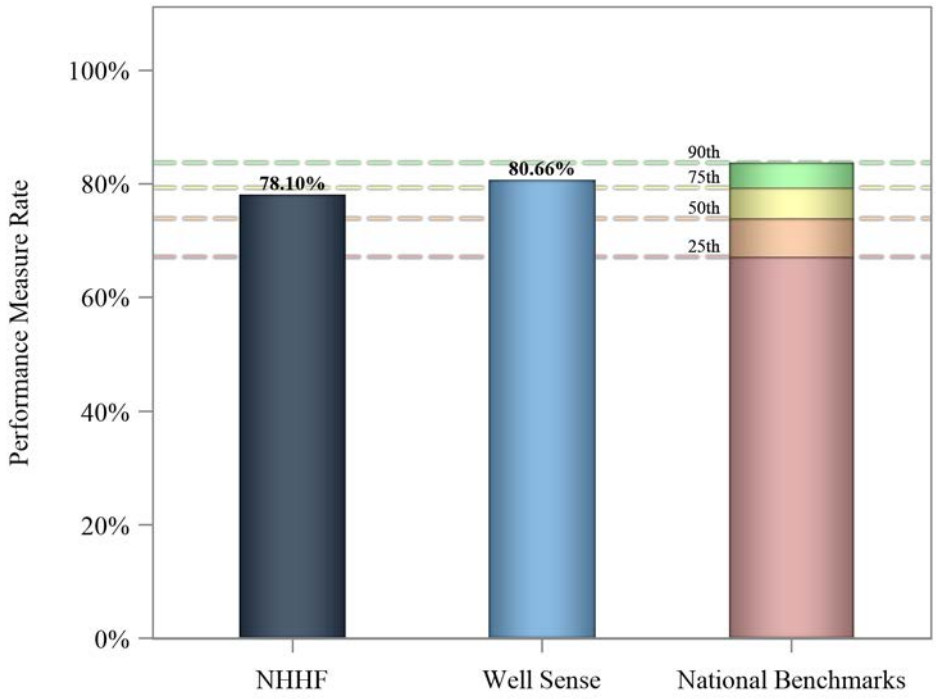


NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

W34 measures the percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during 2018. **NHHF**'s and **Well Sense**'s *W34* measure results are shown in Figure 4-15.

Figure 4-15—CY 2018 *W34* Measure Results

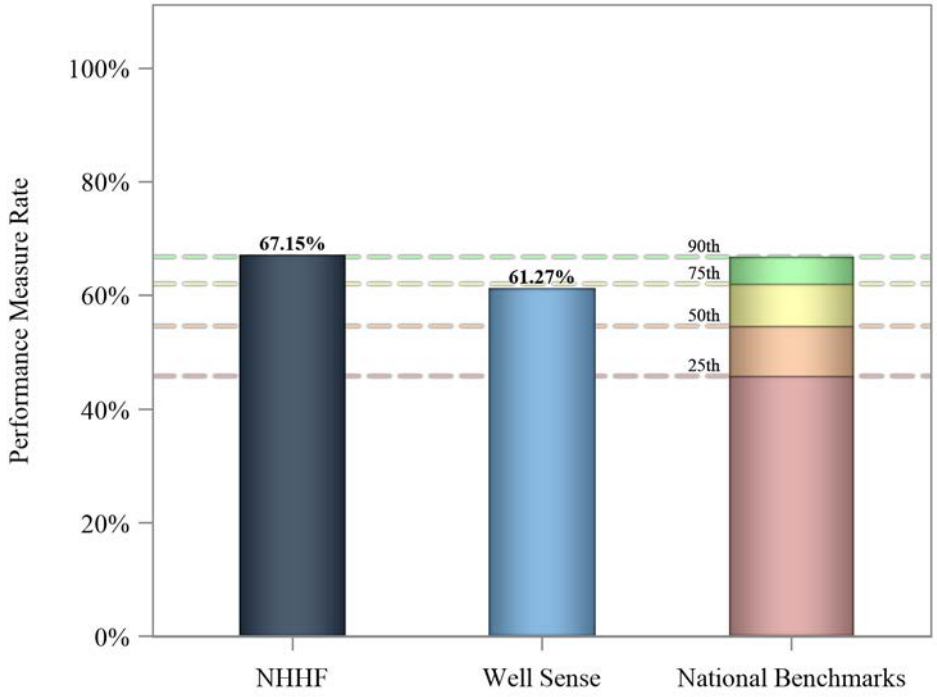


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile. The *W34* measure is also a PIP topic for both **NHHF** and **Well Sense**.

Adolescent Well-Care Visits (AWC)

AWC measures the percentage of members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) practitioner during 2018. **NHHF**'s and **Well Sense**'s *AWC* measure results are shown in Figure 4-16.

Figure 4-16—CY 2018 *AWC* Measure Results

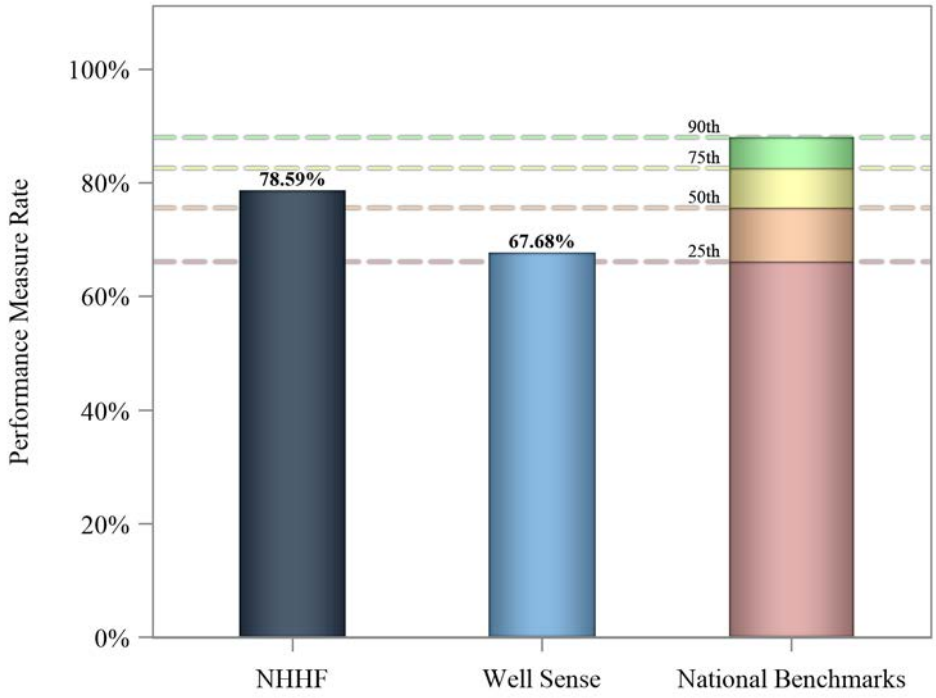


NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile Documentation—Total

WCC—BMI Percentile Documentation—Total measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had documentation of BMI percentile during 2018. **NHHF**'s and **Well Sense**'s *WCC—BMI Percentile Documentation—Total* measure results are shown in Figure 4-17.

Figure 4-17—CY 2018 *WCC—BMI Percentile Documentation—Total* Measure Results

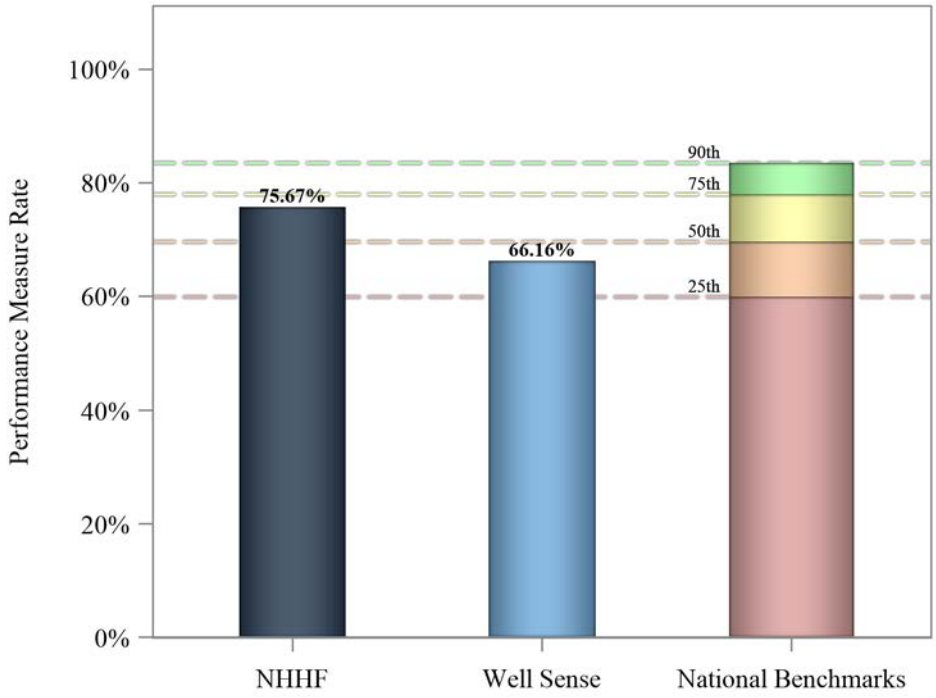


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total

WCC—Counseling for Nutrition—Total measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during 2018. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Nutrition—Total* measure results are shown in Figure 4-18.

Figure 4-18—CY 2018 *WCC—Counseling for Nutrition—Total* Measure Results

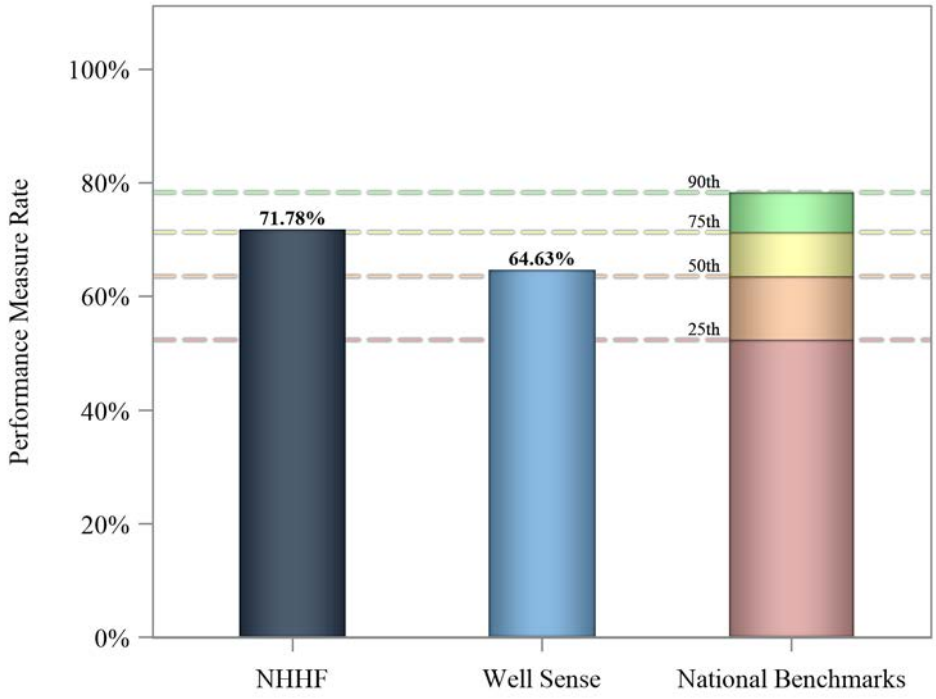


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total

WCC—Counseling for Physical Activity—Total measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during 2018. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Physical Activity—Total* measure results are shown in Figure 4-19.

Figure 4-19—CY 2018 *WCC—Counseling for Physical Activity—Total* Measure Results

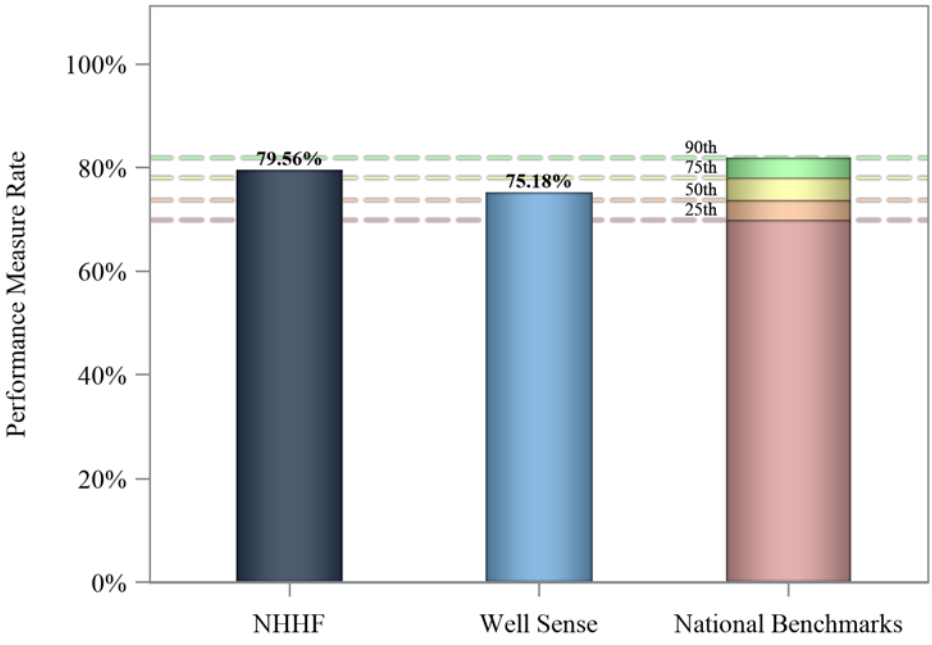


NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Childhood Immunization Status (CIS)—Combination 2

CIS—Combination 2 measures the percentage of children who turned 2 years of age during 2018 and who received four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenzae type B (HiB); three hepatitis B (HepB); and one chicken pox (VZV) vaccines by their second birthday. **NHHF**'s and **Well Sense**'s *CIS—Combination 2* measure results are shown in Figure 4-20.

Figure 4-20—CY 2018 *CIS—Combination 2* Measure Results



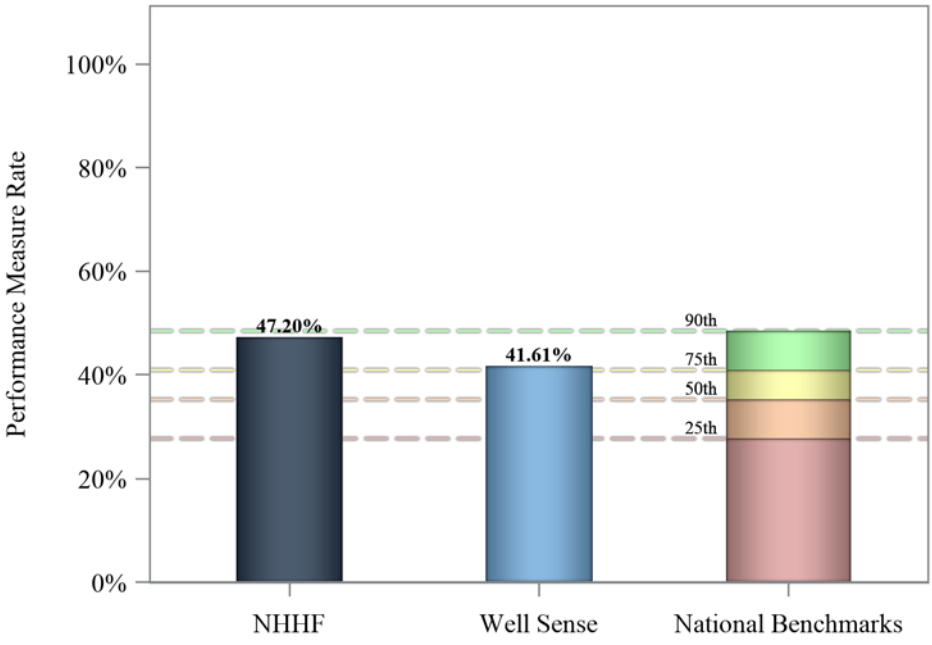
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Childhood Immunization Status (CIS)—Combination 10

CIS—Combination 10 measures the percentage of children who turned 2 years of age during 2018 and who received four DTaP; three IPV; one MMR; three HiB; three HepB; one VZV; four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. **NHHF**'s and **Well Sense**'s *CIS—Combination 10* measure results are shown in Figure 4-21.

Figure 4-21—CY 2018 *CIS—Combination 10* Measure Results



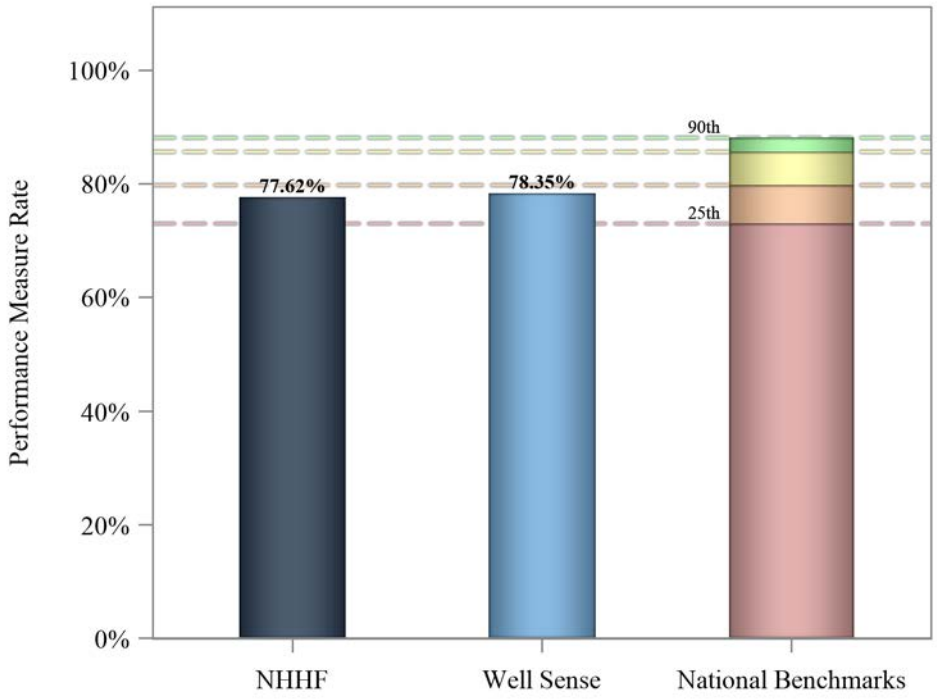
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)

IMA—Combination 1 measures the percentage of adolescents 13 years of age during 2018 who received one meningococcal conjugate vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. **NHHF**'s and **Well Sense**'s *IMA—Combination 1* measure results are shown in Figure 4-22.

Figure 4-22—CY 2018 *IMA—Combination 1* Measure Results

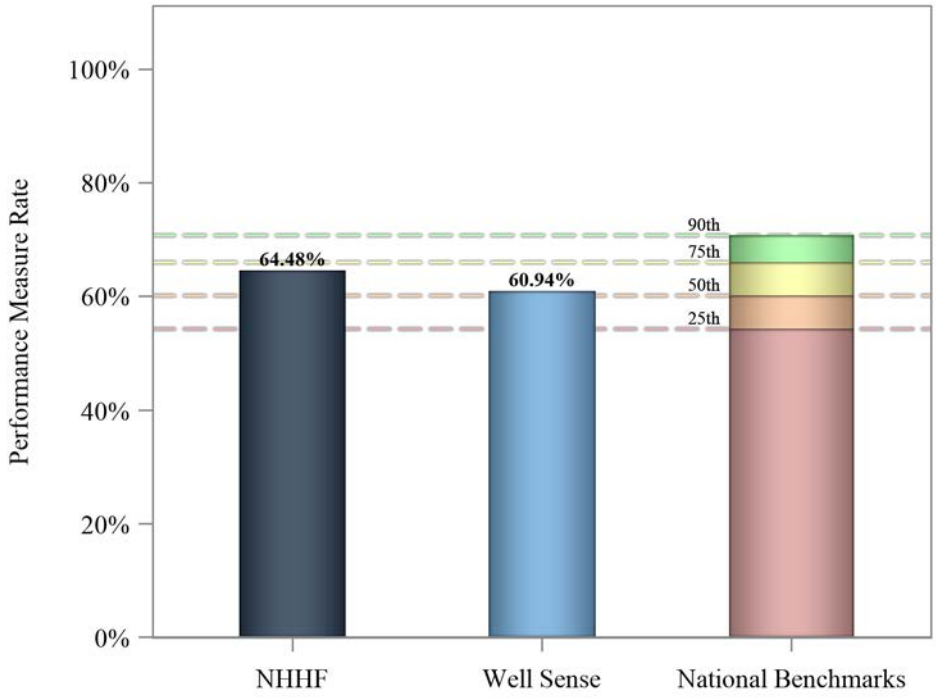


NHHF's and **Well Sense**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Cervical Cancer Screening (CCS)

CCS measures the percentage of women 21 to 64 years of age who met the criteria for appropriate screening for cervical cancer during 2018. **NHHF**'s and **Well Sense**'s *CCS* measure results are shown in Figure 4-23.

Figure 4-23—CY 2018 *CCS* Measure Results

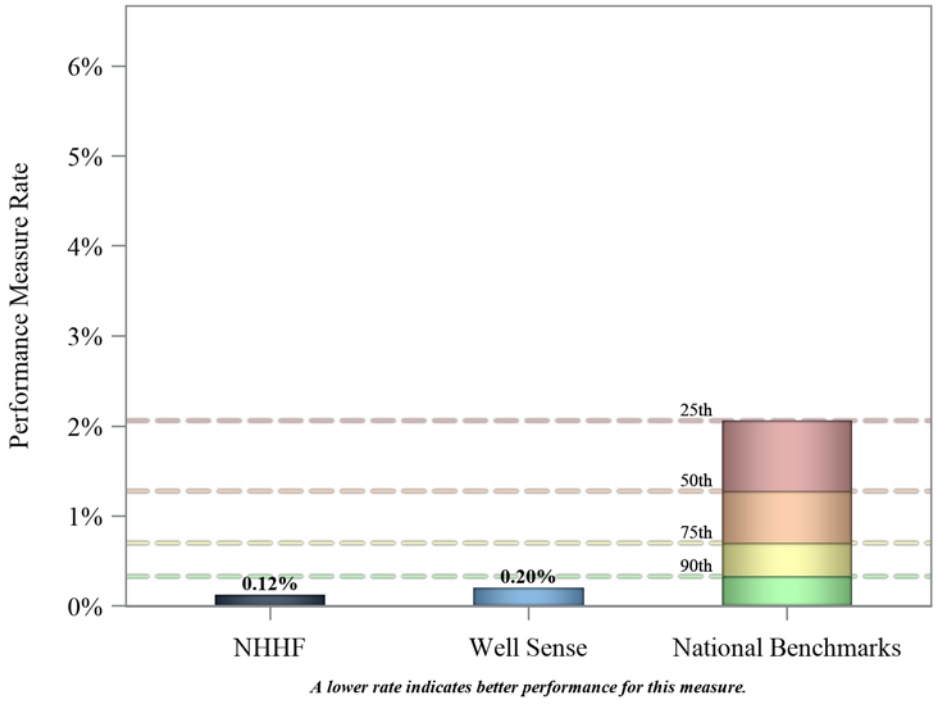


NHHF's and **Well Sense**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

NCS measures the percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer during 2018. **NHHF**'s and **Well Sense**'s *NCS* measure results are shown in Figure 4-24. Note, ***lower rates for this measure indicate better performance.***

Figure 4-24—CY 2018 *NCS* Measure Results

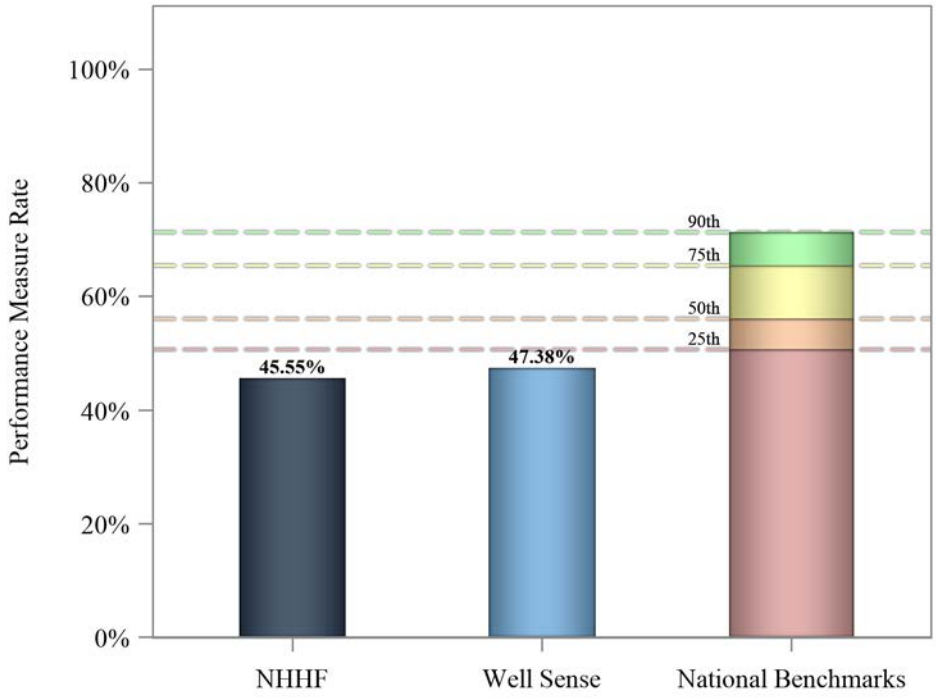


NHHF's and **Well Sense**'s reported rates exceeded the 90th percentile.

Chlamydia Screening in Women (CHL)—Total

CHL—Total measures the percentage of women 16 to 24 years of age identified as sexually active who had at least one test for chlamydia during 2018. **NHHF**'s and **Well Sense**'s *CHL—Total* measure results are shown in Figure 4-25.

Figure 4-25—CY 2018 *CHL—Total* Measure Results

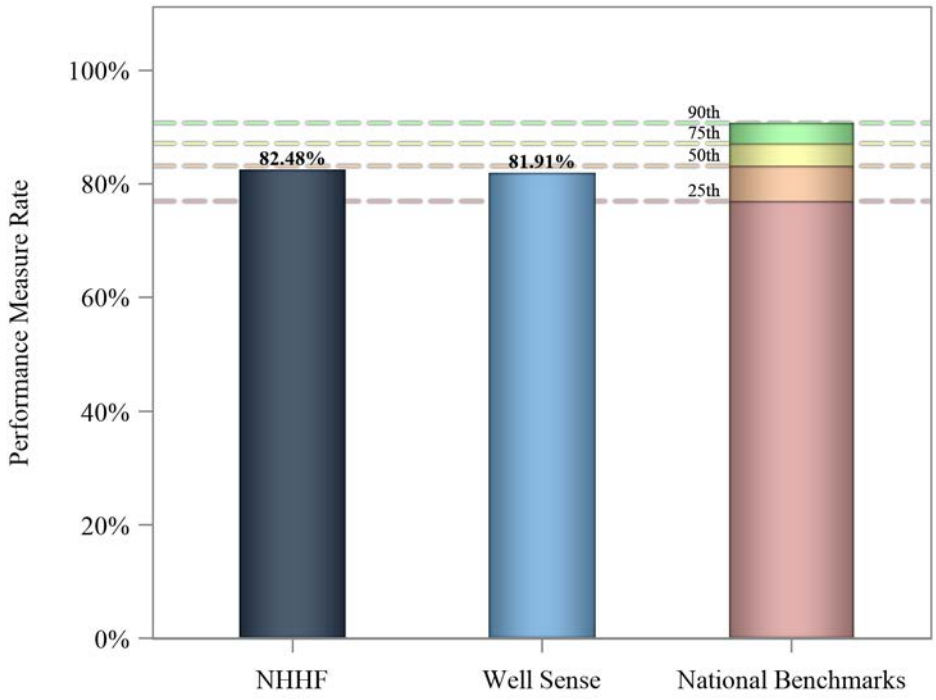


NHHF's and **Well Sense**'s reported rates fell below the 25th percentile. The *CHL—Total* measure is also a PIP topic for **Well Sense**.

Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care

PPC—Timeliness of Prenatal Care measures the percentage of deliveries of live births that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO. **NHHF**'s and **Well Sense**'s *PPC—Timeliness of Prenatal Care* measure results are shown in Figure 4-26.

Figure 4-26—CY 2018 *PPC—Timeliness of Prenatal Care* Measure Results

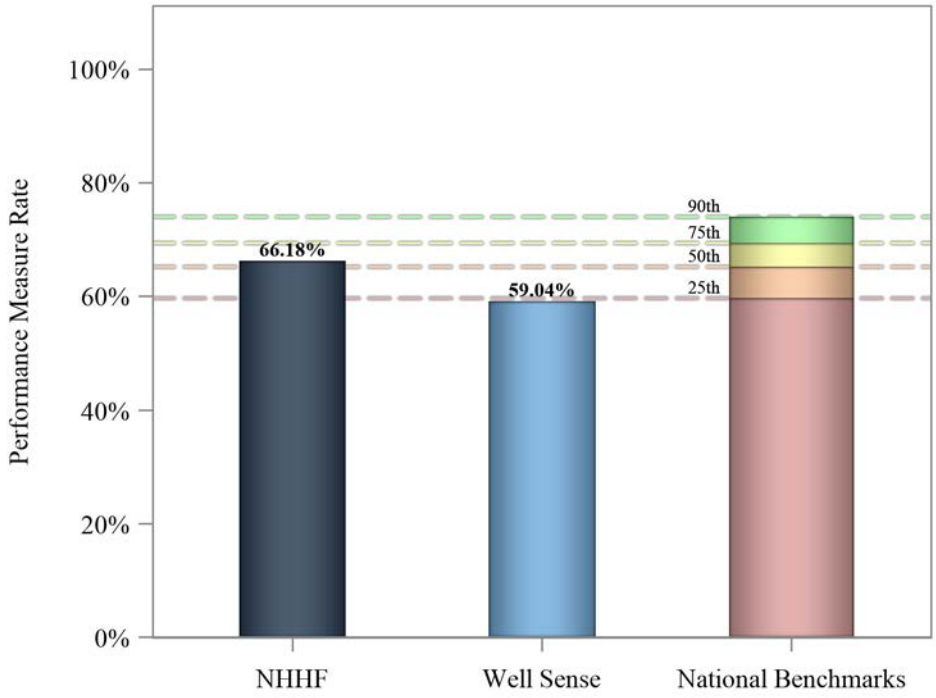


NHHF's and **Well Sense**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Prenatal and Postpartum Care (PPC)—Postpartum Care

PPC—Postpartum Care measures the percentage of deliveries of live births that received a postpartum visit on or between 21 and 56 days after delivery. **NHHF**'s and **Well Sense**'s *PPC—Postpartum Care* measure results are shown in Figure 4-27.

Figure 4-27—CY 2018 *PPC—Postpartum Care* Measure Results



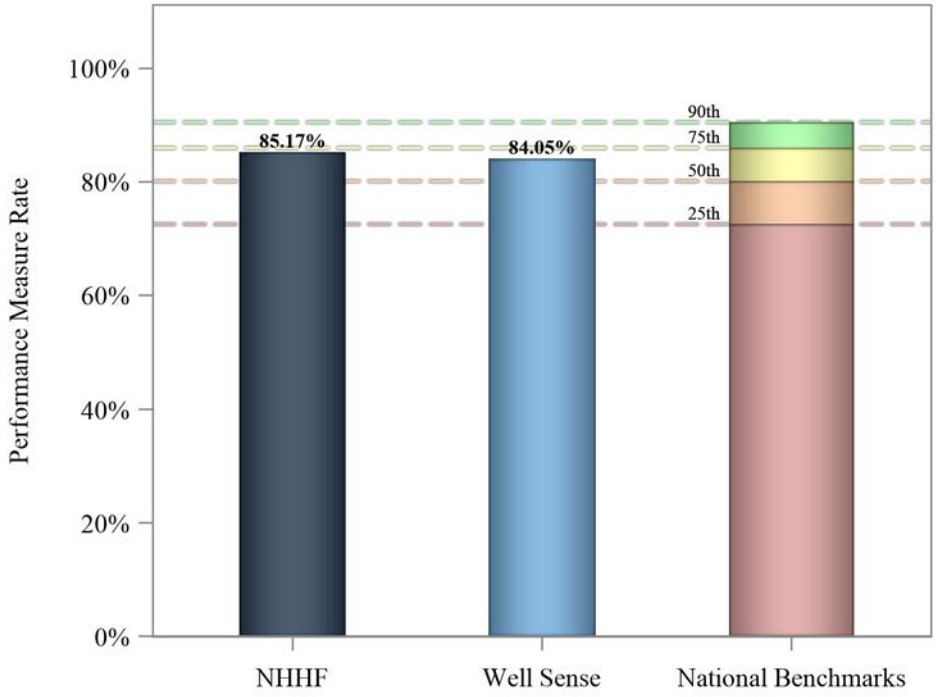
NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate fell below the 25th percentile.

Acute and Chronic Care

Appropriate Testing for Children with Pharyngitis (CWP)

CWP measures the percentage of children 3 to 18 years of age who were diagnosed with pharyngitis during 2018, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. **NHHF**'s and **Well Sense**'s *CWP* measure results are shown in Figure 4-28.

Figure 4-28—CY 2018 *CWP* Measure Results

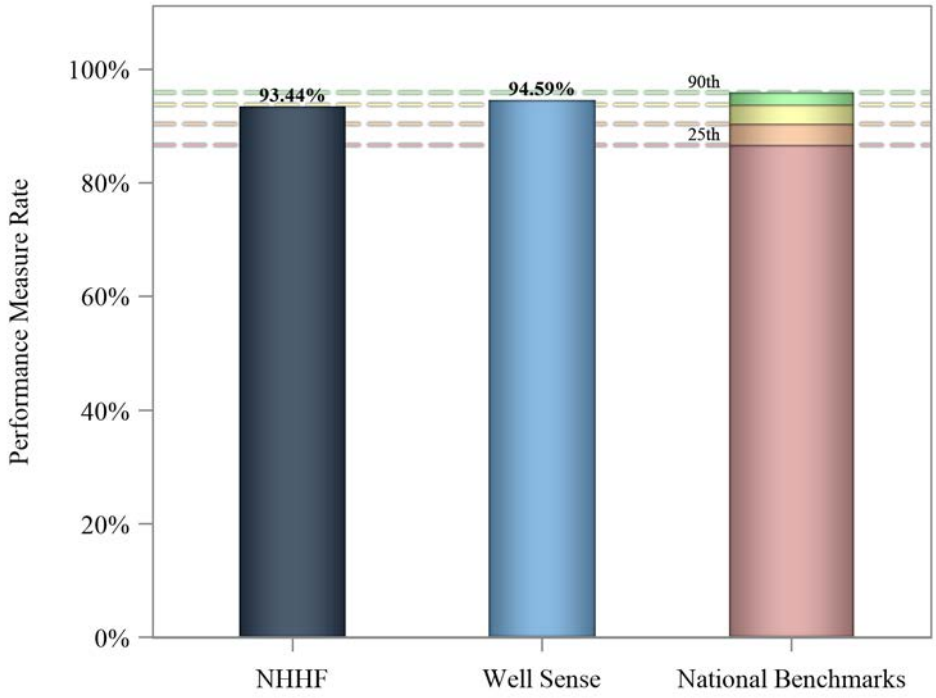


NHHF's and **Well Sense**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

URI measures the percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection during 2018 and were not dispensed an antibiotic prescription. **NHHF**'s and **Well Sense**'s *URI* measure results are shown in Figure 4-29.

Figure 4-29—CY 2018 *URI* Measure Results

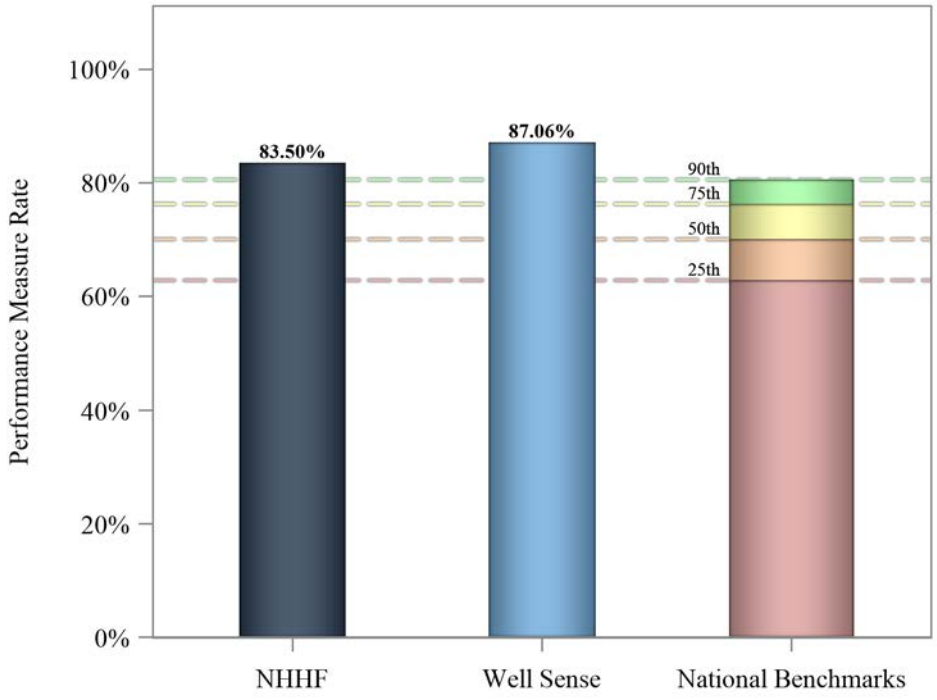


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid

PCE—Systemic Corticosteroid measures the percentage of chronic obstructive pulmonary disease (COPD) exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit and were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event during 2018. **NHHF**'s and **Well Sense**'s *PCE—Systemic Corticosteroid* measure results are shown in Figure 4-30.

Figure 4-30—CY 2018 *PCE—Systemic Corticosteroid* Measure Results

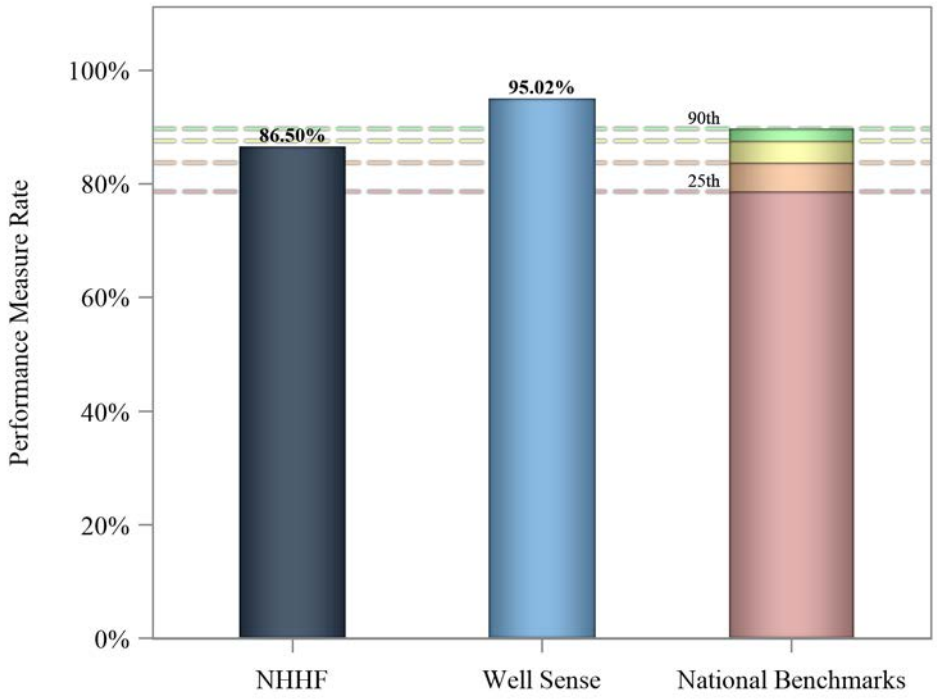


NHHF's and **Well Sense**'s reported rates exceeded the 90th percentile.

Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator

PCE—Bronchodilator measures the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event during 2018. **NHHF**'s and **Well Sense**'s *PCE—Bronchodilator* measure results are shown in Figure 4-31.

Figure 4-31—CY 2018 *PCE—Bronchodilator* Measure Results

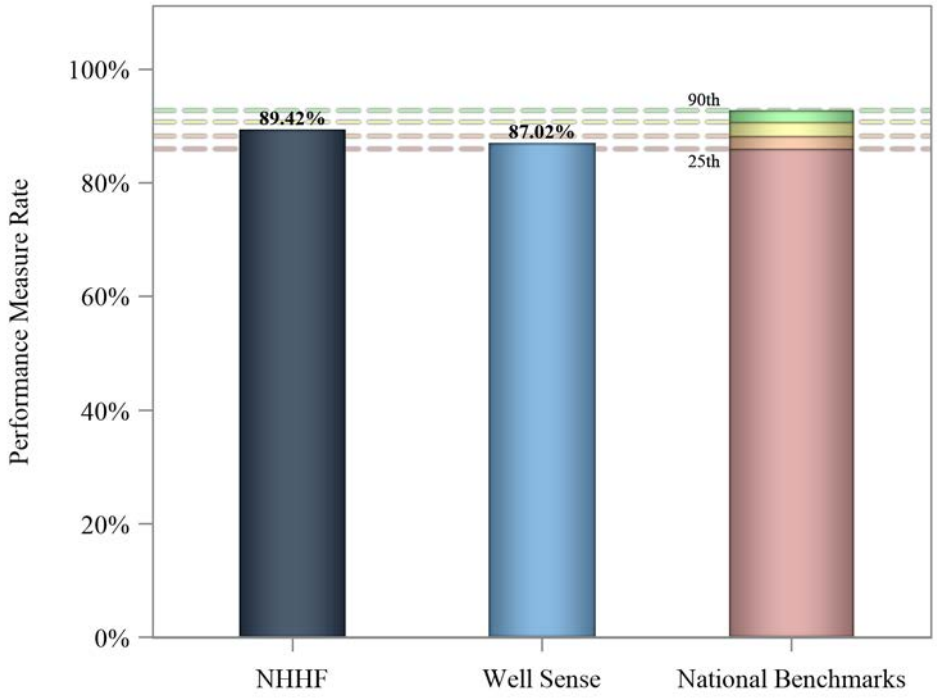


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate exceeded the 90th percentile.

Annual Monitoring for Patients on Persistent Medications (MPM)—Total

MPM—Total measures the percentages of members 18 years of age and older who received at least 180 days of treatment with angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), or diuretics and received at least one therapeutic monitoring event for each appropriate medication during 2018. **NHHF**'s and **Well Sense**'s *MPM—Total* measure results are shown in Figure 4-32.

Figure 4-32—CY 2018 *MPM—Total* Measure Results

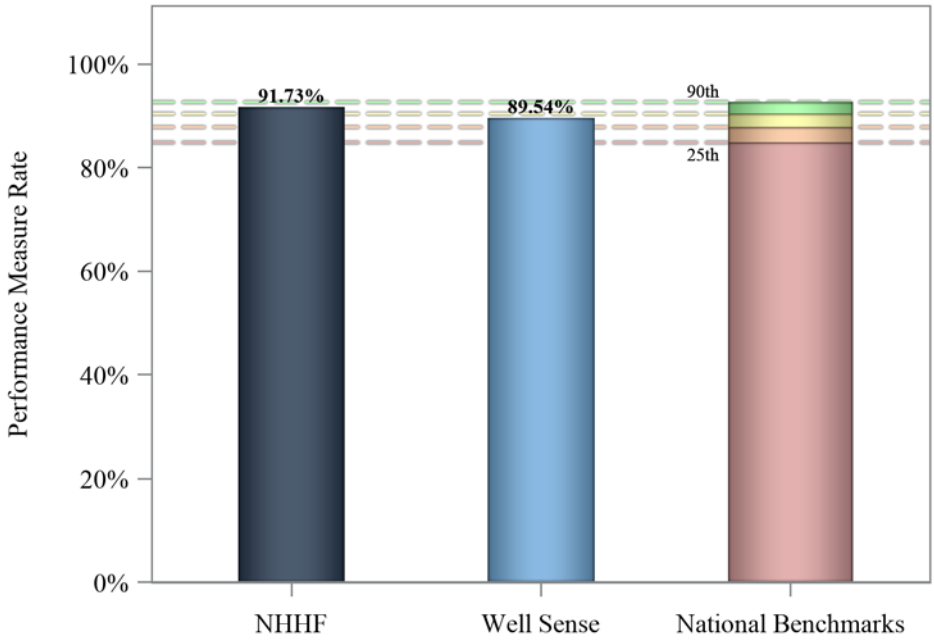


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing

CDC—HbA1c Testing measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during 2018. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Testing* measure results are shown in Figure 4-33.

Figure 4-33—CY 2018 *CDC—HbA1c Testing* Measure Results



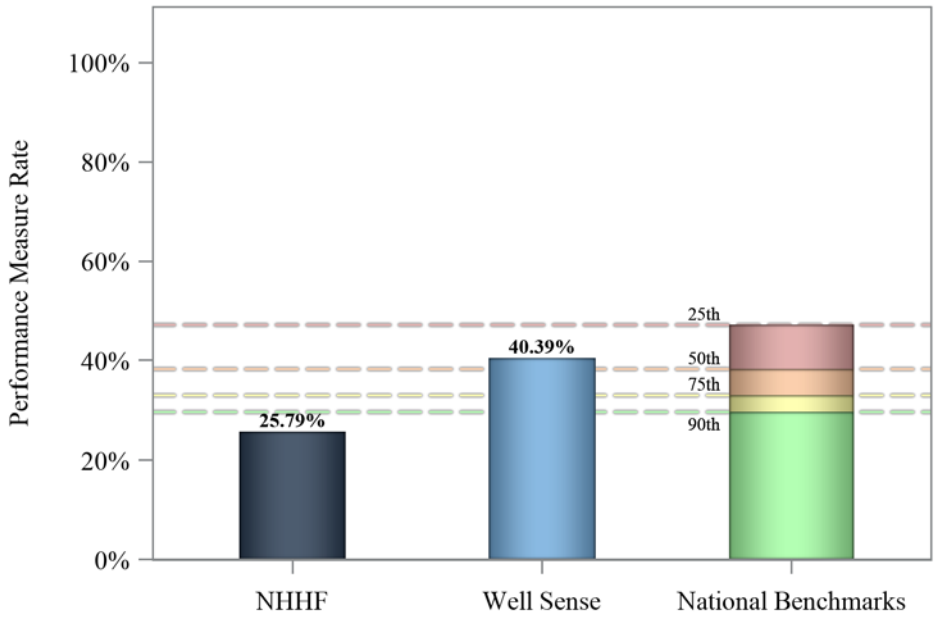
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)

CDC—HbA1c Poor Control (>9.0%) measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c test showed poor control, with levels greater than 9.0 percent during 2018. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Poor Control (>9.0%)* measure results are shown in Figure 4-34. Note, ***lower rates for this measure indicate better performance.***

Figure 4-34—CY 2018 *CDC—HbA1c Poor Control (>9.0%)* Measure Results



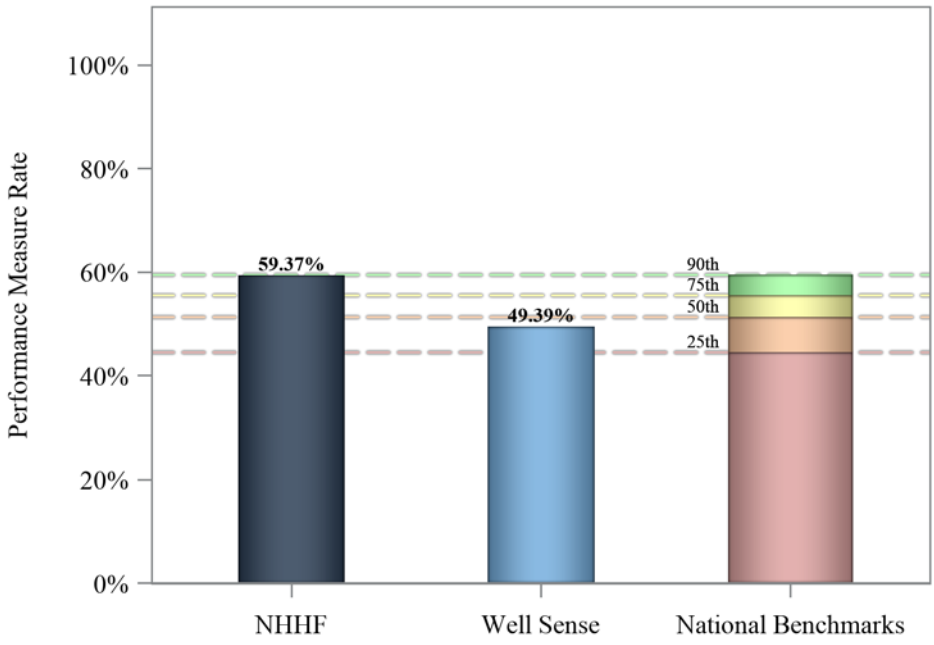
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications. A lower rate indicates better performance for this measure.

NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)

CDC—HbA1c Control (<8.0%) measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c test revealed levels less than 8.0 percent during 2018. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Control (<8.0%)* measure results are shown in Figure 4-35.

Figure 4-35—CY 2018 *CDC—HbA1c Control (<8.0%)* Measure Results



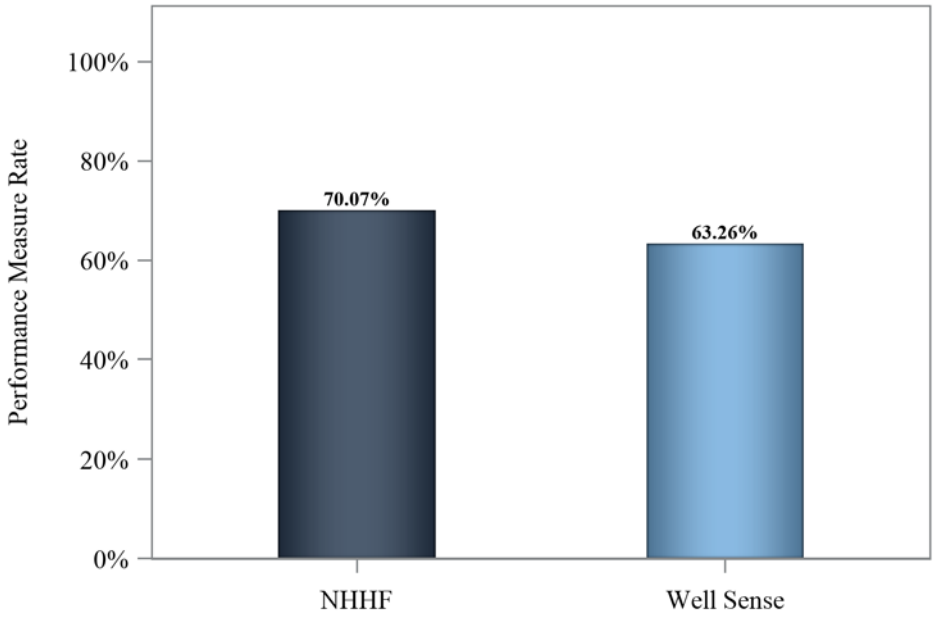
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Controlling High Blood Pressure (CBP)

CBP measures the percentage of members 18 to 85 years of age diagnosed with hypertension whose blood pressure was adequately controlled during 2018. **NHHF**'s and **Well Sense**'s *CBP* measure results are shown in Figure 4-36.

Figure 4-36—CY 2018 *CBP* Measure Results



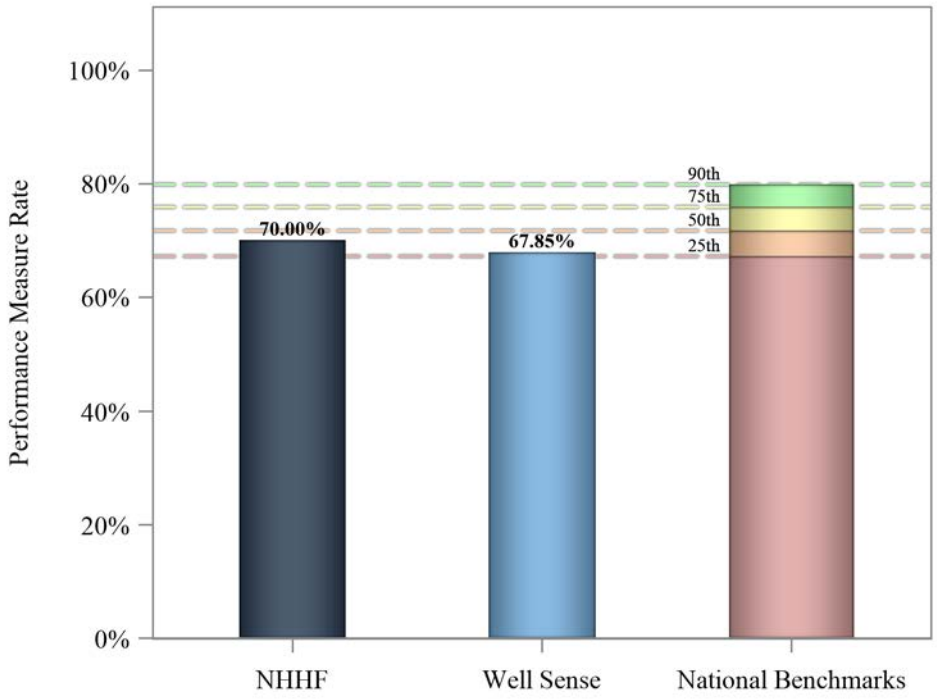
Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks based on HEDIS 2018 technical specifications are not appropriate.

Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.

Use of Imaging Studies for Low Back Pain (LBP)

LBP measures the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, magnetic resonance imaging [MRI], computerized tomography [CT] scan) within 28 days of diagnosis during 2018. **NHHF**'s and **Well Sense**'s *LBP* measure results are shown in Figure 4-37.

Figure 4-37—CY 2018 *LBP* Measure Results

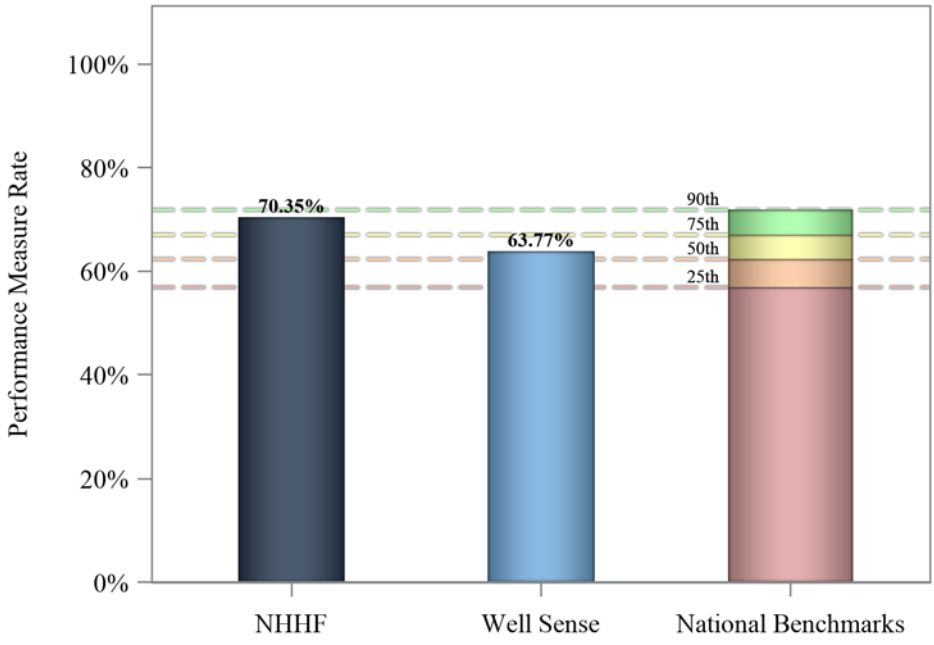


NHHF's and **Well Sense**'s reported rates ranked at or above the 25th percentile but below the 50th percentile.

Asthma Medication Ratio (AMR)—Total

AMR—Total measures the percentage of members 5 to 64 years of age identified as having persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during 2018. **NHHF**'s and **Well Sense**'s *AMR—Total* measure results are shown in Figure 4-38.

Figure 4-38—CY 2018 *AMR—Total* Measure Results



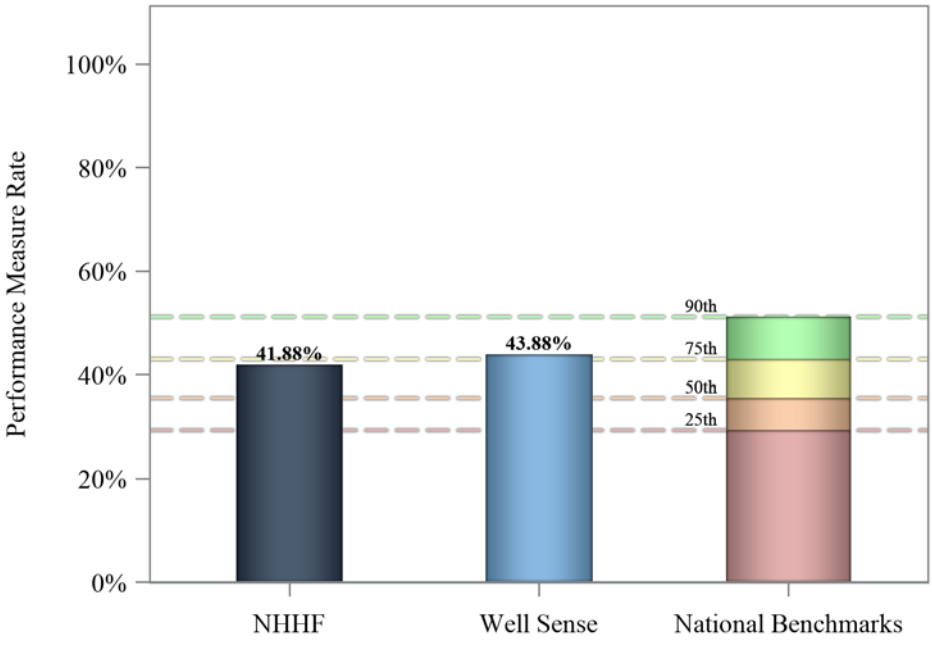
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 75th percentile but below the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total

MMA—Medication Compliance 75%—Total measures the percentage of members 5 to 64 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 75 percent of the time during the treatment period in 2018. **NHHF**'s and **Well Sense**'s *MMA—Medication Compliance 75%—Total* measure results are shown in Figure 4-39.

Figure 4-39—CY 2018 *MMA—Medication Compliance 75%—Total* Measure Results



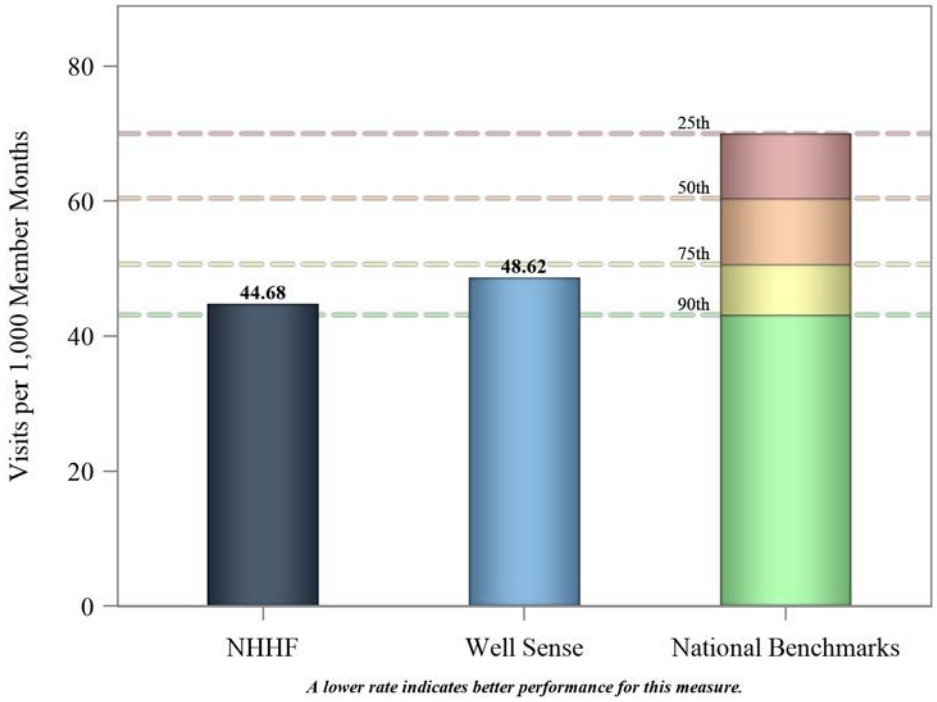
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits—Total

AMB—ED Visits—Total measures the utilization of ED visits among the member population during 2018. **NHHF**'s and **Well Sense**'s *AMB—ED Visits—Total* measure results are shown in Figure 4-40.[4-12] Note, ***a lower rate may indicate better performance for this measure***. HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures. For example, the 10th percentile (a lower rate) was reversed to become the 90th percentile, indicating better performance.

Figure 4-40—CY 2018 *AMB—ED Visits—Total* Measure Results



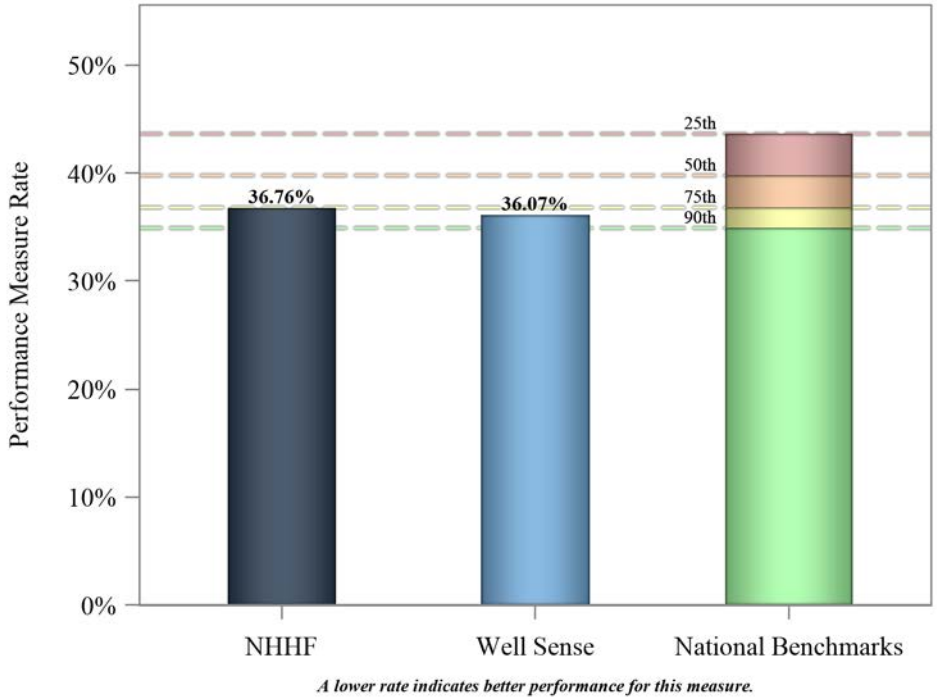
NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

[4-12] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total

ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total measures the percentage of prescriptions for antibiotics of concern compared to the total prescriptions for antibiotics during 2018. **NHHF**'s and **Well Sense**'s *ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total* measure results are shown in Figure 4-41.[4-13] Note, ***a lower rate indicates better performance for this measure.*** HSAG reversed the order of the percentiles to be applied to this measure consistent with the other measures.

Figure 4-41—CY 2018 *ABX—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total* Measure Results



NHHF's and **Well Sense**'s reported rates ranked at or above the 75th percentile but below the 90th percentile.

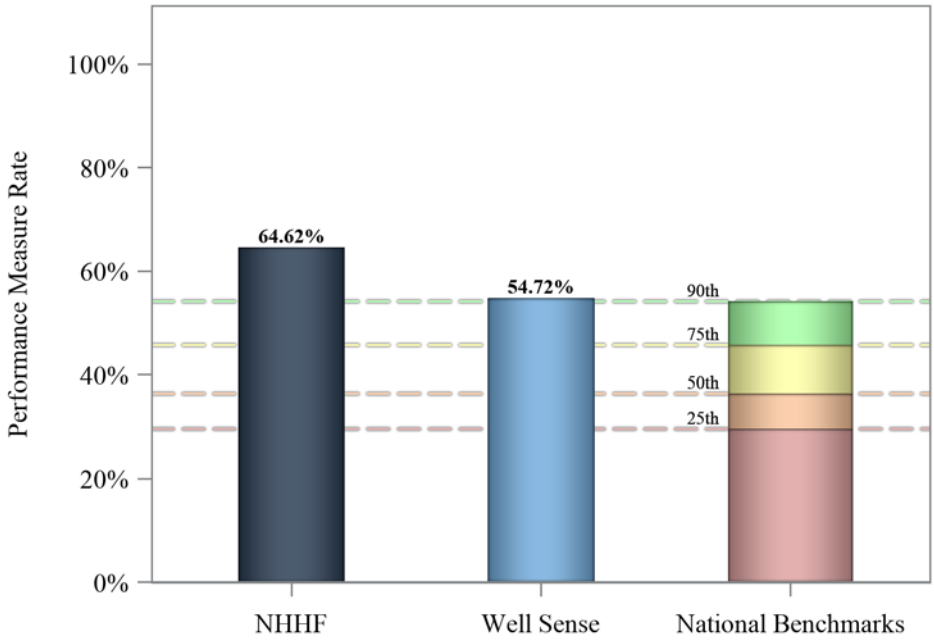
[4-13] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Behavior Health

Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up

FUH—7-Day Follow-Up—Total measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 7 days of discharge during 2018. **NHHF**'s and **Well Sense**'s *FUH—7-Day Follow-Up—Total* measure results are shown in Figure 4-42.

Figure 4-42—CY 2018 *FUH—7-Day Follow-Up* Measure Results



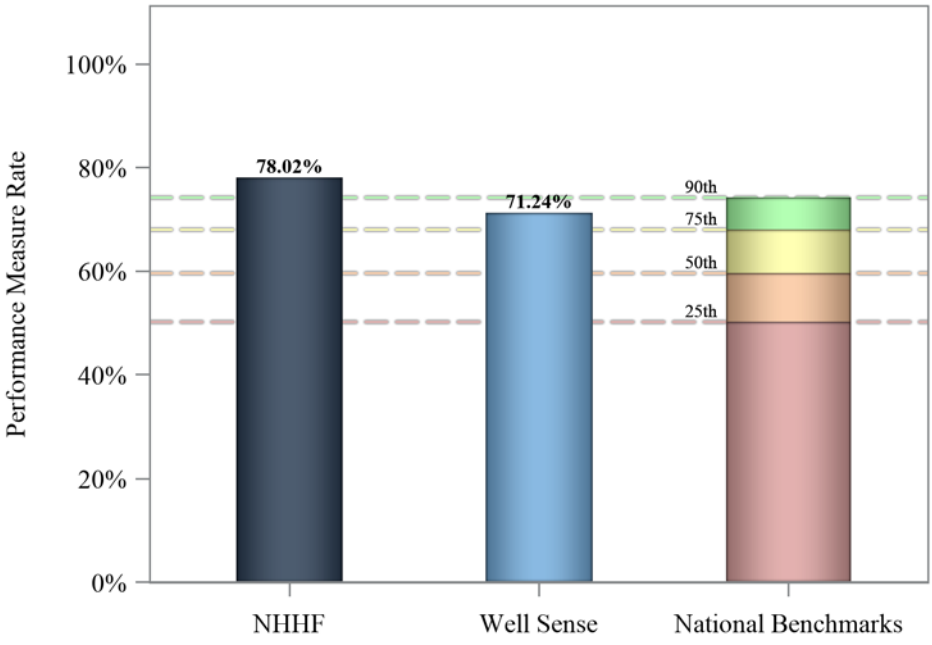
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's and **Well Sense**'s reported rates exceeded the 90th percentile.

Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up

FUH—30-Day Follow-Up—Total measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental illness and intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge during 2018. **NHHF**'s and **Well Sense**'s *FUH—30-Day Follow-Up—Total* measure results are shown in Figure 4-43.

Figure 4-43—CY 2018 *FUH—30-Day Follow-Up* Measure Results



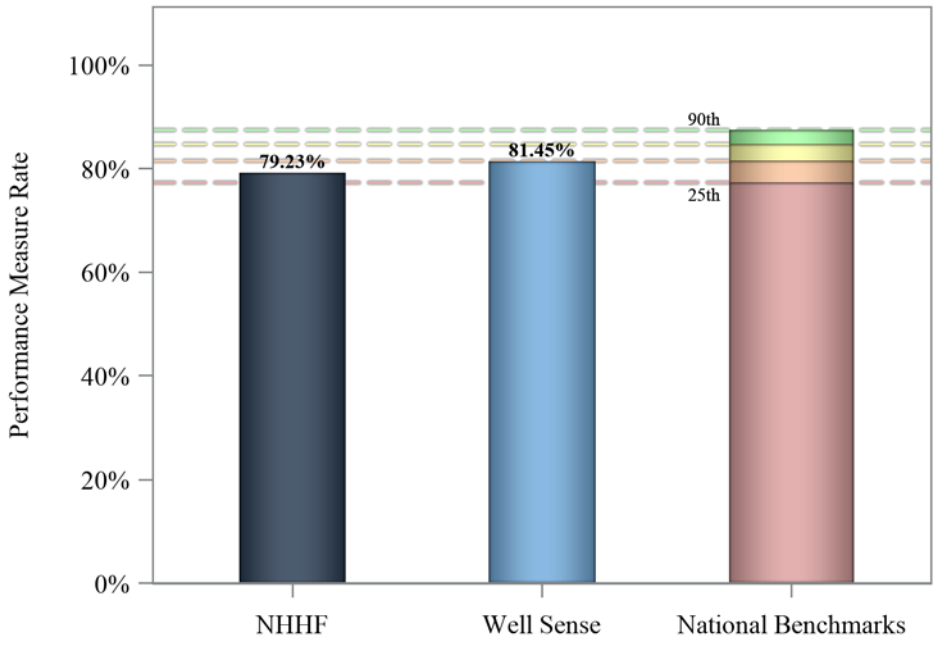
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

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

SSD measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during 2018. **NHHF**'s and **Well Sense**'s *SSD* measure results are shown in Figure 4-44.

Figure 4-44—CY 2018 *SSD* Measure Results



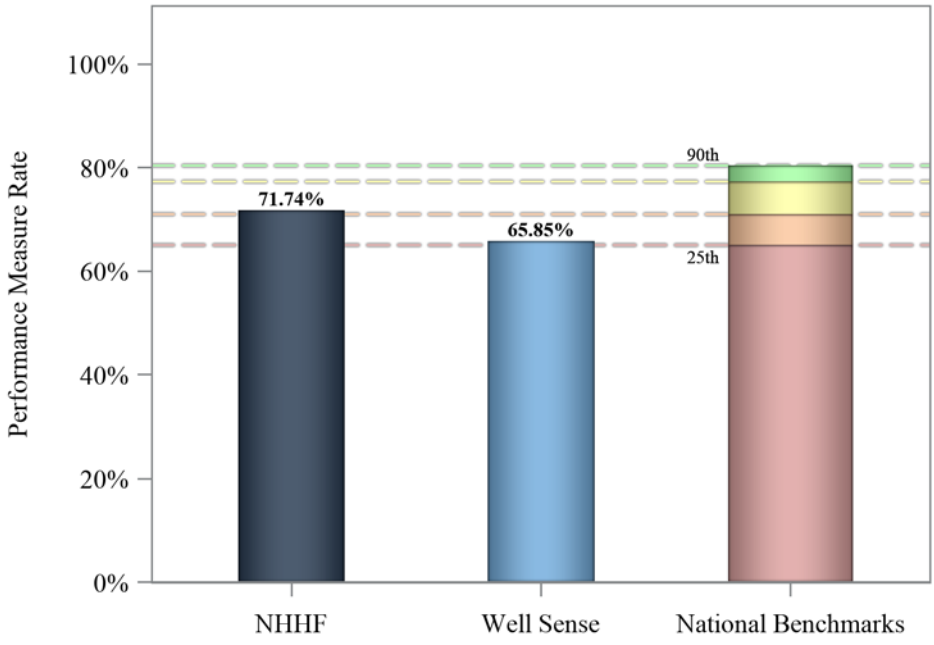
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's and **Well Sense**'s reported rates ranked at or above the 25th percentile but below the 50th percentile. The *SSD* measure is also a PIP topic for **NHHF**.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

SMD measures the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both a low-density lipoprotein-cholesterol (LDL-C) test and an HbA1c test during 2018. **NHHF**'s and **Well Sense**'s *SMD* measure results are shown in Figure 4-45.

Figure 4-45—CY 2018 *SMD* Measure Results



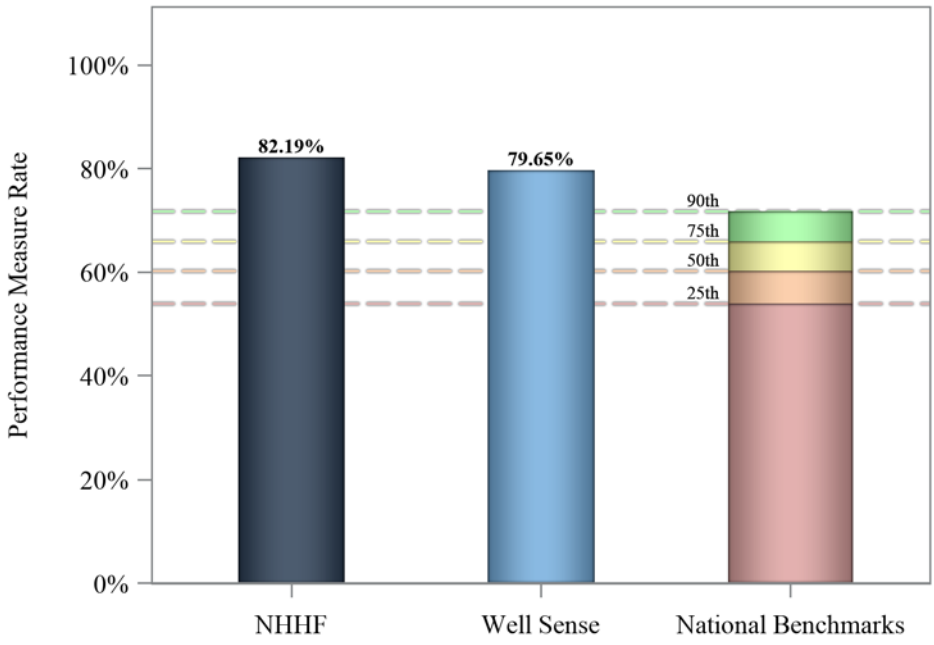
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

SAA measures the percentage of members 19 to 64 years of age with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during 2018. **NHHF**'s and **Well Sense**'s *SAA* measure results are shown in Figure 4-46.

Figure 4-46—CY 2018 *SAA* Measure Results



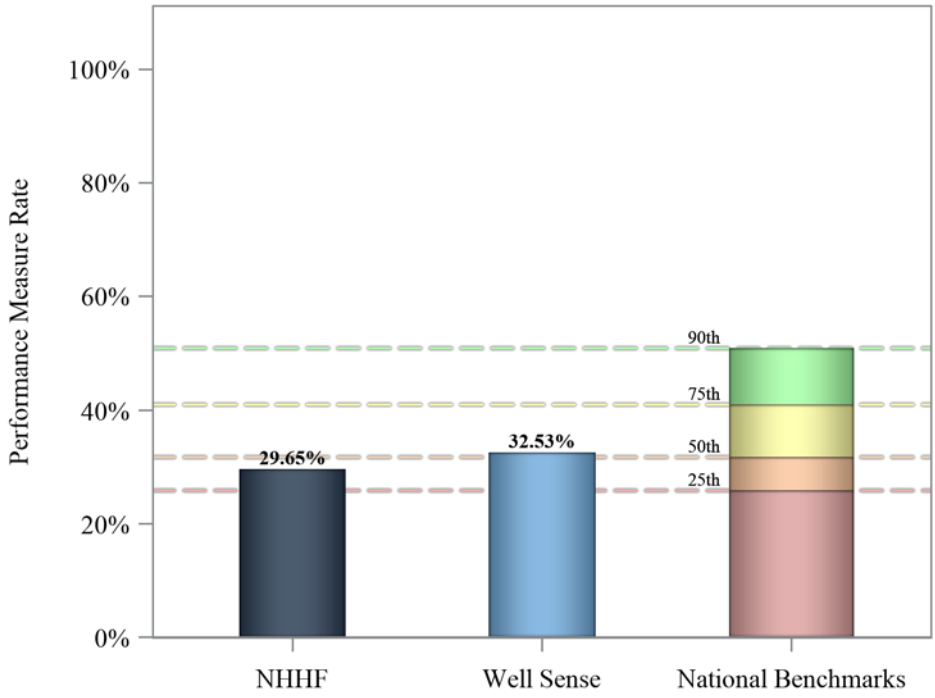
Due to changes in the technical specifications for this measure, NCQA recommends caution be exercised when comparing HEDIS 2019 rates to benchmarks based on HEDIS 2018 technical specifications.

NHHF's and **Well Sense**'s reported rates exceeded the 90th percentile.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total

APM—Total measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during 2018. **NHHF**'s and **Well Sense**'s *APM—Total* measure results are shown in Figure 4-47.

Figure 4-47—CY 2018 *APM—Total* Measure Results

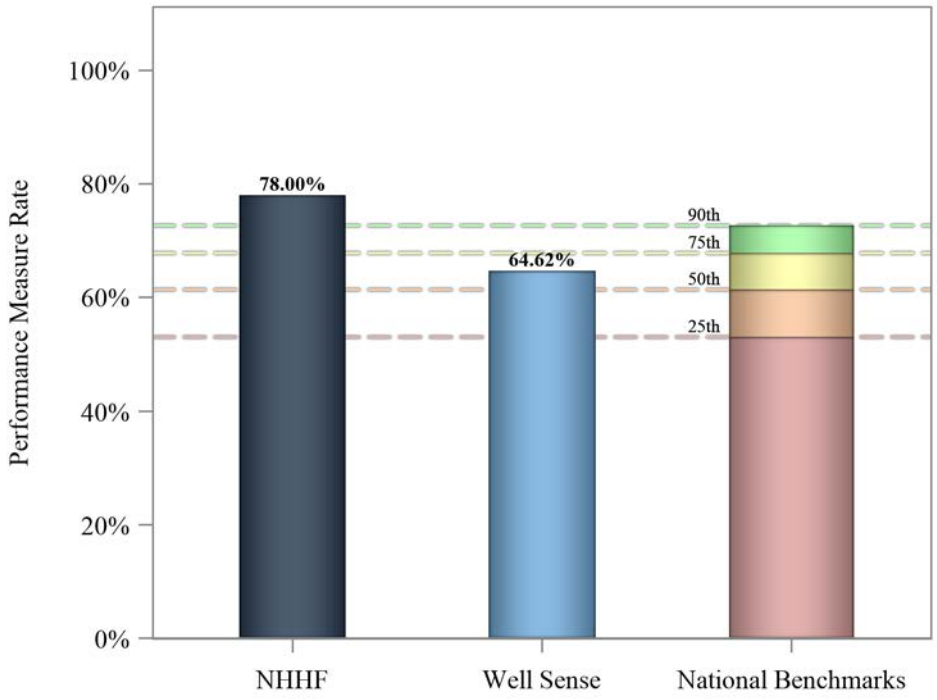


NHHF's reported rate ranked at or above the 25th percentile but below the 50th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total

APP—Total measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment during 2018. **NHHF**'s and **Well Sense**'s *APP—Total* measure results are shown in Figure 4-48.

Figure 4-48—CY 2018 *APP—Total* Measure Results

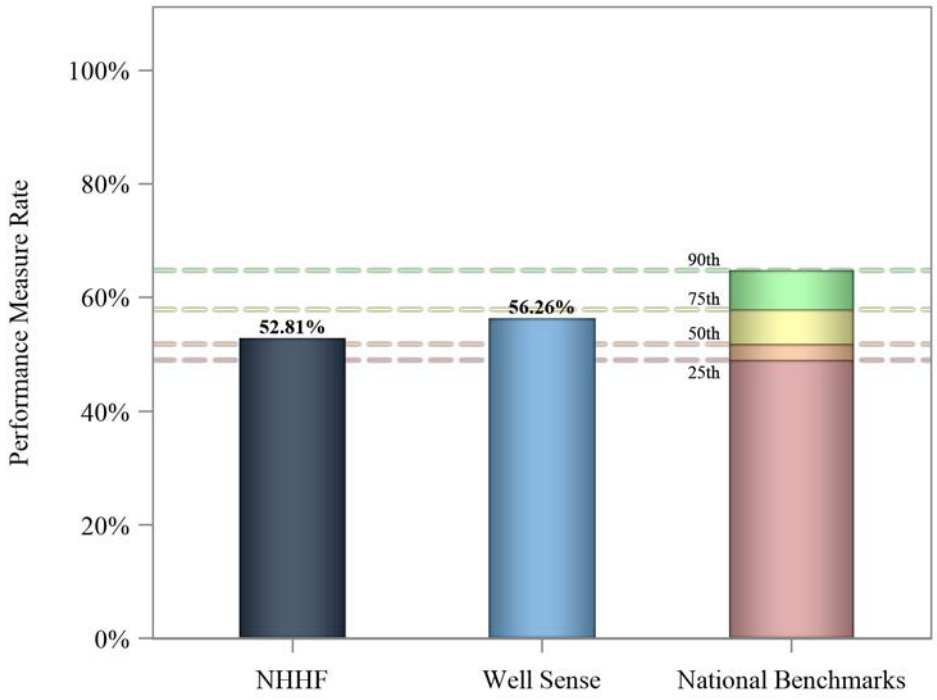


NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment

AMM—Effective Acute Phase Treatment measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks). **NHHF**'s and **Well Sense**'s *AMM—Effective Acute Phase Treatment* measure results are shown in Figure 4-49.

Figure 4-49—CY 2018 *AMM—Effective Acute Phase Treatment* Measure Results

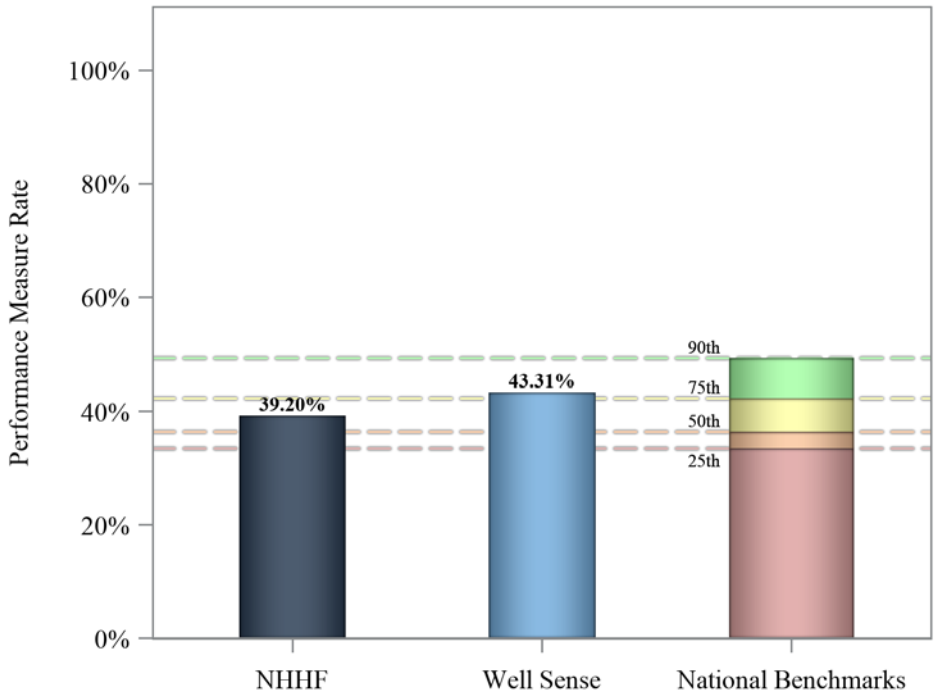


NHHF's and **Well Sense**'s reported rates ranked at or above the 50th percentile but below the 75th percentile.

Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment

AMM—Effective Continuation Phase Treatment measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months). **NHHF**'s and **Well Sense**'s *AMM—Effective Continuation Phase Treatment* measure results are shown in Figure 4-50.

Figure 4-50—CY 2018 *AMM—Effective Continuation Phase Treatment* Measure Results

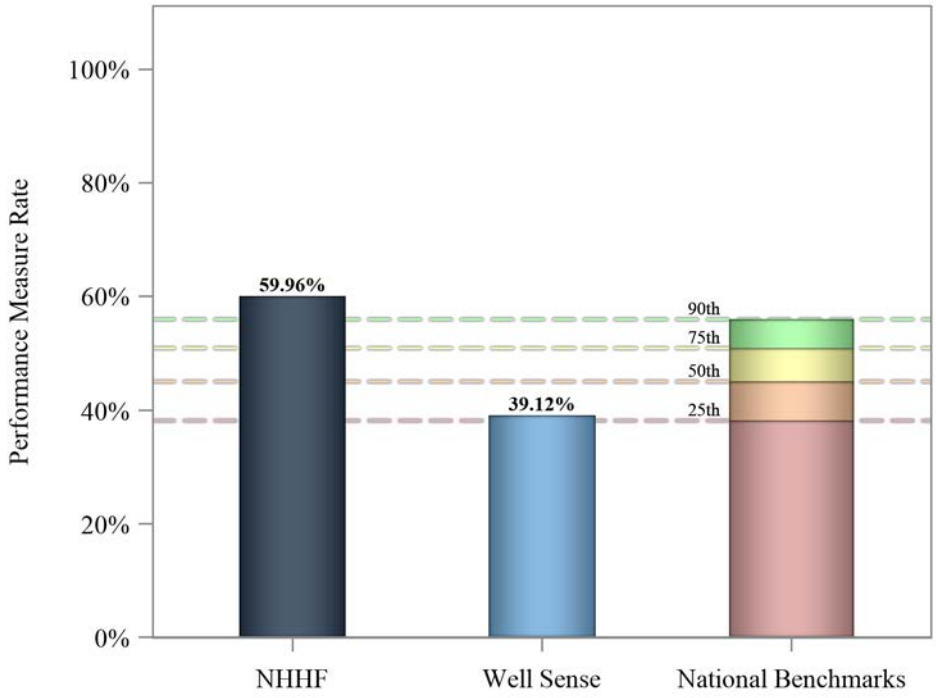


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)—Initiation Phase

ADD—Initiation Phase measures the percentage of members 6 to 12 years of age who were newly prescribed ADHD medication who had a follow-up care visit within 30 days of the first ADHD medication being dispensed. **NHHF**'s and **Well Sense**'s *ADD—Initiation Phase* measure results are shown in Figure 4-51.

Figure 4-51—CY 2018 *ADD—Initiation Phase* Measure Results

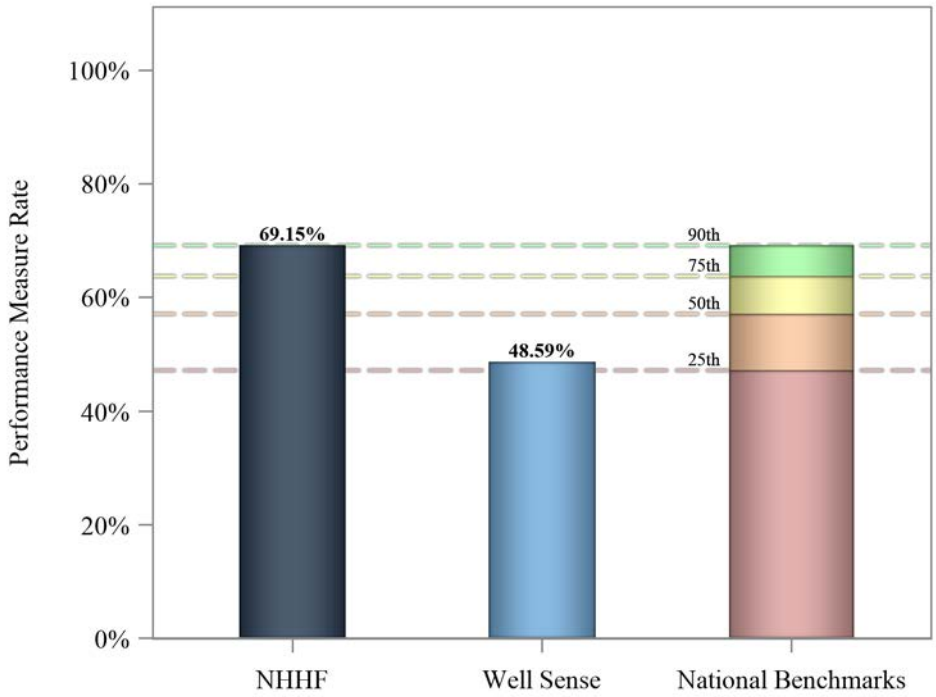


NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase

ADD—Continuation and Maintenance Phase measures the percentage of members 6 to 12 years of age who were newly prescribed ADHD medication, remained on the medication for at least 210 days, and in addition to the follow-up care visit in the initiation phase, had at least two follow-up care visits within 270 days (9 months) after the first 30 days of the first ADHD medication being dispensed. **NHHF**'s and **Well Sense**'s *ADD—Continuation and Maintenance Phase* measure results are shown in Figure 4-52.

Figure 4-52—CY 2018 *ADD—Continuation and Maintenance Phase* Measure Results

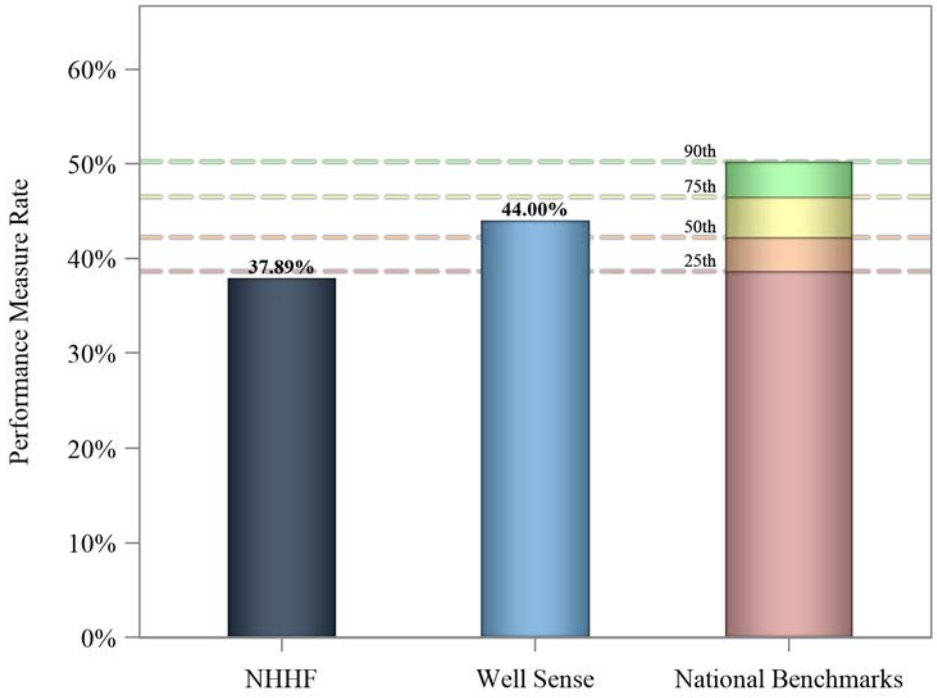


NHHF's reported rate exceeded the 90th percentile, and **Well Sense**'s reported rate ranked at or above the 25th percentile but below the 50th percentile.

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

IET—Initiation of AOD Treatment—Total measures the percentage of adolescent and adult members 13 years of age and older with a new episode of AOD abuse or dependence who initiated appropriate AOD treatment within 14 days of the diagnosis during 2018. **NHHF**'s and **Well Sense**'s *IET—Initiation of AOD Treatment—Total* measure results are shown in Figure 4-53.

Figure 4-53—CY 2018 *IET—Initiation of AOD Treatment—Total* Measure Results

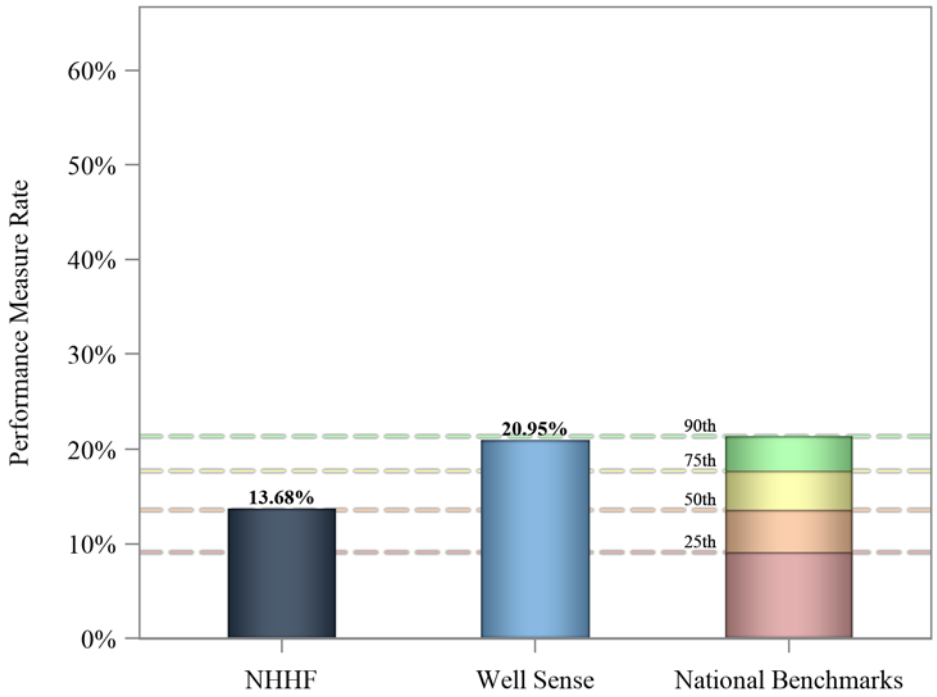


NHHF's reported rate fell below the 25th percentile, and **Well Sense**'s reported rate ranked at or above the 50th percentile but below the 75th percentile.

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

IET—Engagement of AOD Treatment—Total measures the percentage of adolescent and adult members 13 years of age and older with a new episode of AOD abuse or dependence who initiated AOD treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit during 2018. **NHHF**'s and **Well Sense**'s *IET—Engagement of AOD Treatment—Total* measure results are shown in Figure 4-54.

Figure 4-54—CY 2018 *IET—Engagement of AOD Treatment—Total* Measure Results

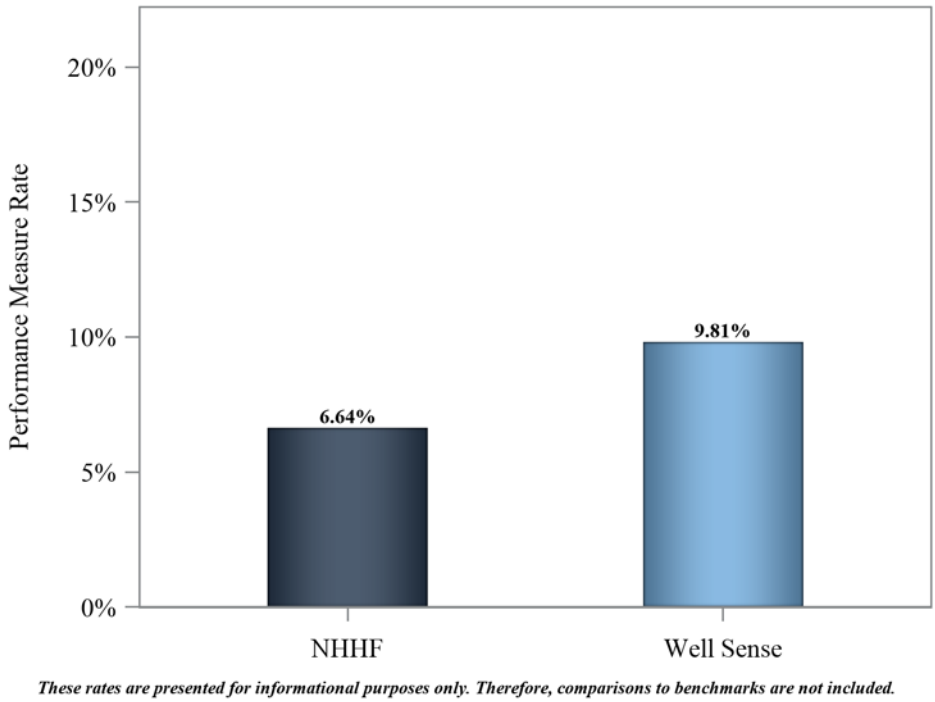


NHHF's reported rate ranked at or above the 50th percentile but below the 75th percentile, and **Well Sense**'s reported rate ranked at or above the 75th percentile but below the 90th percentile.

Identification of Alcohol and Other Drug Services (IAD)—Any Service

IAD—Any Service measures the percentage of members with an alcohol or other drug claim who received any chemical dependency services during 2018. **NHHF**'s and **Well Sense**'s *IAD—Any Service* measure results are shown in Figure 4-55.[4-14] Since the rates reported for this measure do not take into consideration the demographic and clinical characteristics of each MCO's members, comparisons to national benchmarks are not performed. These utilization rates in isolation do not correlate with the quality of services provided. Therefore, these rates are provided strictly for informational purposes.

Figure 4-55—CY 2018 *IAD—Any Service* Measure Results



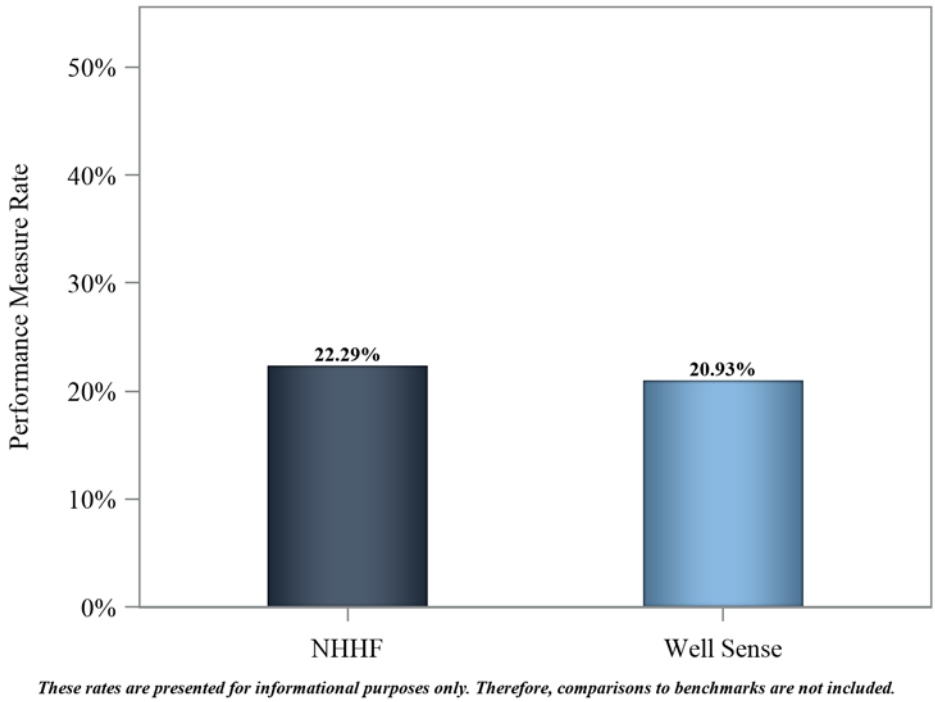
NHHF's reported rate was more than three percentage points lower than **Well Sense**'s reported rate.

[4-14] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Mental Health Utilization (MPT)—Any Service

MPT—Any Service measures the percentage of members receiving any mental health services during 2018. **NHHF**'s and **Well Sense**'s *MPT—Any Service* measure results are shown in Figure 4-56. Since the rates reported for this measure do not take into consideration the demographic and clinical characteristics of each MCO's members, comparisons to national benchmarks are not performed. These utilization rates in isolation do not correlate with the quality of mental health services provided. Therefore, these rates are provided strictly for informational purposes.

Figure 4-56—CY 2018 *MPT—Any Service* Measure Results



These rates are presented for informational purposes only. Therefore, comparisons to benchmarks are not included.

Rates for this measure were similar between **NHHF** and **Well Sense**.

Conclusions and Recommendations

NHHF

Based on the MCO's HEDIS 2019 (CY 2018) performance measure results, **NHHF** scored at or above the 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile.

Prevention

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years*
- *Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits*
- *Adolescent Well-Care Visits (AWC)**
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total*
- *Childhood Immunization Status (CIS)—Combination 2*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**

Acute and Chronic Care

- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Comprehensive Diabetes Care (CDC)—HbA1c Testing*
- *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)**
- *Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)*
- *Asthma Medication Ratio (AMR)—Total*
- *Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits—Total*
- *Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total*

Behavioral Health

- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—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**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase**
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase**

NHHF scored below the 25th percentile for the following measures and should focus future QI activities in these areas:

Prevention

- *Chlamydia Screening in Women (CHL)—Total*

Behavioral Health

- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*

Well Sense

Based on the MCO's HEDIS 2019 (CY 2018) performance measure results, **Well Sense** scored at or above the 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile.

Prevention

- *Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total**
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
- *Childhood Immunization Status (CIS)—Combination 10*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**

Acute and Chronic Care

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid**
- *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator**
- *Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total*
- *Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits—Total*
- *Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions—Total*

Behavioral Health

- *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total**
- *Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**

- *Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Engagement of AOD Treatment—Total*

Well Sense scored below the 25th percentile for the following measures and should focus future QI activities in these areas:

Prevention

- *Chlamydia Screening in Women (CHL)—Total*
- *Prenatal and Postpartum Care (PPC)—Postpartum Care*

EDV

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DHHS requires its contracted MCOs to submit high-quality encounter data. For SFY 2019, DHHS contracted HSAG for the following two EDV activities:

- Using the EDQRS, evaluate the quality of encounter data files submitted by the MCOs. The EDQRS was designed to import, store, and review incoming encounter data and generate automated, weekly/monthly/quarterly validation reports for DHHS.
- Conduct an IS review to assess DHHS' and the MCOs' information systems/processes.

Methodology for EDQRS

HSAG used the same general process and files as DHHS' fiscal agent, Conduent, when collecting and processing encounter data. The EDV activity focused on providing the State with an assessment of the overall quality of encounter data submitted by its contracted MCOs. Daily or weekly, participating MCOs prepare and translate claims and encounter data into the 837P/I and NCPDP 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; 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 the 837 (P/I) files are successfully translated by HSAG, 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. All HSAG edits are customized to address DHHS' overall project goals. Additionally, the MCOs' NCPDP files are processed simultaneously through a comparable process; however, the NCPDP files do not undergo EDI translation. Instead, the NCPDP files are processed directly into HSAG's data warehouse.

Measures in the EDQRS

The weekly EDV report assesses the submission accuracy and completeness measures in the following domain:

- **Domain 1—Submission Accuracy and Completeness (SAC)**: Measures in this domain assess the MCOs' overall adherence to DHHS' encounter submission standards through a direct assessment of encounters processed by HSAG, as well as submission documentation provided by the MCOs. These measures examine whether the submitted encounters pass X12 EDI compliance edits. Additionally, these measures assess the level to which the MCOs' reconciliation reports align with the submitted encounter files regarding the names of files submitted and overall counts for specific data elements from the files. Results from these metrics facilitate addressing submission quality from the MCOs.

The monthly EDV report assesses encounter data completeness, encounter data accuracy, supplemental measures, and orphan void records in the following domains:

- **Domain 2—Encounter Data Completeness (EDC)**: Measures in this domain demonstrate the MCOs' trends in encounter submission volume over time. These metrics analyze several aspects of submission, including encounter submission volume by submission month (i.e., months during which encounters were submitted to HSAG), monthly visit volume in relation to 1,000 enrolled members per service month (i.e., the month during which services associated with encounters were provided), monthly proportions of distinct professional visits by place of service category, and monthly proportions of distinct institutional visits by type of bill category. HSAG assessed monthly trends in MCO paid amounts in terms of the submission month, as well as the service month. Finally, submitted encounters are assessed for line-level duplication (i.e., using selected data elements in relation to each encounter type).
- **Domain 3—Encounter Data Accuracy (EDA)**: Measures in this domain demonstrate the overall quality of submitted encounters, specifically examining the proportion of submitted encounters with non-null and accurate values for key data elements. The data elements selected for this evaluation provide critical information in terms of service provision and costs.
- **Supplemental Measures**: The supplemental measures provide additional insight into encounter accuracy issues through providing the top five most frequently reported incorrect values for key data elements. Additionally, HSAG presented the 20 most frequently reported values and the 20 costliest values for key data elements.
- **Supplemental File for Orphan Voids**: The monthly supplemental file lists all void records for which HSAG could not locate the associated original records. This file provides the source data DHHS needs to solve the orphan void issue with the MCOs.

The quarterly EDV report assesses encounter data timeliness in the following domain:

- **Domain 4—Encounter Data Timeliness (EDT)**: Measures in this domain assess the MCOs' compliance with time-based submission standards for encounter data. These metrics focus on the overall regularity with which encounters are submitted to DHHS and HSAG, time-to-submission

after provider payment by MCOs, and time-to-submission regarding the date for which services are rendered. In addition to overall compliance with DHHS standards, this domain facilitates real-time detection of lags in encounter submission.

Overall, results for all measures are displayed at the MCO and statewide levels for the appropriate encounter type.

EDQRS Implementation

During SFY 2019, DHHS made no notable changes to the EDQRS.

Findings for EDQRS

For encounters received from MCOs in SFY 2019 (i.e., July 1, 2018, to June 30, 2019), this section presents the aggregate rates for five standards within Exhibit A-Amendment #12 of the MCM Contract.[4-15]

Standard 25.2.24.2.1 specifies that "Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the New Hampshire Medicaid Management Information System (MMIS) threshold and repairable compliance edits." While an evaluation of the "MMIS threshold and repairable compliance edits" is out of scope for the EDV report, Table 4-13 shows that all 837P and 837I encounters received in SFY 2019 passed the X12 EDI compliance edits for both **NHHF** and **Well Sense** as shown in Table 4-13.

Table 4-13—Percentage of Encounters Passing X12 EDI Compliance Edits

Encounter Type	Standard	NHHF	Well Sense
837P Encounters	98.0%	100.0%	100.0%
837I Encounters	98.0%	100.0%	100.0%

Table 4-14 displays the results from Standard 25.2.24.2.3 requiring that "One-hundred percent (100%) of member identification numbers shall be accurate and valid." For all encounter types from both MCOs, Table 4-14 shows that the member identification numbers were present on 100 percent of encounters. In addition, at least 99 percent of member identification numbers were valid for all three encounter types for both **NHHF** and **Well Sense**, which was just slightly lower than the standard (i.e., 100 percent).

[4-15] New Hampshire Department of Health and Human Services. (2015). *Medicaid Managed Care Organization Contract Amendment #12.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: Sept 27, 2019.

Table 4-14—Percentage Present and Percentage Valid for Member Identification Numbers

Encounter Type	Standard	NHHF		Well Sense	
		% Present	% Valid*	% Present	% Valid*
837P Encounters	100.0%	100.0%	99.8%	100.0%	99.2%
837I Encounters	100.0%	100.0%	99.8%	100.0%	99.0%
NCPDP Encounters	100.0%	100.0%	99.9%	100.0%	99.9%

* To be considered valid, the member identification number should meet the following three criteria: (1) included in the member file, (2) eligible for Medicaid on the date of service, and (3) enrolled in a specific MCO on the date of service.

Table 4-15 displays the results from Standard 25.2.24.2.4 requiring that "Ninety-eight percent (98%) of servicing provider information will be accurate and valid." Table 4-15 shows that the servicing provider numbers were present for 100 percent of encounters for both **NHHF** and **Well Sense**. While the validity rates for the 837P and NCPDP encounters either met the standard (i.e., 98 percent) or slightly below the standard (i.e., 837P encounters for **Well Sense)**, the validity rates for the 837I encounters were 15.2 and 17.2 percentage points below the standard for **NHHF** and **Well Sense**, respectively. For both MCOs, the invalid servicing providers from the 837I encounters were primarily from the following five billing provider National Provider Identifiers (NPIs). Note that the first five digits of the NPIs have been deidentified.

- #####18104 (Wentworth Douglass Hospital)
- #####95234 (LRGHealthcare—Laconia)
- #####81516 (Cheshire Medical Center)
- #####70683 (HCA Health Services of New Hampshire Inc)
- #####60895 (LRGHealthcare—Franklin)

Table 4-15—Percentage Present and Percentage Valid for Servicing Provider Information†

Encounter Type	Standard	NHHF		Well Sense	
		% Present	% Valid*	% Present	% Valid*
837P Encounters	98.0%	100.0%	99.3%	100.0%	96.4%
837I Encounters	98.0%	100.0%	82.8%	100.0%	80.8%
NCPDP Encounters	98.0%	100.0%	100.0%	100.0%	99.5%

† For professional encounters, "servicing provider information" refers to the rendering provider numbers (i.e., NPIs) or the billing provider NPIs if the rendering provider NPIs are missing. For institutional and NCPDP encounters, "servicing provider information" refers to the billing provider NPIs.

* To be considered valid, the servicing provider number should have been included in the daily provider file received from DHHS for the reporting period.

Standard 25.2.24.3.1 states that "Encounter data shall be submitted weekly, within five (5) business days of the end of each weekly period and within thirty (30) calendar days of claim payment." The following two measures were used to evaluate this timeliness standard:

- Measure EDT.1: Percentage of weeks with at least one file submission in SFY 2019

- Measure EDT.2: Percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date

Table 4-16 shows the percentage of the 52 weeks in SFY 2019 with at least one file submission. For 837P and 837I encounters, **NHHF** did not submit a file from December 24, 2018, to December 30, 2018. For NCPDP encounters, **NHHF** did not submit any files for six weeks from December 3, 2018, to January 13, 2019. **Well Sense** submitted all three encounter types to DHHS for all weeks except one week for each encounter type in SFY 2019 (i.e., **Well Sense** did not submit an 837P or 837I file from March 25, 2019, to March 31, 2019 or an NCPDP file from June 17, 2019, to June 23, 2019.)

Table 4-16—Percentage of Weeks With at Least One File Submission

Encounter Type	Standard	NHHF	Well Sense
837P Encounters	100.0%	98.1%	98.1%
837I Encounters	100.0%	98.1%	98.1%
NCPDP Encounters	100.0%	88.5%	98.1%

Table 4-17 presents the percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date, and the list below shows the findings. Of note, all encounters submitted to DHHS were included in the evaluation. If an encounter was missing a claim payment date in the detail file, it was considered to not meet the standard.

- For the 837P encounters, 82.6 percent of **NHHF**'s encounters were submitted to DHHS within 30 days of the claim payment date due to longer lag days between the claim payment date and the submission date. The rate for **Well Sense** was much lower (i.e., 66.2 percent) due to missing detail payment dates in the submitted encounter data. If supplementing missing detail payment dates with header payment dates, the rate for **Well Sense** would increase from 66.2 percent to 88.1 percent.
- For the 837I encounters, 97.5 percent and 66.8 percent of encounters were submitted to DHHS within 30 days of the claim payment date for **NHHF** and **Well Sense**, respectively. For both MCOs, the noncompliance was primarily due to missing detail payment dates in the submitted data. If supplementing missing detail payment dates with header payment dates, the rates for **NHHF** and **Well Sense** would increase to 99.5 percent and 75.5 percent, respectively.
- For the NCPDP encounters, while the rate for **NHHF** was 91.5 percent, the rate for **Well Sense** was much lower (i.e., 64.1 percent). However, when increasing the lag days from 30 calendar days to 45 calendar days, more than 93 percent of **Well Sense**'s NCPDP encounters were submitted to DHHS within 45 calendar days.

Table 4-17—Percentage of Encounters Submitted to DHHS Within 30 Calendar Days of Claim Payment

Encounter Type	Standard	NHHF	Well Sense
837P Encounters	100.0%	82.6%	66.2%
837I Encounters	100.0%	97.5%	66.8%
NCPDP Encounters	100.0%	91.5%	64.1%

Conclusions and Recommendations for EDQRS

NHHF

NHHF's submitted encounters met the standards for the X12 EDI compliance edits and the accuracy for servicing providers in its 837P and NCPDP encounters.

HSAG recommends that **NHHF** focus on three areas to improve its encounter data submissions: data accuracy related to member identification numbers for all three encounter types; data accuracy related to servicing provider information for its 837I encounters; and timely encounter data submissions, including both weekly encounter submissions to DHHS and submissions to DHHS within 30 days of the claim payment date for all three encounter types.

Well Sense

Well Sense's submitted encounters met the standards for the X12 EDI compliance edits and the accuracy for servicing providers for its NCPDP encounters.

HSAG recommends that **Well Sense** focus on three areas to improve its encounter data submissions: data accuracy related to member identification numbers for all three encounter types, data accuracy related to servicing provider information for its 837P and 837I encounters, and timely encounter data submissions including both weekly encounter submissions to DHHS and submissions to DHHS within 30 days of the claim payment date for all three encounter types. To improve the percentage of encounters submitted to DHHS within 30 calendar days of the claim payment date, **Well Sense** should ensure that claim payment dates are included in the encounters submitted to DHHS and that the encounter data are submitted to DHHS in a timely manner.

Information Systems (IS) Review

HSAG designed the IS review to define how each participant in the encounter data process collects and processes encounter data such that the flow of the data from the MCOs' vendors to the MCOs and from the MCOs to DHHS is understood. The IS review is key to understanding whether the IS infrastructures in place are likely to produce complete and accurate encounter data.

Methodology for the IS Review

The IS review portion of the EDV activity consisted of a three-stage process:

- **Document Review**: HSAG conducted a thorough desk review of documents related to current encounter data initiatives/validation activities. HSAG used documents such as policies and procedures, encounter system edits, and DHHS' current encounter data submission requirements to develop a targeted questionnaire designed to address specific topics of interest for DHHS.
- **Development and Fielding of Customized Encounter Data Assessments**: In collaboration with DHHS, HSAG developed a targeted IS questionnaire, designed to gather both general and specific

information regarding data processing, personnel, and data acquisition capabilities for DHHS and the MCOs to complete. The questionnaire included assessment items grouped into the following four topic areas:
  - Encounter Data Sources and Systems
  - Data Exchange Policies and Procedures
  - Management of Encounter Data: Collection, Storage, and Processing
  - Encounter Data Quality Monitoring and Reporting
- **Key Personnel Interviews**: Upon completion of the customized encounter data assessment, HSAG followed up with key personnel at DHHS, **NHHF**, and **Well Sense** to clarify any information provided through questionnaire responses.

Of note, information obtained from DHHS' and the MCOs' questionnaire responses was self-reported, and HSAG did not validate the responses for accuracy.

Findings for the IS Review

HSAG finalized a single aggregate report in February 2019, which contained key findings for DHHS, **NHHF**, and **Well Sense** and aggregate and MCO-specific conclusions and recommendations. This section provides detailed information in the four key areas.

Encounter Data Sources and Systems

DHHS receives 837P, 837I, and proprietary flat pharmacy files from **NHHF** and **Well Sense** though encounter files for specific service categories that originate with external vendors are modified prior to submission to facilitate formatting specifications. The 837P and 837I files then go through DHHS' EDI X12 compliance checks and MMIS edits, while the pharmacy files go through the MMIS edits only. For every transaction file MCOs submit to DHHS, the MCOs receive a standard X12 999 response file and a customized MMIS response file, if appropriate. The 999 response file details any issues the file had with the EDI X12 compliance checks, whereas the MMIS response file details any issues the file encountered when processing through DHHS' MMIS data quality checks/edits. The MCOs use these response files to determine if an encounter should be voided, corrected, and resubmitted or if an exception should be requested.

NHHF and **Well Sense** employ provider enrollment processes that include validation activities to incorporate new and updated information in their provider directories. Both MCOs limit in-house data reconciliation activities to provider data associated with services that are not externally managed. However, provider data from external vendors are reviewed for completeness and accuracy, and vendors are required to manage reconciliation requests. For example, the MCOs and their external vendors link provider information to claims data through specific sets of identifying fields to ensure that the appropriate provider information accompanies claims; both MCOs indicated that claims missing provider-identifying information are rejected.

MCOs receive daily enrollment data transmissions in the form of EDI 834 transaction files, along with TPL supplemental files. Both MCOs employ enrollment data management processes that include daily data review, storage, and transmission to external service management vendors. DHHS also transmits member reconciliation and claims payment/remittance data to the MCOs monthly (EDI 834 and 835 transaction files, respectively).

Data Exchange Policies and Procedures

DHHS provides regularly updated information on the encounter submission and processing rules in its Encounter Submission Guidelines documentation. Both **NHHF** and **Well Sense** employ encounter file generation and review processes that have been tailored to meet DHHS' submission specifications; this includes the use of quality controls to ensure encounter files meet DHHS' content, formatting, completeness, and accuracy requirements. Additionally, both MCOs have developed review and reconciliation practices that ensure compliance with DHHS' error resolution requirements for historic and newly submitted encounter files.

Management of Encounter Data: Collection, Storage, and Processing

Regarding the pricing methodology, **NHHF** and **Well Sense** reported the use of New Hampshire Medicaid's Medicare Severity Diagnosis Related Groups (MS-DRGs) methodology to price inpatient hospital claims, New Hampshire Medicaid fee schedule rates for laboratory claims, and a cost-to-charge ratio method for payment of non-laboratory outpatient claims. The MCOs bundled permitted federally qualified health centers and rural health clinics services, as outlined in DHHS' billing manuals, although **Well Sense** bundled additional services.

Both **NHHF** and **Well Sense** collect TPL data for their managed care members, though information is processed at different points in their adjudication processes. Medicare crossover information is managed similarly to TPL information for both MCOs—eligibility and coverage information is added to adjudication software/systems, where it is stored and consulted to facilitate prospective claims payment actions.

Both **NHHF** and **Well Sense** apply capitated payments to some providers for specific services. Claims for these services are processed as zero-pay encounters.

Encounter Data Quality Monitoring and Reporting

The completeness and accuracy of claims data submitted from providers and clearinghouses are generally verified through data validation checks that are incorporated into the MCOs' adjudication processes. These validation checks verify that claims data are not missing values for vital fields and that non-missing values are reasonable (e.g., valid International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] diagnosis codes or valid NPI values). Additionally, these checks verify Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and that claims data meet DHHS' specifications for 837I or 837P transactions.

For encounter data from the MCOs' vendors, both MCOs monitor the completeness and accuracy of submitted encounters, in addition to verifying that submitted files are in the appropriate X12 format and can pass DHHS' data quality specifications.

DHHS' EDI vendor verifies that submitted encounter transactions meet 837 formatting specifications and are HIPAA compliant, while DHHS' MMIS applies "scrubs" to detect noncompliance with data quality specifications. DHHS transmits 999 Functional Acknowledgement files and encounter response files to MCOs that verify receipt of submitted encounter files and their acceptance/rejection status. **NHHF** and **Well Sense** monitor the processing status of their encounters through various reconciliation activities. Both MCOs work with external vendors to review encounter rejection findings associated with encounters created by their external vendors. Vendors are required to implement corrective actions to ensure that their encounter data meet DHHS' data quality specifications.

DHHS collaborated with HSAG to develop EDV metrics that assess data submission trends, quality, and timeliness. HSAG produces a standardized set of validation reports weekly, monthly, and quarterly to complement DHHS' ability to assess compliance with its data quality standards.

Conclusions and Recommendations

NHHF

Based on its review, HSAG recommends the following for **NHHF** to strengthen its encounter data quality:

- **NHHF** acknowledges that a considerable proportion of submitted encounters do not pass business rule "scrubs" and compliance checks implemented by DHHS' MMIS, primarily due to issues with the provider data. In collaboration with DHHS, **NHHF** should consider conducting an in-depth assessment of all encounter rejections based on the provider data issues that would involve the following: (1) identifying distinct rejection reasons, (2) ranking rejection reasons based on frequency, (3) reviewing internal edits and compliance checks for loopholes that permit noncompliance, and (4) implementing stricter edit checks for prospective claims/encounters.
- **NHHF** described encounter data quality monitoring activities that were reliant on response files from DHHS. **NHHF** should add more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS. For example, review of encounter volume by service month would add a dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.
- **NHHF** should consider incorporating timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS.

Well Sense

Based on its review, HSAG recommends the following for **Well Sense** to strengthen its encounter data quality:

- **Well Sense** indicated that a relatively small proportion of its submitted encounter records are rejected by DHHS' EDI translator. However, the MCO acknowledged that roughly 30 percent of encounters are rejected by DHHS' MMIS due to noncompliance with business rules or other specifications. Though **Well Sense** did not describe specific issues contributing to its high rejection rate, the MCO did acknowledge that DHHS' adjudication process employs business rules that differ from those employed by the MCO. In collaboration with DHHS, **Well Sense** should consider an assessment of all encounter rejections based on provider data issues that would involve the following: (1) identifying distinct rejection reasons, (2) ranking rejection reasons based on frequency, (3) reviewing internal edits and compliance checks for loopholes that permit noncompliance, and (4) implementing stricter edit checks for prospective claims/encounters.
- **Well Sense** described encounter data quality monitoring activities that were reliant on response files from DHHS. **Well Sense** should add more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHHS. For example, review of encounter volume by service month would add a dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established. Another example assessment would be conducting regular audits on the claims for completeness and accuracy.
- **Well Sense** should consider implementing a submission frequency assessment in its review of encounter files submitted by external service management vendors.
- **Well Sense** should consider incorporating timeliness standards to facilitate assessment regarding the time between service administration and encounter submission to DHHS.

Other EQR Activities

Specialty Provider Survey

DHHS contracted with HSAG during SFY 2019 to conduct a telephone survey among providers contracted with a Medicaid MCO and specializing in one of 13 physical health specialties.[4-16] HSAG evaluated providers in New Hampshire's Medicaid managed care network to address the following goals:

[4-16] The Specialty Provider Survey included the following physical health specialties, with varying provider data values by MCO: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology (Ear, Nose, and Throat), Gastroenterology, Hematology and Oncology, Neurology, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Pulmonology, and Urology.

- Determine whether providers accept patients enrolled with a Medicaid MCO.
- Determine whether providers accept new patients.
- Determine appointment availability with the sampled providers for urgent and non-urgent (routine) services.

The two MCOs participating in the MCM Program, **NHHF** and **Well Sense**, submitted provider data files to DHHS for HSAG's use. To include a comparison of the MCM Program results to a commercial insurance plan, HSAG assessed appointment availability using Anthem. HSAG completed calls to all sampled provider locations during August and September 2019, recording survey responses in an electronic data collection tool.

Results

HSAG attempted to contact 4,419 provider location ("cases"), with a 58.6 percent response rate. Due to the revealed caller nature of the study, providers' offices may have ended the caller's conversation for a case without offering responses for all survey elements.

More than 95.0 percent of applicable survey respondents indicated that the provider location was accepting new patients and these results were similar for all three health plans (i.e., **NHHF**, **Well Sense**, and Anthem). However, more than 50.0 percent of applicable cases indicated that the sampled provider only served adult members.

Table 4-18 summarizes the number of survey cases and potential outcomes by health plan.

Table 4-18—Summary of Survey Case Outcomes by Health Plan

Plan	Total Survey Cases	Cases Reached	Cases with Correct Location and Specialty	Providers Offering Services for Children	Providers Confirming Enrollment with Health Plan	Accepting New Patients
NHHF	2,005	1,171	611	275	442	427
Well Sense	2,414	1,420	852	406	554	528
Anthem*			1,357		776	747

* For Anthem, data were not displayed for the "Total Survey Cases," "Cases Reached," and "Providers Offering Services for Children" categories because cases were not sampled separately for Anthem.

Table 4-19 displays a summary of the overall median appointment wait times in calendar days. **Well Sense** cases had the longest median appointment wait times across all appointment scenarios.

Table 4-19—Summary of Median Appointment Wait Times in Calendar Days by Health Plan

Plan	New Patient		Existing Patient	
	Routine Visit	Urgent Issue	Routine Visit	Urgent Issue
NHHF	33.0	20.0	31.0	14.0
Well Sense	40.0	25.5	33.5	15.0
Anthem	35.0	22.0	32.0	14.0

Recommendations

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

- HSAG was unable to reach more than 41 percent of sampled cases for each MCO. Callers noted a key non-response reason was that the provider location did not offer the specialty noted in the provider data supplied by the MCO. DHHS should supply each MCO with case-level survey data with identified provider data deficiencies (e.g. incorrect or disconnected telephone phone numbers, incorrect address or provider specialty information) and have MCOs address these deficiencies.
- DHHS should consider having the EQRO collect provider network data directly from the MCOs for EQRO activities, enabling HSAG to provide specific instructions and technical assistance related to provider data field contents. For example, the address should reflect the physical location at which the provider sees patients and the telephone number should reflect the most direct number from which patients can schedule an appointment with the provider.
- DHHS should consider conducting a provider directory audit to verify that the MCOs' publicly available provider data accurately represents the provider data supplied to members.
- Per the MCOs' contracts with DHHS, each MCO is required to maintain provider network capacity to ensure appointment wait times from the member's PCP or another provider. However, overall survey results for average and median appointment wait times exceed MCOs' contractual requirements.
  - Therefore, DHHS should request that each MCO supply copies of its documentation regarding the MCO's processes for monitoring and evaluating members' ability to access care in a timely manner, including both geographic access and timely access to care.
  - DHHS could also consider reviewing the current appointment timeliness standards to determine whether the State should establish separate timeliness standards for visits with PCPs versus physical health specialty providers (e.g., allowing 15 calendar days for a non-urgent symptomatic appointment with a specialist, but only 10 calendar days for the same type of appointment with a PCP).

- Differences in appointment wait times by provider specialty and MCO suggest that providers willing to serve Medicaid members may not be contracted with both Medicaid MCOs. DHHS should consider comparing each MCO's provider network to DHHS data on all providers contracted to serve New Hampshire Medicaid members (i.e., a saturation analysis) to determine the extent to which each MCO is contracted with available providers.

5. Follow-Up on Prior Recommendations

The following section presents HSAG's recommendations made in the prior year's EQR technical report and an assessment of the actions that were implemented by **NHHF** and **Well Sense** to correct the areas needing improvement.

New Hampshire Healthy Families

The SFY 2018 EQR Technical Report contained opportunities for improvement for **NHHF** in the contract compliance audit, PIPs, HEDIS, and EDV. Table 5-1 through Table 5-4 display the self-reported follow-up activities conducted by **NHHF** during SFY 2019 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG conducted a contract compliance audit to assess MCO performance with respect to requirements found in 42 CFR §438 and the DHHS contract with **NHHF**. HSAG reviewed 14 standards containing 128 applicable elements for **NHHF**. HSAG received a CAP from **NHHF** for the elements found to be non-compliant in three standards (i.e., Delegation and Subcontracting, Care Management/Care Coordination, and Member Enrollment and Disenrollment), and all items were found to be compliant with the revisions instituted by **NHHF** in the CAPs completed in August 2018.

Table 5-1 contains a list of the recommendations from the SFY 2018 New Hampshire Compliance Review and **NHHF**'s response concerning the follow-up activities conducted to improve the activity.

Table 5-1—Follow-Up Activities by NHHF to Improve MCO Contractual Compliance Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure	Follow-Up by NHHF
Contract Compliance Audit	*Delegation and Subcontracting:* The MCO has a written agreement between the MCO and each subcontractor in which the subcontractor: a. Agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and MCO contract provisions; b. Agrees to hold harmless DHHS, and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO;	HSAG found that three subcontract agreements did not meet all the requirements included in this element. During the CAP process, **NHHF** submitted the revised New Hampshire Medicaid Vendor Product Attachment for use with all subcontractor agreements. HSAG's review of the vendor product attachment confirmed that the document met the requirements of this element. This CAP was completed by **NHHF**.

EQR Activity	Measure	Follow-Up by NHHF
Contract Compliance Audit	c. Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor or its agents, officers, employees, or contractors; d. Agrees that the State, CMS, the Health and Human Services (HHS) Inspector General, or their designees have the right to audit, evaluate, and inspect any premises, physical facilities, books, records, contracts, computers, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO managed care activities; e. Agrees that it can be audited for 10 years from the final date of the contract period or from the date of any completed audit, whichever is later; and f. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk.	
	Delegation and Subcontracting: The written agreement between the MCO and the subcontractor specifies the activities and responsibilities delegated to the subcontractor and a transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate as determined by the MCO or DHHS. In the written agreement, the subcontractor also agrees to perform the delegated activity and related reporting responsibilities, as specified in the subcontractor agreement and the applicable responsibilities in the Agreement.	HSAG found that one subcontract agreement did not meet the requirements of this element. The revised contract amendment and the vendor product attachment met the requirements of this element. **NHHF** completed the CAP for this element.

EQR Activity	Measure	Follow-Up by NHHF
Contract Compliance Audit	*Delegation and Subcontracting:* The MCO monitors the subcontractor's performance on an ongoing basis, consistent with industry standards and State and federal laws and regulations (at least annually or when there is a substantial change in the scope or terms of the subcontract agreement).	HSAG found that **NHHF** did not monitor one subcontractor's performance at least annually or when there was a substantial change in the scope or terms of the subcontract agreement. **NHHF** scheduled an audit and revised their audit plan to ensure that monitoring would be conducted annually or when there is a substantial change in the scope or terms of the subcontract agreements. **NHHF** completed the CAP for this element.
	Care Management/Care Coordination: The MCO conducts a health needs assessment for all new members within the following time frames from the date of enrollment in the MCO: a. 30 calendar days for pregnant women, children with special health care needs (SHCN), adults with special health care needs; and b. 90 calendar days for all other members, including members residing in a nursing facility longer than 100 days	HSAG found that **NHHF** sent initial welcome packets to all new members with a health needs assessment that could be completed and returned to **NHHF**; however, **NHHF** did not make follow-up attempts with members residing in a nursing facility longer than 100 days to obtain the assessment within 90 calendar days from the date of enrollment. **NHHF** had difficulties reaching newly eligible nursing facility members by telephone. **NHHF** submitted workflow documents to confirm that two additional mailings would be sent to those members and that **NHHF** would monitor the efforts to determine if the health plan received the assessment from the members. **NHHF** completed the CAP for this element.
	Member Enrollment and Disenrollment: The MCO notifies members and their representatives with written notice of their disenrollment rights at least 60 calendar days before the start of each re-enrollment period.	HSAG found that **NHHF** did not send members or their representatives written notice of their disenrollment rights at least 60 calendar days before the start of each re-enrollment period. **NHHF** sent a copy of the August 2018 member newsletter to confirm that members were informed of their disenrollment rights at least 60 calendar days prior to the start of the 2018 re-enrollment period. **NHHF** completed the CAP for this element.

PIPs

HSAG validated three PIPs submitted by **NHHF**: *Comprehensive Diabetes Screening—Vision Screening, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication,* and *Well-Child Visits for 3-to-6-Year-Olds.* HSAG validated the three PIPs through the design, implementation, and outcomes phase of the PIP process. One PIP, *Comprehensive Diabetes Screening—Vision Screening,* successfully demonstrated sustained improvement in outcomes at Remeasurement 2. The SFY 2018 New Hampshire EQR Technical Report contained opportunities for improvement for the additional two PIPs, as noted in Table 5-2.

Table 5-2—Follow-Up Activities by NHHF to Improve PIP Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by NHHF
PIPs	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications:* Using the lessons learned to drive further development and review results, timing, and effectiveness of the interventions.	**NHHF** made small changes to the outreach during the 2018 PIP initiative to attempt to streamline the process with our providers. This adjustment did not prove beneficial and our rates decreased from the prior year. The only way to determine if the change in the process caused a decrease in our results would be to return our initiative to the same format as it was in 2017. That is being considered for the current year.
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: **NHHF** should consider the use of another tool for barrier analysis that may lead to a new or revised intervention.	**NHHF** has completed a fishbone diagram and, as recommended, a failure modes and effects analysis (FMEA) to ascertain if there are other barriers that may be limiting our improvement. That analysis is currently underway and will be brought to our internal HEDIS Steering Committee for discussion now that the final rates have been collected for CY 2018.
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: **NHHF** should consider any applicable strategies, processes, or lessons learned from one of the other successful PIPs.	**NHHF** has reviewed the intervention and analysis that were done for the *CDC – Eye Measure.* The intervention was very specific and a much less sensitive topic, which makes it difficult to crosswalk this measure. The process of direct outreach to members, which is the approach taken for the successful diabetic eye exam initiative, does not appear to be a feasible strategy with the mental health measure, due to the sensitivity of the diagnosis and prescription. The focus on assisting providers with identifying members who are not compliant with the screening can be replicated from the other successful PIPs, and more frequent reminders, such as monthly updates, can be implemented.

EQR Activity	Measure Standard	Follow-Up by NHHF
PIPs	*Well-Child Visits for 3-to-6-Year-Olds:* Use the lessons learned to drive further development and review results, timing, and effectiveness of the interventions.	**NHHF** has used the knowledge from our medical records reviews, Member Advisory Board, prior interventions, and discussions with providers to guide current initiatives. Further evaluation of barriers needs to be investigated to reach those members who are not currently compliant with this measure. Member outreach appears to have the best results, yet this has not provided us with the lift in member visits that we had anticipated. The incentive program that was in place, but had low utilization, was improved. Marketing of this program was increased to share information about this program. **NHHF** is also working with providers, using analytical tools and incentives to encourage their continued outreach to members in need of services.
	Well-Child Visits for 3-to-6-Year-Olds: **NHHF** should consider the use of another tool for barrier analysis that may lead to a new or revised intervention.	**NHHF** has used the tools suggested by HSAG to identify other barriers for this measure (key driver diagram, root cause analysis worksheet, and comparative analysis). The results of this evaluation will be shared with the internal HEDIS Steering Committee. The measure is followed closely by QI staff, and more intensive outreach is anticipated for the current year.
	Well-Child Visits for 3-to-6-Year-Olds: **NHHF** should consider any applicable strategies, processes, or lessons learned from one of the other successful PIPs.	**NHHF** has reviewed the other PIPs, in addition to study results publicized on the subject, and concluded that direct member contact is the best form of outreach to encourage compliancy with well visits. Calls to members, together with mailers as reminders, tend to provide the most improvement. These calls were conducted in 2018 and outreach is ongoing this current year. **NHHF** will continue to explore different outreach methodologies and analyze language barriers and the timing of these initiatives to identify any missed opportunities to improve our well visits.

HEDIS

NHHF contracted with a NCQA Licensed Organization to have its measure rates reviewed by a CHCA. **NHHF** also contracted with an external software vendor to assist in HEDIS measure production and rate calculation. The rates for two HEDIS measures fell below the 25th percentile for the HEDIS Audit Means and Percentiles (national Medicaid HMO percentiles). The opportunities for improvement in HEDIS for **NHHF** are shown in Table 5-3.

Table 5-3—Follow-Up Activities by NHHF to Improve HEDIS Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by NHHF
HEDIS	*Chlamydia Screening in Women—Total*	Chlamydia testing continues to be a challenge in the State of New Hampshire. Younger members between the ages of 16 and 20 years consistently have the lowest rate of compliance. **NHHF** has requested input from multiple pediatric providers to ascertain the barrier for this testing. We will continue to outreach to providers and members, review the barriers, and attempt to educate members about the need for testing. **NHHF** will collaborate with the other Medicaid MCOs in the State to prioritize this initiative and provide a unified approach to the provider community.
	Diabetes Monitoring for People With Diabetes and Schizophrenia	Members who are diagnosed with diabetes or schizophrenia are monitored regularly by **NHHF** for follow-up care, including HbA1c monitoring annually and well visits, which include annual standard laboratory testing. Outreach is completed to providers who prescribe medications to members with a diagnosis of schizophrenia with the intent of encouraging them to see members regularly for monitoring. However, due to the sensitive diagnosis of this measure and respect for member privacy, direct member outreach is not the preferred tactic to improve this measure. **NHHF** has been coordinating with CMHCs who provide much of the behavioral health services in our network and other providers who care for members with this diagnosis. Collaboration between PCPs and behavioral health care providers has improved in the State of New Hampshire due to involvement in Integrated Delivery Networks and other options for care coordination. **NHHF** is reviewing opportunities to encourage care coordination between these provider types and will evaluate possible initiatives throughout the year.

EDV

During SFY 2018, HSAG continued to use an EDQRS to evaluate the quality of encounter data files submitted by the MCOs. The rates for the validity of the member identification number and the timeliness of the submission of claim payment fell below the standard of 100 percent, and the rate for the validity of servicing provider information fell below the standard of 98 percent. The opportunities for improvement in EDV for **NHHF** are shown in Table 5-4.

Table 5-4—Follow-Up Activities by NHHF to Improve EDV Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by NHHF
Encounter Data Validation (EDV)	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	These discrepancies are related to a timing issue due to retroactive eligibility terminations. **NHHF** will continue to ensure the eligibility files are processed immediately upon receipt and review encounter rejections as they are received.
	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	These discrepancies are related to a timing issue due to retroactive eligibility terminations. **NHHF** will continue to ensure the eligibility files are processed immediately upon receipt and review encounter rejections as they are received.
	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	These discrepancies are related to a timing issue due to retroactive eligibility terminations. **NHHF** will continue to ensure the eligibility files are processed immediately upon receipt and review encounter rejections as they are received.
	837I: Validity of Servicing Provider Information—Percent Valid	**NHHF** will look to add additional upfront and post-scrub edits to identify if the provider is not registered with Medicaid.
	837P: Timeliness—Submission Within 30 Days of Claim Payment	For the 837I and 837P, **NHHF** is reviewing which post scrubs can be turned off to ensure all encounters are submitted within 30 days of claim payment.
	837I: Submission Within 30 Days of Claim Payment	For the 837I and 837P, **NHHF** is reviewing which post scrubs can be turned off to ensure all encounters are submitted within 30 days of claim payment.
	NCPDP: Submission Within 30 Days of Claim Payment	For NCPDP, **NHHF** is requesting that the pharmacy vendor, CVS, provide timeliness reports upon submission of their files to ensure all NCPDP encounters are meeting the timeliness measure.

Well Sense

The SFY 2018 EQR Technical Report contained opportunities for improvement for **Well Sense** in the contract compliance audit, PIPs, CAHPS, HEDIS, and EDV. Table 5-5 through Table 5-9 display the self-reported follow-up activities conducted by **Well Sense** during SFY 2019 to correct the issues identified as requiring improvement.

MCO Contractual Compliance

HSAG conducted a Contract Compliance Audit to assess MCO performance with respect to requirements found in 42 CFR §438 and the DHHS contract with **Well Sense**. HSAG reviewed 14 standards containing 128 applicable elements for **Well Sense**. HSAG received a CAP from **Well Sense** for the elements found non-compliant in two standards (i.e., Delegation and Subcontracting and Plans Required by Contract), and all items were found to be compliant with the revisions instituted by **Well Sense** in the CAPs completed in August 2018.

Table 5-5 contains a list of the recommendations from the SFY 2018 New Hampshire Compliance Review and **Well Sense**'s response concerning the follow-up activities conducted to improve the activity.

Table 5-5—Follow-Up Activities by Well Sense to Improve MCO Contractual Compliance Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-up by Well Sense
Contract Compliance Audit	*Delegation and Subcontracting:* The MCO has a written agreement between the MCO and each subcontractor in which the subcontractor: a. Agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and MCO contract provisions; b. Agrees to hold harmless DHHS, and its employees, and all members served under the terms of this Agreement in the event of non-payment by the MCO; c. Agrees to indemnify and hold harmless DHHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against DHHS or its employees through intentional misconduct, negligence, or omission of the subcontractor or its agents, officers, employees, or contractors; d. Agrees that the State, CMS, the HHS Inspector General, or their designees have the right to audit,	HSAG found that five subcontract agreements did not meet all requirements included in this element. During the CAP process, **Well Sense** submitted contract addendums for the five subcontract agreements, and the addendums met the requirements of this element. **Well Sense** completed the CAP for this element.

EQR Activity	Measure Standard	Follow-up by Well Sense
Contract Compliance Audit	evaluate, and inspect any premises, physical facilities, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of the MCO Managed Care activities; e. Agrees that it can be audited for 10 years from the final date of the contract period or from the date of any completed audit, whichever is later; and f. Agrees that the State, CMS, or the HHS Inspector General can conduct an audit at any time if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk.	
	Delegation and Subcontracting: The written agreement between the MCO and the subcontractor specifies the activities and responsibilities delegated to the subcontractor and a transition plan in the event of termination and provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate as determined by the MCO or DHHS. In the written agreement, the subcontractor also agrees to perform the delegated activity and related reporting responsibilities, as specified in the subcontractor agreement and the applicable responsibilities in the Agreement.	HSAG found that one subcontract agreement did not include the requirements of this element. **Well Sense** submitted a contract addendum for that subcontractor, which included the requirements noted in this element. **Well Sense** completed the CAP for this element.
	Plans Required by Contract: The MCO submits an updated communications plan to DHHS for review and approval at least 60 calendar days prior to the commencement of each Agreement year.	HSAG found that **Well Sense** did not submit an updated communication plan to DHHS, as required in this element. **Well Sense** reported that the requirement to submit the updated communications plan was added to the rolling reporting log for all DHHS documents. The master grid of the submissions to DHHS will provide **Well Sense** staff members with the ability to monitor the timeline to ensure submission at least 60 calendar days prior to the commencement of each Agreement year. **Well Sense** completed the CAP for this element.

PIPs

HSAG validated three PIPs submitted by **Well Sense**: *Chlamydia Screening*, *Reducing Hospital Readmissions (to New Hampshire Hospital)*, and *Well-Child Visits for 3-to-6-Year-Olds.* HSAG validated the three PIPs through the design, implementation, and outcomes phase of the PIP process. One PIP, *Chlamydia Screening*, achieved statistically significant improvement over baseline at Remeasurement 2. The SFY 2018 New Hampshire EQR Technical Report contained opportunities for improvement for the additional two PIPs, as noted below.

Table 5-6—Follow-Up Activities by Well Sense to Improve PIP Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by Well Sense
PIPs	*Reducing Hospital Readmissions to New Hampshire Hospital*	QI is focused on sustained improvement over time through multiple cycles of testing to see what will improve, using more than one intervention throughout the process. Although the short-term effectiveness analysis did not demonstrate statistically significant improvement, we successfully sustained improvement as a result of multiple interventions. **Well Sense** continues to develop and implement interventions to continue to reduce New Hampshire Hospital readmissions.
	Well-Child Visits for 3-to-6-Year-Olds	QI is focused on sustained improvement over time through multiple cycles of testing to see what will improve, using more than one intervention throughout the process. **Well Sense** successfully sustained improvement over the baseline based on the administrative rates monitored throughout the year; however, based on the sample in the hybrid results for the short term effectiveness analysis, we were unable to demonstrate the same trend. **Well Sense** continues to develop and implement interventions to increase the well child visit rates for members 3–6 years old.

CAHPS

Well Sense was responsible for obtaining a NCQA-certified HEDIS/CAHPS survey vendor to administer the survey to adult members and parents or caretakers of child members, and the process to complete the surveys followed NCQA's 2018 data collection protocol. One rate generated by responses from **Well Sense**'s adult members was below the 2017 NCQA national average, as shown below.

Table 5-7—Follow-Up Activities by Well Sense to Improve CAHPS Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by Well Sense
Adult CAHPS	*Rating of Personal Doctor*	**Well Sense** implemented a number of activities as shown below: • Included the "How to prepare for your next doctor's visit" article in member newsletter to educate members about Coordination of Care. • Used member newsletter to encouraged members to schedule an appointment with their PCP. • Asked Member Advisory Council for qualitative feedback on *Rating of Personal Doctor*. • Fielded off-cycle CAHPS survey that included custom questions around experience with doctor: – How many days did you usually have to wait for an appointment when you needed care right away? – How many days did you usually have to wait for an appointment for a check-up or routine care? – Did you need care during evenings, weekends, or holidays? – What are the most important things that you look for in a health care provider and the staff in his or her office? – Focus on any experience with your provider and the staff in his or her office that you wish had gone differently. Please explain what happened. • Reviewed GeoAccess and Lead Time reports to identify potential gaps in access/availability. • Explored whether prior-authorization policies caused additional re-direction for New Hampshire members back to New Hampshire providers.

HEDIS

Well Sense contracted with an NCQA licensed organization to have its measure rates reviewed by a CHCA. **Well Sense** also contracted with an external software vendor to assist in HEDIS measure production and rate calculation. The rates for two HEDIS measures fell below the 25th percentile for the HEDIS Audit Means and Percentiles (national Medicaid HMO percentiles). The opportunities for improvement in HEDIS for **Well Sense** are shown in the tables below.

Table 5-8—Follow-Up Activities by Well Sense to Improve HEDIS Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by Well Sense
HEDIS	*Chlamydia Screening in Women—Total*	**Well Sense** continues to implement interventions to improve this measure; however, there are many barriers that prevent the rate from increasing. Some barriers include provider concern for member confidentiality. Commercial payers are required to send evidence of benefits documents to the household after a treatment, which may contain chlamydia testing information in the document. One concern for providers is that the guardian/parent may find out and raise concerns about the test. In order to prevent a breach of confidentiality, providers are choosing to perform the chlamydia test without sending a claim; members also go to clinics where the tests are performed for free based on grants. The stigma of having these tests is a barrier with providers and with guardians/parents of members in the age cohort with the lowest compliance (16–20). **Well Sense** continues to work with providers to share best practices and offer incentives to members and education to parents/guardians. **Well Sense** will continue to develop and implement interventions to achieve improvement in the rate and performance compared to national benchmarks.
	Diabetes Monitoring for People With Diabetes and Schizophrenia	**Well Sense** is working with providers to improve this measure through education and best practices. Member letters are also being distributed to encourage talking to the doctor about diabetes monitoring. **Well Sense** is also performing outreach calls to members, reminding them of the importance of annual screenings. Further drilldown of members in the cohort is being performed to identify more targeted outreach and educational opportunities.

EDV

During SFY 2018, HSAG continued to use an EDQRS to evaluate the quality of encounter data files submitted by the MCOs. The rates for the validity of the member identification number, timeliness of weekly submissions, and timeliness of the submission of claim payment fell below the standard of 100 percent. The validity of servicing provider information fell below the standard of 98 percent. The opportunities for improvement in EDV for **Well Sense** are shown in the tables below.

Table 5-9—Follow-Up Activities by Well Sense to Improve EDV Recommendations from the SFY 2018 EQR Technical Report

EQR Activity	Measure Standard	Follow-Up by Well Sense
EDV	837 Professional Encounters (837P): Validity of Member Identification Number—Percent Valid	As directed by DHHS/HSAG during a call on 1/29/2020, **Well Sense** modified its validation activities and has implemented a new member identification number validation which has shown to be effective. In reviewing distinct active members with professional paid claims for the period 7/1/2017 and 6/30/2018, **Well Sense**'s result on this measure was found to be 99.99%. **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** provides each with membership data to be loaded into their systems for payment of claims in timely manner. In cases where a claim is paid for an ineligible member, the vendor would recoup and reprocess the claim under updated eligibility information. **Well Sense** continues to work closely with vendors on process improvements. **Well Sense** will review the process and work with vendors in the event this scenario occurs to adjust the claims and membership information appropriately and to return it to **Well Sense**.
	837 Institutional Encounters (837I): Validity of Member Identification Number—Percent Valid	As directed by DHHS/HSAG during a call on 1/29/2020, **Well Sense** modified its validation activities and has implemented a new member identification number validation which has shown to be effective. In reviewing distinct active members with professional paid claims for the period 7/1/2017 and 6/30/2018, **Well Sense**'s result on this measure was found to be 99.99%. **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** provides each with membership data to be loaded into their systems for payment of claims in timely manner. In cases where a claim is paid for an ineligible member, the vendor would recoup and reprocess the claim under updated eligibility information. **Well Sense** continues to work closely with vendors on process improvements. **Well Sense** will review the process and work with vendors in the event this scenario occurs to adjust the claims and membership information appropriately and to return it to **Well Sense**.

EQR Activity	Measure Standard	Follow-Up by Well Sense
EDV	Pharmacy Encounters: National Council for Prescription Drug Program (NCPDP): Validity of Member Identification Number—Percent Valid	**Well Sense** delegates management of certain administrative functions to its vendor partners, including its pharmacy benefit manager (PBM). In these cases, **Well Sense** is responsible for providing each vendor partner with current and complete membership data, with each vendor subsequently responsible for loading the data into their respective systems in a timely basis. **Well Sense** works closely with all vendors on a regular basis, including our PBM, on process improvements similar to those in this scenario, and will continue ongoing monitoring activities.
	837I: Validity of Servicing Provider Information—Percent Valid	As directed by DHHS/HSAG during a call on 1/29/2020, **Well Sense** modified its validation activities and has implemented a new servicing provider NPI number validation which has shown to be effective. In reviewing all distinct paid professional claims for the period 7/1/2017 and 6/30/2018, **Well Sense**'s result on this measure was found to be 99.99%. **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment. In these cases, **Well Sense** provides each with membership data to be loaded into their systems for payment of claims in timely manner. In cases where a claim is paid for an ineligible member, the vendor would recoup and reprocess the claim under updated eligibility information. **Well Sense** continues to work closely with vendors on process improvements and on monitoring this measure.
	837P: Timeliness—Weekly Submissions	**Well Sense**'s modified validation approach was directed by DHHS and HSAG during a call on 1/29/2020. The requirement and approach were documented and reviewed with DHHS/HSAG. **Well Sense** has implemented a new weekly submission validation process with results for this measure at 100%. As with other measures, **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** continues to work closely with vendors on process improvements and on monitoring this measure.
	837I: Timeliness—Weekly Submissions	**Well Sense**'s modified validation approach was directed by DHHS and HSAG during a call on 1/29/2020. The requirement and approach were documented and reviewed with DHHS/HSAG. **Well Sense** has implemented a new weekly submission validation process with results for this measure at 100%. As with other measures, **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** continues to work closely with vendors on process improvements and on monitoring this measure.

EQR Activity	Measure Standard	Follow-Up by Well Sense
EDV	837P: Timeliness—Submission Within 30 Days of Claim Payment	**Well Sense**'s modified validation approach was directed by DHHS and HSAG during a call on 1/29/2020. The requirement and approach were documented and reviewed with DHHS/HSAG. With this new approach, **Well Sense** has seen the result for this measure increase to 76.46%. During this time period, **Well Sense** had an error in the claims submission process where claims submitted without the payment details. This error was fixed to ensure future claims submission are complete with all required payment information. **Well Sense** also successfully resubmitted the claims with complete payment information. As with other measures, **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** continues to work closely with vendors on process improvements and on monitoring this measure to ensure quality data is submitted. Additionally, **Well Sense** tracks internally the timeliness standard as it applies to claims that we send to DHHS for the weekly encounters process, and will continue to work with DHHS on a periodic basis to review specific issues and develop new business rules to be included as part of data validation rule in appropriate scenarios or apply for waivers for the DHHS exception process.
	837I: Submission Within 30 Days of Claim Payment	**Well Sense**'s modified validation approach was directed by DHHS and HSAG during a call on 1/29/2020. The requirement and approach were documented and reviewed with DHHS/HSAG. With this new approach, **Well Sense** has seen the result for this measure increase to 41.86%. During this time period, **Well Sense** had an error in the claims submission process where claims submitted without the payment details. This error was fixed to ensure future claims submission are complete with all required payment information. **Well Sense** also successfully resubmitted the claims with complete payment information. As with other measures, **Well Sense** delegates management of certain administrative functions to vendor partners (i.e., behavior health, non-emergency medical transportation, pharmacy, and durable medical equipment). In these cases, **Well Sense** continues to work closely with vendors on process improvements and on monitoring this measure to ensure quality data is submitted. Additionally, **Well Sense** tracks internally the timeliness standard as it applies to claims that we send to DHHS for the weekly encounters process, and will continue to work with DHHS on a periodic basis to review specific issues and develop new business rules to be included as part of data validation rule in appropriate scenarios or apply for waivers for the DHHS exception process.

EQR Activity	Measure Standard	Follow-Up by Well Sense
EDV	NCPDP: Submission Within 30 Days of Claim Payment	**Well Sense** is collaboratively working with its PBM to review the claim reporting specifications to ensure the PBM is adhering to the specifications provided by DHHS and populating all required fields, including but not limited to capturing the claim adjudication date. Submissions are carefully monitored by **Well Sense** staff and regular, ongoing conversations are occurring between **Well Sense** and PBM leadership to ensure that future submissions are timely and result in a favorable, upward trend.

Appendix A. Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

- **AAP—**Adults' Access to Preventive/Ambulatory Health Services
- **ABX—**Antibiotic Utilization
- **ACE—**angiotensin converting enzyme
- **ADD—**Follow-up Care for Children Prescribed ADHD Medication
- **ADHD—**attention deficit/hyperactivity disorder
- **AMB—**Ambulatory Care
- **AMM—**Antidepressant Medication Management
- **AMR—**Asthma Medication Ratio
- **ANSI—**American National Standards Institute
- **AOD—**Alcohol and Other Drug Dependence
- **APM—**Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **APP—**Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics
- **ARB—**angiotensin receptor blocker
- **ASAM—**American Society for Addiction Medicine
- **AWC—**Adolescent Well-Care Visits
- **BBA—**federal Balanced Budget Act of 1997
- **BCCP—**Breast and Cervical Cancer Program
- **BMI—**body mass index
- **CAHPS—**Consumer Assessment of Healthcare Providers and Systems
- **CAP—**Children and Adolescents' Access to Primary Care Practitioners
- **CAP—**corrective action plan
- **CBP—**Controlling High Blood Pressure
- **CCC—**Children with Chronic Conditions
- **CCS—**Cervical Cancer Screening
- **CDC—**Comprehensive Diabetes Care
- **CFR—**Code of Federal Regulations
- **CHCA—**Certified HEDIS compliance auditor
- **CHL—**Chlamydia Screening in Women

- **CIS—**Childhood Immunization Status
- **CM—**clinical modification
- **CMHC**—Community Mental Health Center
- **CMS—**Centers for Medicare & Medicaid Services
- **COPD—**chronic obstructive pulmonary disease
- **CT—**Computerized Tomography
- **CWP—**Appropriate Testing for Children with Pharyngitis
- **CY—**calendar year
- **DHHS—**State of New Hampshire, Department of Health and Human Services
- **DTaP—**diphtheria, tetanus, and acellular pertussis vaccine
- **ED—**emergency department
- **EDA—**Encounter Data Accuracy
- **EDC—**Encounter Data Completeness
- **EDI—**electronic data interchange
- **EDQRS—**Encounter Data Quality Reporting System
- **EDT—**Encounter Data Timeliness
- **EDV—**encounter data validation
- **EMR—**electronic medical record
- **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
- **FMEA—**failure modes and effects analysis
- **FUH—**Follow-up After Hospitalization for Mental Illness
- **HbA1c—**hemoglobin A1c; a measure of longer-term glucose management
- **HEDIS—**Healthcare Effectiveness Data and Information Set
- **HepA—**hepatitis A vaccine
- **HepB—**hepatitis B vaccine
- **HHS—**Health and Human Services
- **HiB—**Haemophilus influenzae type B
- **HIPAA—**Health Insurance Portability and Accountability Act of 1996
- **HIV—** Human Immunodeficiency Virus
- **HMO—**Health Maintenance Organization

- **HSAG—**Health Services Advisory Group, Inc.
- **I—**institutional
- **IAD—**Identification of Alcohol and Other Drug Services
- **ICD—**International Classification of Diseases
- **IDSS—**Interactive Data Submission System
- **IET—**Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment
- **IMA—**Immunizations for Adolescents
- **IPV—**polio vaccine
- **IS—**information system
- **ISCAT—**Information System Capability Assessment Tool
- **LBP—**Use of Imaging Studies for Low Back Pain
- **LDL-C—**Low-density lipoprotein-cholesterol
- **LO—**National Committee for Quality Assurance-Licensed Organization
- **LOC—**Level of Care
- **MCM—**Medicaid Care Management
- **MCO—**managed care organization
- **MMA—**Medication Management for People with Asthma
- **MMIS—**New Hampshire Medicaid Management Information System
- **MMR—**measles, mumps, and rubella vaccine
- **MPM—**Annual Monitoring for Patients on Persistent Medications
- **MPT—**Mental Health Utilization
- **MRI—**Magnetic Resonance Imaging
- **MS-DRG**—Medicare Severity Diagnosis Related Group
- **N—**number
- **NA—**not applicable; for HEDIS, small denominator
- **NB—**no benefit
- **NCPDP—**National Council for Prescription Drug Program
- **NCQA—**National Committee for Quality Assurance
- **NCS—**Non-recommended Cervical Cancer Screening in Adolescent Females
- **NHHF—**New Hampshire Healthy Families
- **NHHPP—**New Hampshire Health Protection Program
- **NPI—**National Provider Identifier
- **NR—**not reported
- **OB/GYN—**obstetrician/gynecologist

- **P—**professional
- **PAHP—**prepaid ambulatory health plan
- **PAP—**Premium Assistance Program
- **PBM—**Pharmacy Benefit Manager
- **PCCM—**primary care case management
- **PCE—**Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation
- **PCP—**primary care provider
- **PCV—**pneumococcal conjugate vaccine
- **PDSA—**Plan-Do-Study-Act
- **PIHP—**prepaid inpatient health plan
- **PIP—**performance improvement project
- **PMV—**performance measure validation
- **POC—**point of contact
- **PPC—**Prenatal and Postpartum Care
- **QHP—**Qualified Health Plan
- **QI—**quality improvement
- **R—**report
- **RV—**rotavirus
- **SAA—**Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **SAC—**Submission Accuracy and Completeness
- **SFTP—** secure file transfer protocol
- **SFY—**state fiscal year
- **SHCN—**special health care needs
- **SMD—**Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SPHA—**Symphony Performance Health Analytics
- **SSD—**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- **STD—**Sexually Transmitted Disease
- **SUD—**substance use disorder
- **Tdap—**tetanus, diphtheria, and acellular pertussis vaccine
- **TPA—**Third Party Administrator
- **TPL**—third party liability
- **UM**—utilization management
- **URI—**Appropriate Treatment for Children with Upper Respiratory Infection

- **VBP—**value-based purchasing
- **VZV—**varicella (chicken pox) vaccine
- **W15—**Well-Child Visits in the First 15 Months of Life
- **W34—**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- **WCC—**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Appendix B. Methodologies for Conducting EQR Activities

MCO Contractual Compliance

According to 42 CFR §438.358(b)(1)(iii), for each MCO, PIHP, or PAHP a review, conducted within the previous 3-year period, must be performed to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in 42 CFR §438 Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330.[B-1] The standards evaluated during the compliance reviews must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access to care, structure and operations, and quality measurement and improvement.[B-2] To meet these requirements, DHHS:

- Continued to ensure that its agreement with the MCOs included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- Contracted with HSAG as its EQRO to conduct reviews to assess the MCOs' performance in complying with the federal Medicaid managed care regulations and DHHS's agreement with **NHHF** and **Well Sense**.
- Maintained its focus on encouraging and supporting the MCOs in targeting areas for continually improving its performance in providing quality, timely, and accessible care to members.

The primary objective of HSAG's compliance review is to provide meaningful information to DHHS and the MCOs that can be used to:

- Evaluate the quality of care, timeliness of care, and access to care and services the MCOs furnished to members.
- Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services for the New Hampshire MCM Program.

To conduct a compliance review, HSAG assembles a review team to:

- Collaborate with DHHS to determine the scope of the review as well as the scoring methodology; data collection methods; desk review, on-site review activities, and timelines; and on-site review agenda.
- Collect data and documents from the MCOs and review the information before and during the on-site review.
- Conduct the on-site review.

B-1 U. S. Government Printing Office. (2019). *Activities related to external quality reviews.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Jan 2, 2019.

B-2 U. S. Government Printing Office. (2019). *Activities related to external quality reviews.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Jan 2, 2019.

- Aggregate and analyze the data and information collected.
- Prepare the report of its findings and any recommendations or suggestions for improvement.

Table B-1 contains the 9-step process HSAG uses to conduct a compliance review.

Table B-1—The Compliance Review Methodology

Step 1:	**Establish the review schedule.**
	HSAG works with DHHS and the MCOs before the review to establish the on-site review schedule and assigns HSAG reviewers to the review team.
Step 2:	**Prepare the data collection tool and submit it to DHHS for review and comment.**
	To ensure that all applicable information is collected, HSAG develops a compliance review tool consistent with CMS protocols. HSAG uses the requirements in the Agreement between DHHS and the MCOs to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also uses the federal Medicaid managed care regulations described at 42 CFR §438. Additional criteria that are critical in developing the monitoring tool include applicable State and federal requirements. Prior to finalizing the tool, HSAG submits the draft to DHHS for its review and comments.
Step 3:	**Prepare and submit the Compliance Information Letter to the MCOs.**
	HSAG prepares and forwards a letter to the MCOs and requests that the MCOs submit information and documents to HSAG by a specified date. The letter includes instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's on-site review.
Step 4:	**Develop an on-site review agenda and submit the agenda to DHHS and the MCOs.**
	HSAG develops the agendas to assist the MCO staff members in planning to participate in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames allotted for the reviews.
Step 5:	**Provide technical assistance.**
	As requested by the MCOs, and in collaboration with DHHS, HSAG staff members respond to any MCO questions concerning the requirements HSAG uses to evaluate MCO performance during the compliance reviews. Frequently when an MCO is new to a state, HSAG conducts a webinar to explain information about the compliance review activity.

Step 6:	Receive MCOs' documents for HSAG's desk review and evaluate the information before conducting the on-site review.
	The HSAG team reviews the documentation received from the MCOs to gain insight into access to care and timeliness and quality of care, and the organization's structure, services, operations, resources, information systems, quality program, and delegated functions. The team then begins compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers: • Document findings from the review of the materials submitted as evidence of MCOs' compliance with the requirements. • Identify areas and issues requiring further clarification or follow-up during the on-site interviews. • Identify information not found in the desk review documentation to be requested during the on-site review.
Step 7:	**Conduct the on-site portion of the review.**
	Staff members from the MCO answer questions during the on-site review to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: • Conduct an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, MCO's overview of its structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. • Conduct interviews with the MCO's staff. HSAG uses the interviews to obtain a complete picture of the MCO's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of MCO's performance. • Review additional documentation. The HSAG on-site team reviews additional documentation and uses the review tool to identify relevant information sources. Documents required for the on-site review include, but are not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. While on-site, MCO staff members also discuss the organization's information system data collection process and reporting capabilities related to the standards included in the review. • Summarize findings at the completion of the on-site portion of the review. As a final step, HSAG conducts a closing conference to provide the MCO's staff members and DHHS with a high-level summary of HSAG's preliminary findings. For each of the standards, a brief overview is given that includes HSAG's assessment of the MCO's strengths; if applicable, any area requiring corrective action; and HSAG's suggestions for further strengthening the MCO's processes, performance results, and/or documentation.

Step 8:	Calculate the individual scores and determine the overall compliance score for performance.
	HSAG evaluates and analyzes the MCOs' performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which each MCO complies with each of the requirements. A designation of not applicable (*NA)* is used if an individual requirement does not apply to the MCO during the period covered by the review. For each of the standards, HSAG calculates a percentage of compliance rate and then an overall percentage of compliance score across all standards.
Step 9:	**Prepare a report of findings.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepares a draft report that describes HSAG's compliance review findings; the scores assigned for each requirement within each standard; and HSAG's assessment of each MCO's strengths, any areas requiring corrective action, and HSAG's suggestions for further enhancing the MCO's performance results, processes, and/or documentation. HSAG forwards the report to DHHS for review and comment. Following DHHS's review of the draft, HSAG sends the draft report to the MCOs. After the MCO review, HSAG issues the final report.

Determining Conclusions

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.

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*.

Information Reviewed During the 2014–2019 Compliance Reviews

The SFY 2014 compliance activities consisted of reviewing 14 standards containing 294 elements for **NHHF** and 295 elements for **Well Sense**. Since that time, HSAG has reviewed one-third of the elements in the standards each year with a few exceptions. In 2016, DHHS requested that HSAG include all elements from the SUD standard which increased the number of standards to 15. HSAG reviewed the entire SUD standard in 2016 and 2019.

HSAG included 14 standards in four of the six years, and in the remaining two years, HSAG reviewed 12 and 13 standards. When a standard was not included in the compliance review, DHHS agreed to eliminate the review of that standard due to the few number of elements that year. HSAG added those elements to the standard in the next year's compliance review. The only exception to that process was the SUD review, which contained the entire standard each time it was reviewed, and the care management/care coordination standard. In 2016 HSAG conducted a quality study concerning the care management/care coordination processes and systems at **NHHF** and **Well Sense**. Due to many of the same requirements being contained in the quality study and the compliance review, DHHS requested that the results of the quality study be used to satisfy the requirement to review that standard in 2016. Table B-2 displays the names of the standards and indicates their inclusion in the compliance reviews from 2014–2019.

Table B-2—Standards Included in the NHHF and Well Sense Compliance Reviews 2014–2019

	Standard Name	2014	2015	2016	2017	2018	2019
I.	Delegation and Subcontracting	X	X	X	X	X	
II.	Plans Required by the Contract	X	X	X	X	X	X
III.	Emergency and Post-Stabilization Care	X	X	X	X	X	
IV.	Care Management/Care Coordination	X	X		X	X	X
V.	Wellness and Prevention	X	X		X	X	
VI.	Behavioral Health	X	X	X	X	X	X
VII.	Member Enrollment and Disenrollment	X	X	X	X	X	X

	Standard Name	2014	2015	2016	2017	2018	2019
VIII.	Member Services	X	X	X	X	X	X
IX.	Cultural Considerations	X	X	X	X	X	X
X.	Grievances and Appeals	X	X	X	X	X	X
XI.	Access	X	X	X	X	X	X
XII.	Network Management	X	X	X	X	X	X
XIII.	Utilization Management	X	X	X	X	X	X
XIV.	Quality Management	X	X	X	X	X	X
XV.	Substance Use Disorder			X			X

HSAG developed checklists to review items that are required in a specific area or a specific document. Table B-3 illustrates the 10 checklists created for the New Hampshire compliance reviews. The 2014 review included all 10 checklists, and no checklists were included in the 2015 and 2018 reviews. HSAG included nine of the checklists in the 2016 and 2017 reviews, and five checklists in the 2019 compliance review. HSAG retired the checklist for Culturally and Linguistically Appropriate Services due to changing requirements in the contract between the MCOs and DHHS.

Table B-3—Checklists Included in the NHHF and Well Sense Compliance Reviews

	Checklist	2014	2015*	2016	2017	2018*	2019
1.	Access Standards	X		X			X
2.	Call Center	X			X		
3.	Culturally and Linguistically Appropriate Services**	X					
4.	Provider Directory	X		X			X
5.	Member Handbook	X		X			X
6.	ID Cards	X			X		
7.	MCO website	X		X			X
8.	Network Management	X			X		
9.	Notice Requirements	X			X		
10.	Member Rights	X		X			X

* No checklists were included in the 2015 and 2018 compliance reviews.

** Requirements included in this checklist were revised in the contract between the MCOs and DHHS, and the checklist was retired.

HSAG included file reviews for grievances, appeals, denials of service, credentialing, and recredentialing in the 2014 compliance review. Five file reviews were dispersed between the compliance review in 2016 and the compliance review in 2017 as shown in Table B-4. No file reviews were included in the 2015 and 2018 compliance reviews; however, the 2019 review included three file reviews.

Table B-4—File Reviews Included in the NHHF and Well Sense Compliance Reviews

	File Reviews	2014	2015*	2016	2017	2018*	2019
1.	Grievances	X		X			X
2.	Appeals	X		X			X
3.	Denials of Service	X		X			X
4.	Credentialing	X			X		
5.	Recredentialing	X			X		

* No file reviews were included in the 2015 and 2018 compliance reviews.

PIPs

HSAG's PIP validation process includes two key components of the QI process:

Evaluation of the technical structure of the PIP to ensure that the MCO designed, conducted, and reported the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's evaluation determines whether the PIP design (e.g., study question, population, indicator(s), sampling techniques, and data collection methodology) is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and indicators used have the capability to achieve statistically significant and sustained improvement.

Evaluation of the Implementation of the PIP

Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves its rates by implementing effective processes (i.e., barrier analyses, intervention, and evaluation of results). HSAG conducts a critical analysis of the MCO's processes for identifying barriers and evaluating the effectiveness of interventions. HSAG presents detailed feedback based on the findings of this critical analysis. This type of feedback provides the MCO with guidance on how to refine its approach in identifying specific barriers that impede improvement, as well as identifying more appropriate interventions that can overcome these barriers and result in meaningful improvement in the targeted areas. The process also helps to ensure that the PIP is not simply an exercise in documentation, but that the process is fully implemented in a way that can positively affect health care delivery and/or outcomes of care.

HSAG uses an outcome-focused scoring methodology to rate a PIP's compliance with each of the 10 activities listed in the CMS protocols. HSAG's outcome-focused validation methodology places greater emphasis on actual study indicator(s) outcomes. Each evaluation element within a given activity will be given a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIP documentation and study indicator outcomes. *Not Applicable* is used for those situations in which the

evaluation element does not apply to the PIP. For example, in Activity V, if the MCO did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG uses the *Not Assessed* scoring designation when the PIP has not progressed to a particular activity.

In Activity IX (real improvement achieved), statistically significant improvement over the baseline must be achieved across all study indicators to receive a *Met* score. For Activity X (sustained improvement achieved), HSAG will assess for sustained improvement once each study indicator has achieved statistically significant improvement and a subsequent measurement period of data has been reported.

The goal of HSAG's PIP validation is to ensure that DHHS and other key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP. HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG will report the overall validity and reliability of the findings as one of the following:

- *Met* = high confidence/confidence in the reported findings.
- *Partially Met* = low confidence in the reported findings.
- *Not Met* = reported findings are not credible.

HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all the critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical evaluation element that receives a score of *Not Met* will result in an overall PIP validation rating of *Not Met*. A PIP that accurately documents CMS protocol requirements has high validity and reliability. Validity is the extent to which the data collected for a PIP measures its intent. Reliability is the extent to which an individual can reproduce the study results. For each completed PIP, HSAG assesses threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met, Partially Met*, and *Not Met*. The outcome of these calculations determines the validation status of *Met*, *Partially Met*, or *Not Met*.

PMV

Validation of performance measures, as set forth in 42 CFR §438.358(b)(1)(ii),[B-3] is one of the mandatory EQR activities. The primary objectives of the PMV process is to:

- Evaluate the accuracy of the performance measures data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

Table B-5 presents the 15 State-selected performance measures for the 2019 validation activities. HSAG completed the reports for this activity in March 2019.

Table B-5—Performance Measures Audited by HSAG for SFY 2019

Performance Measures
AMBCARE.18: Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
APPEALS.18: Services Authorized within 72 Hours Following a Reversed Appeal
BHDISCHARGE.02: Community Hospital Discharges for Mental Health Conditions Where Patient Had a Visit with a Mental Health Practitioner within 30 Calendar Days of Discharge by Subpopulation
GRIEVANCE.03: Member Grievances Received per 1,000 Member Months
NEMT.15: Non-Emergent Medical Transportation (NEMT) Services Delivered by Type of Medical Service
NHHDISCHARGE.16: New Hampshire Hospital Discharges—New Community Mental Health Center (CMHC) Patient Had an Intake Appointment With a CMHC within 7 Calendar Days of Discharge
PHARMQI.09: Safety Monitoring Prior Authorized Fills for Opioid Prescriptions with a Dosage Over 100 milligrams
CLAIM.01: Timely Professional and Facility Medical Claim Processing: 30 Calendar Days
CLAIM.09: Timely Professional and Facility Medical Claim Processing: 60 Days of Receipt
CLAIM.05: Claims Quality Assurance: Claims Processing Accuracy
CLAIMS.07: Claims Quality Assurance: Claims Financial Accuracy
CLAIMS.17: Average Pharmacy Claim Processing Time
NEMT.21: Non-Emergent Medical Transportation—Contracted Transportation & Wheelchair Van Provider Scheduled and Delivered Trips—Timeliness
SERVICEAUTH.03: Medical Service, Equipment, and Supply Service Authorization Timely (14 Day) Determination Rate: New Routine Requests
TPLCOB.03: Coordination of Benefits: Pharmacy Costs Recovered Claim Log

[B-3] U. S. Government Printing Office. (2019). *Activities related to external quality reviews.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Jan 2, 2019.

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[B-4]

The same process was followed for each PMV conducted by HSAG and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed MCO responses to the Information System Capability Assessment Tool (ISCAT); and (2) on-site activities such as interviews with staff members, primary source verification, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the MCOs' information system 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 an area of noncompliance was noted with any validation component listed in the CMS protocol, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

Each measure verified by the HSAG review team received an audit result consistent with one of the three designation categories listed in Table B-6.

Table B-6—Designation Categories for Performance Measures Audited by HSAG

Report (R)	Measure was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which the MCO rate was materially biased.
No Benefit (NB)	Measure was not reported because the MCO did not offer the benefit required by the measure.

[B-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Oct 25, 2019.

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

- Completed responses to the ISCAT by each MCO.
- Source code, computer programming, and query language (if applicable) used by the MCOs to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Final performance measure rates.

Information was also obtained through interaction, discussion, and formal interviews with key staff members, as well as through system demonstrations and data processing observations.

After completing the validation process, HSAG prepared a final report detailing the PMV findings and any associated recommendations for each MCO. These reports were provided to DHHS and to each MCO.

HEDIS

To draw conclusions about the quality and timeliness of, and access to, care provided by the MCOs, HSAG assigned each of the HEDIS measures to one or more of these three domains, as depicted in Table B-7. The measures marked N/A relate to utilization of services.

Table B-7—Assignment of HEDIS Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measures	Quality	Timeliness	Access
Prevention			
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total			✓
Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*			✓
Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	✓		
Adolescent Well-Care Visits (AWC)	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	✓		

Performance Measures	Quality	Timeliness	Access
Documentation—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*			
Childhood Immunization Status (CIS)—Combinations 2 and *10*	✓		
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	✓		
Cervical Cancer Screening (CCS)	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	✓		
Chlamydia Screening in Women (CHL)—Total	✓		
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Acute and Chronic Care			
Appropriate Testing for Children With Pharyngitis (CWP)	✓		
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	✓		
Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid and *Bronchodilator*	✓	✓	
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	✓		
Comprehensive Diabetes Care (CDC)—HbA1c Testing, *HbA1c Poor Control (>9.0%)*, and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure (CBP)	✓		
Use of Imaging Studies for Low Back Pain (LBP)	✓		
Asthma Medication Ratio (AMR)—Total	✓		
Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total	✓		
Ambulatory Care (Per 1,000 Member Months) (AMB)—ED Visits—Total	N/A	N/A	N/A
Antibiotic Utilization (ABX)—Percentage of Antibiotics of Concern for all Antibiotic Prescriptions—Total	N/A	N/A	N/A
Behavioral Health Measures			
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	✓	✓
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	✓	✓	✓

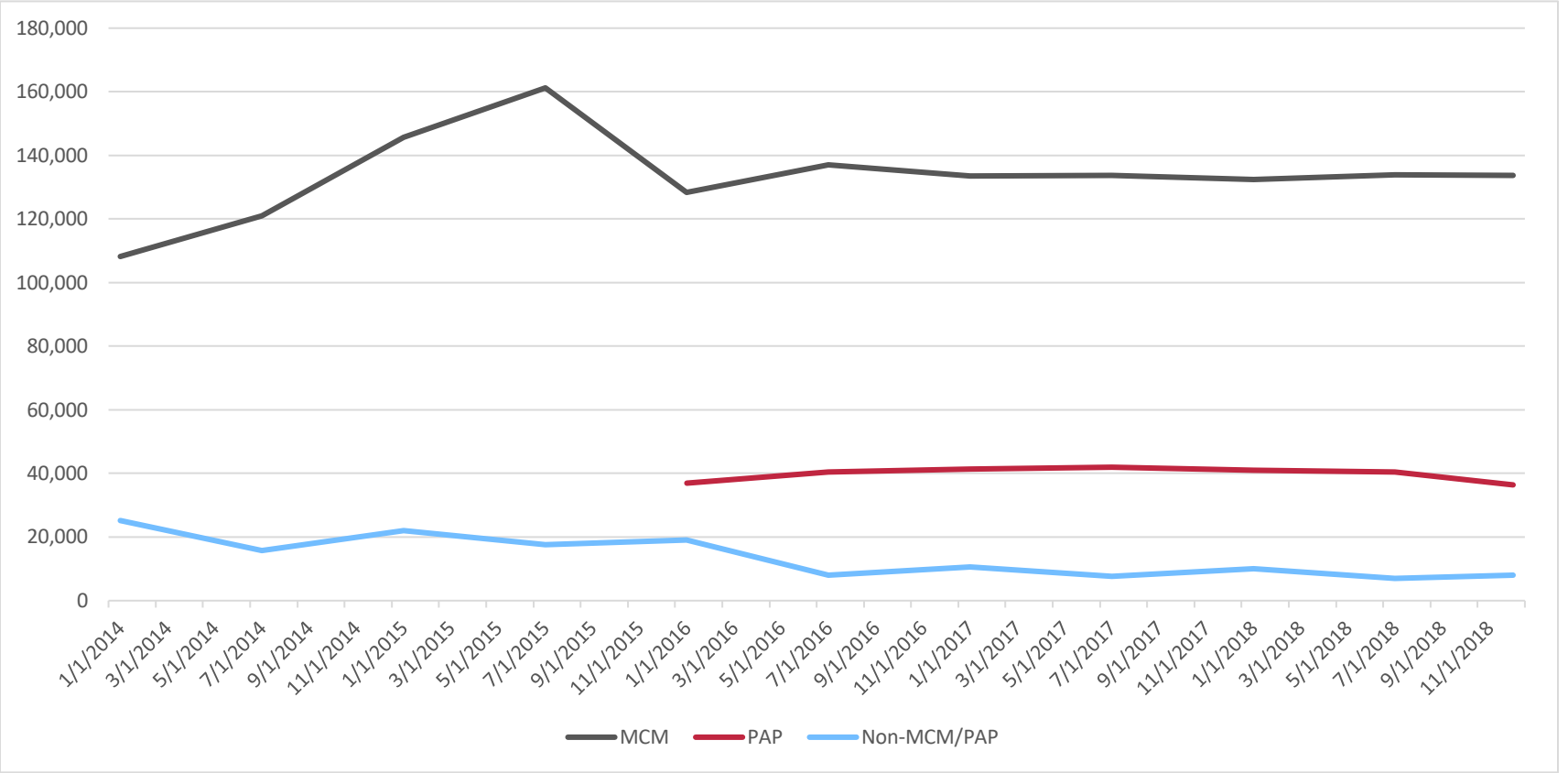
Performance Measures	Quality	Timeliness	Access
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total	✓		
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	✓	✓	✓
Identification of Alcohol and Other Drug Services (IAD)—Any Service	N/A	N/A	N/A
Mental Health Utilization (MPT)—Any Service	N/A	N/A	N/A

Appendix C. Demographics of the New Hampshire MCM Program

DHHS furnished the demographic information displayed in this section of the report.

The following figures provide information concerning enrollment in the New Hampshire MCM Program from its inception on December 2, 2013, to December 2, 2018. Charts also are included to indicate the eligibility categories for the **NHHF** and **Well Sense** membership on December 2, 2018, and the distribution of enrollment by county and by MCO. The average quarterly enrollment for the seven eligibility categories is shown in the tables at the end of this section.

Figure C-1—New Hampshire MCM Enrollment and Non-MCM Enrollment from December 1, 2013, to December 1, 2018



Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans).

New Hampshire Health Protection Program (NHHPP) members who enrolled after 10/1/2015 were temporarily assigned to a Non-MCM benefit plan in anticipation of the Premium Assistance Program (PAP) beginning on 1/1/2016, when they were placed in a Qualified Health Plan (QHP).

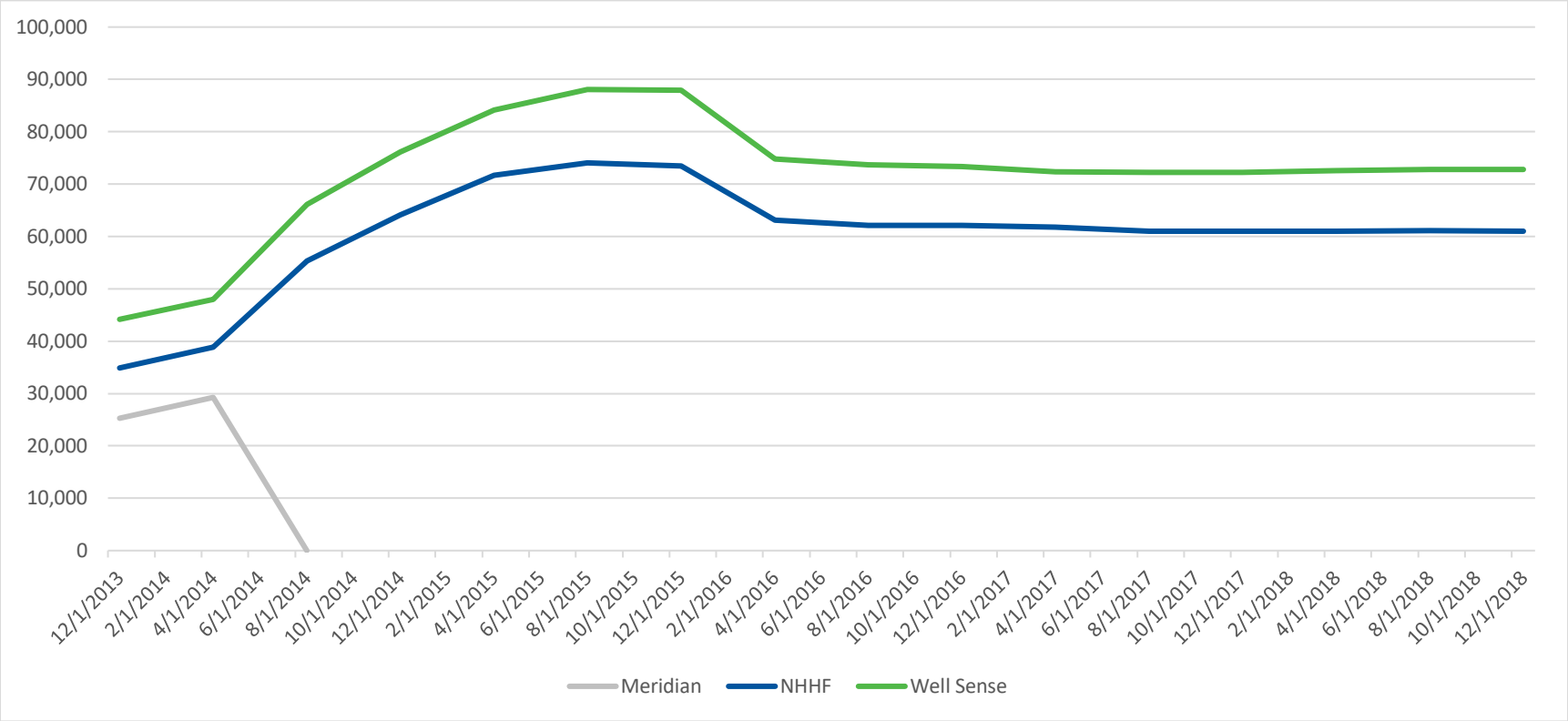
The NHHPP PAP began 1/1/2016, when members were moved from MCM or Non-MCM/PAP to a PAP QHP.

The 1915(b) population that began as voluntary in the MCM Program transitioned to mandatory as of 2/1/2016.

Source: New Hampshire MMIS as of 12/2/2018 for the most current period; data subject to revision.

Figure C-2 displays the enrollment in the MCOs since the inception of the MCM Program in New Hampshire.

Figure C-2—Enrollment in the New Hampshire MCM by MCO from December 2, 2013, to December 2, 2018



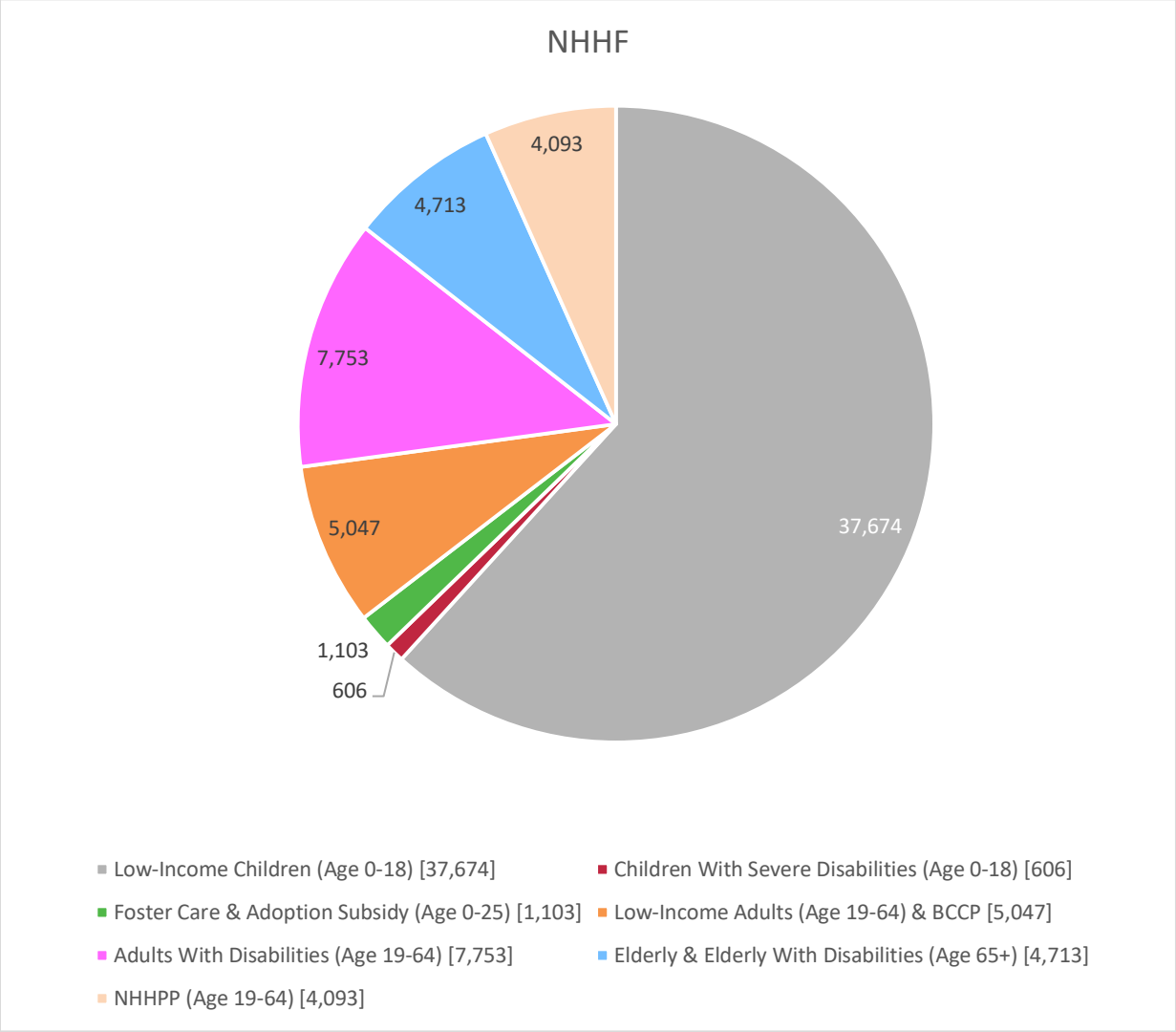
New NHHPP members who enrolled after 10/1/2015 were temporarily assigned to a Non-MCM benefit plan in anticipation of the PAP beginning on 1/1/2016, when they were placed in a QHP.

The NHHPP PAP began 1/1/2016, when members were moved from MCM or Non-MCM/PAP to a PAP QHP.

Source: New Hampshire MMIS as of 12/2/2018 for the most current period; data subject to revision.

Figure C-3 displays the **NHHF** eligibility categories of MCO members as of December 2, 2018.

Figure C-3—Point-in-Time Eligibility Category for NHHF as of December 2, 2018



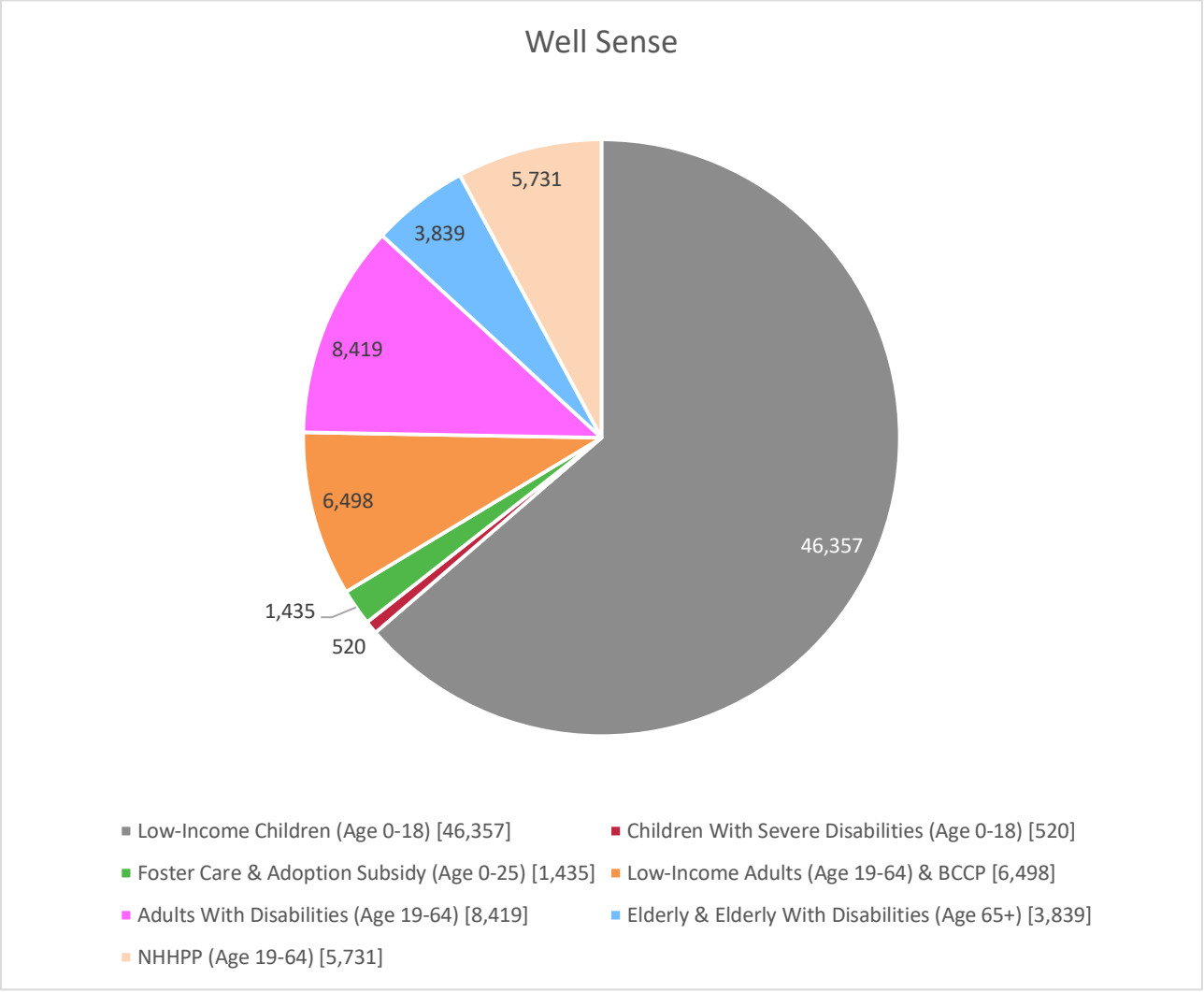
Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.

Source: New Hampshire MMIS as of 12/2/2018; data subject to revision.

The largest eligibility category, low-income children, represented 61.8 percent of **NHHF** members. The smallest eligibility category, children with severe disabilities, represented 1.0 percent of **NHHF** members. Total **NHHF** membership on December 1, 2018, in the seven eligibility categories was 60,989.

Figure C-4 displays the **Well Sense** eligibility categories of MCO members as of December 2, 2018.

Figure C-4—Point-in-Time Eligibility Category for Well Sense as of December 2, 2018



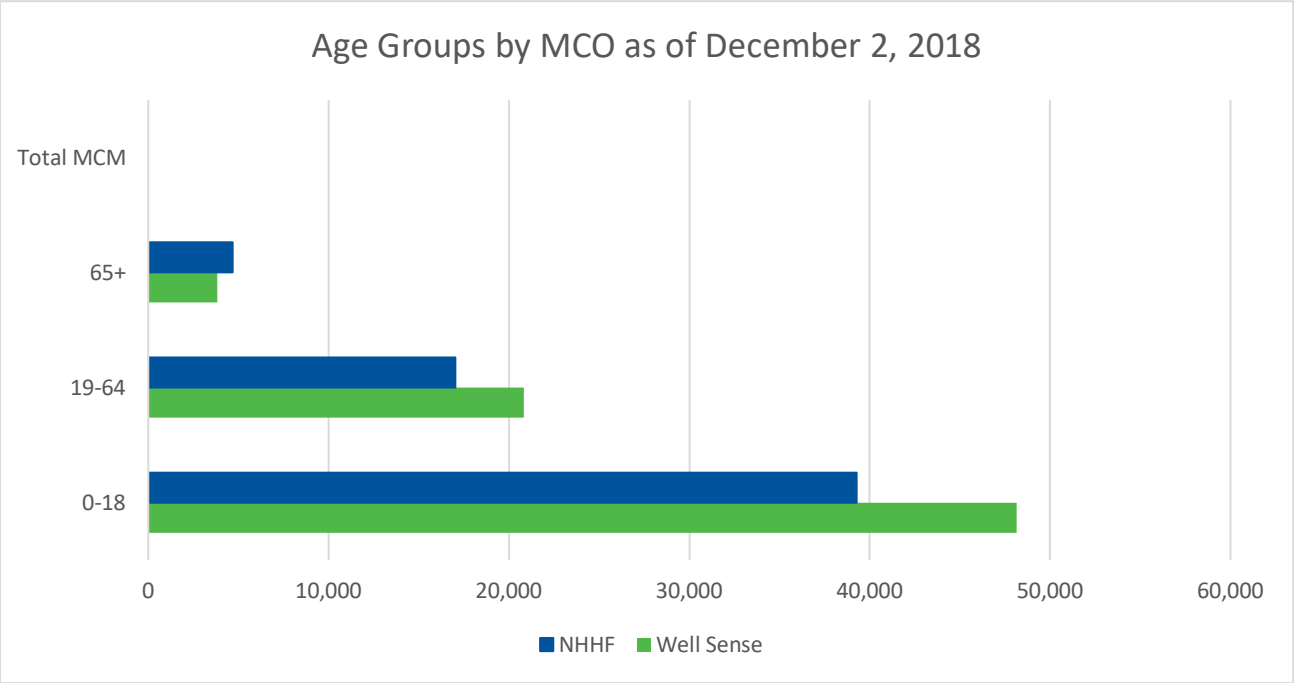
Note: Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans), and non-MCM includes members transitioning into MCM.

Source: New Hampshire MMIS as of 12/2/2018; data subject to revision.

The largest eligibility category, low-income children, represented 63.7 percent of **Well Sense** members. The smallest eligibility category, children with severe disabilities, represented 0.7 percent of **Well Sense** members. Total **Well Sense** membership on December 2, 2018, in the seven eligibility categories was 72,799.

Figure C-5 displays information concerning the age groups of the Medicaid members in **NHHF** and **Well Sense** as of December 2, 2018.

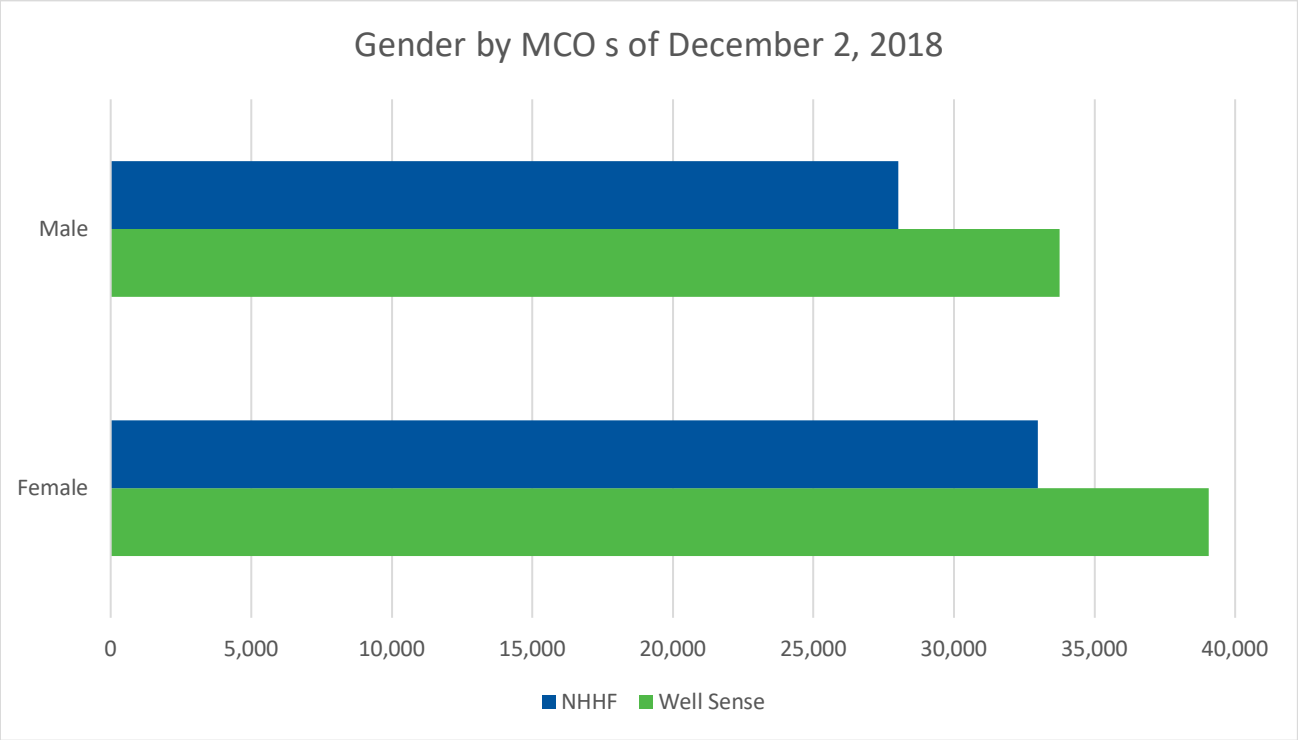
Figure C-5—Point-in-Time Age Groups by MCO as of December 2, 2018



The age distribution across the two MCOs was very similar. A total of 64.4 percent of the **NHHF** population was 0–18 years old as was 66.1 percent of the **Well Sense** population. A total of 27.9 percent of the **NHHF** population was 19–64 years old as was 28.6 percent of the **Well Sense** population. The **NHHF** population 65 years of age and older totaled 7.7 percent, and the **Well Sense** population 65 years of age and older totaled 5.3 percent.

Figure C-6 presents the gender distribution of the MCO members as of December 2, 2018.

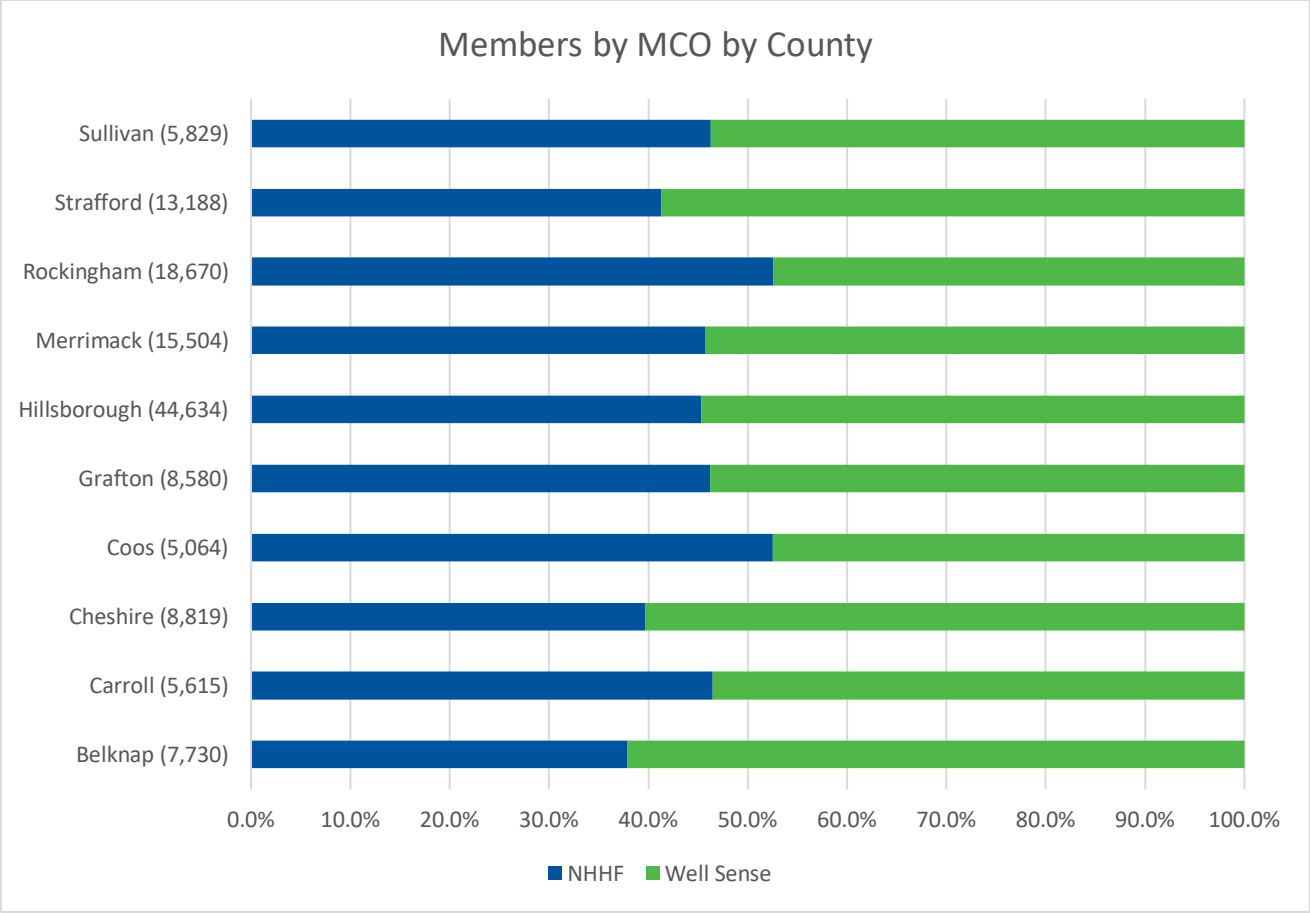
Figure C-6—Point-in-Time Gender by MCO as of December 2, 2018



The gender distribution across both plans was very similar. Female members comprised 54.1 percent of the membership in **NHHF** and 53.6 percent of the membership in **Well Sense**. Male members comprised 45.9 percent of the membership in **NHHF** and 46.4 percent of the membership in **Well Sense**.

Figure C-7 shows the percentage of membership in the two MCOs for the 10 counties in New Hampshire as of December 2, 2018. The numbers listed next to the county name show the total MCM enrollment by county.

Figure C-7—Point-in-Time County Breakout by MCO as of December 2, 2018

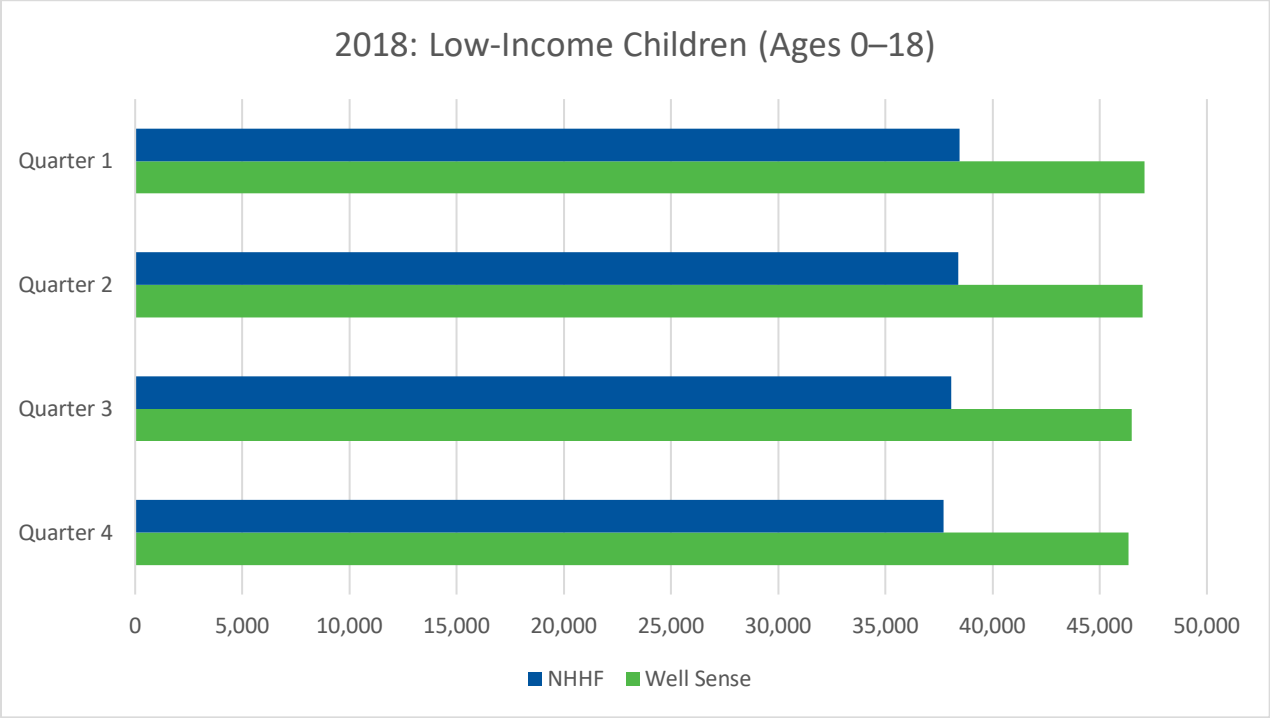


The **NHHF** membership percentages across counties varied between 37.9 percent in Belknap County to 52.6 percent in Rockingham County. The **Well Sense** membership percentages across counties varied between 47.4 percent in Rockingham County to 62.1 percent in Belknap County. An additional 155 members could not be categorized by county because of issues identifying their addresses.

Figure C-8 through Figure C-14 provide information concerning the average quarterly MCO enrollment in seven eligibility categories during the four quarters of 2018. The seven eligibility categories include low-income children, children with severe disabilities, beneficiaries in foster care and with adoption subsidies, low-income adults and adults in the breast and cervical cancer program (BCCP), adults with disabilities, the elderly/elderly with disabilities, and NHHPP.

Figure C-8 shows the average quarterly enrollment for low-income children by MCO during 2018.

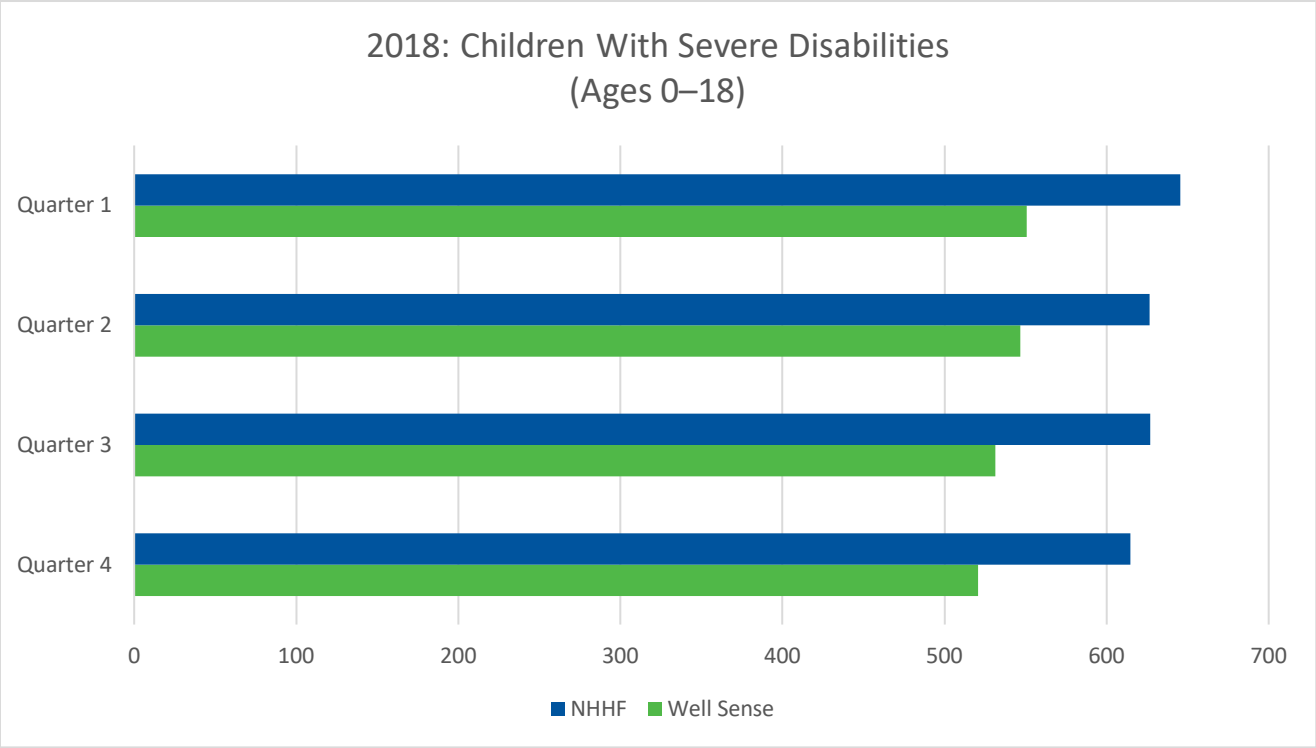
Figure C-8—Average Quarterly Enrollment for Low-Income Children (Ages 0–18) by MCO During 2018



The average quarterly enrollment of low-income children in the MCOs decreased in each quarter of 2018 with Quarter 1 enrollment at 85,548 and Quarter 4 enrollment at 84,034.

Figure C-9 displays the average quarterly enrollment for children with severe disabilities by MCO during 2018.

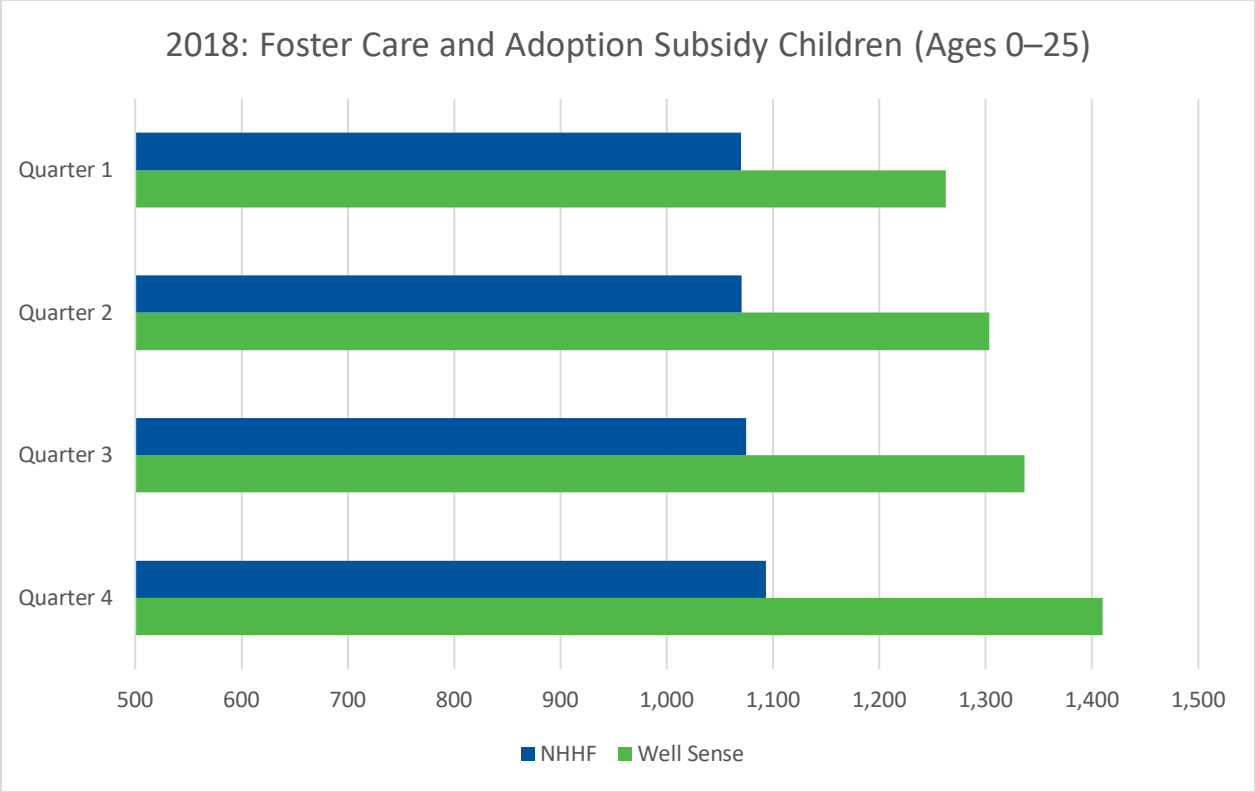
Figure C-9—Average Quarterly Enrollment for Children With Severe Disabilities (Ages 0–18) by MCO During 2018



The overall number of children with severe disabilities enrolled in the MCOs remained relatively constant in 2018, with an average quarterly enrollment of 1,196 children during first quarter 2018 and an average quarterly enrollment of 1,135 children during fourth quarter 2018.

Figure C-10 shows the average quarterly enrollment for foster care children and children with adoption subsidies by MCO during 2018.

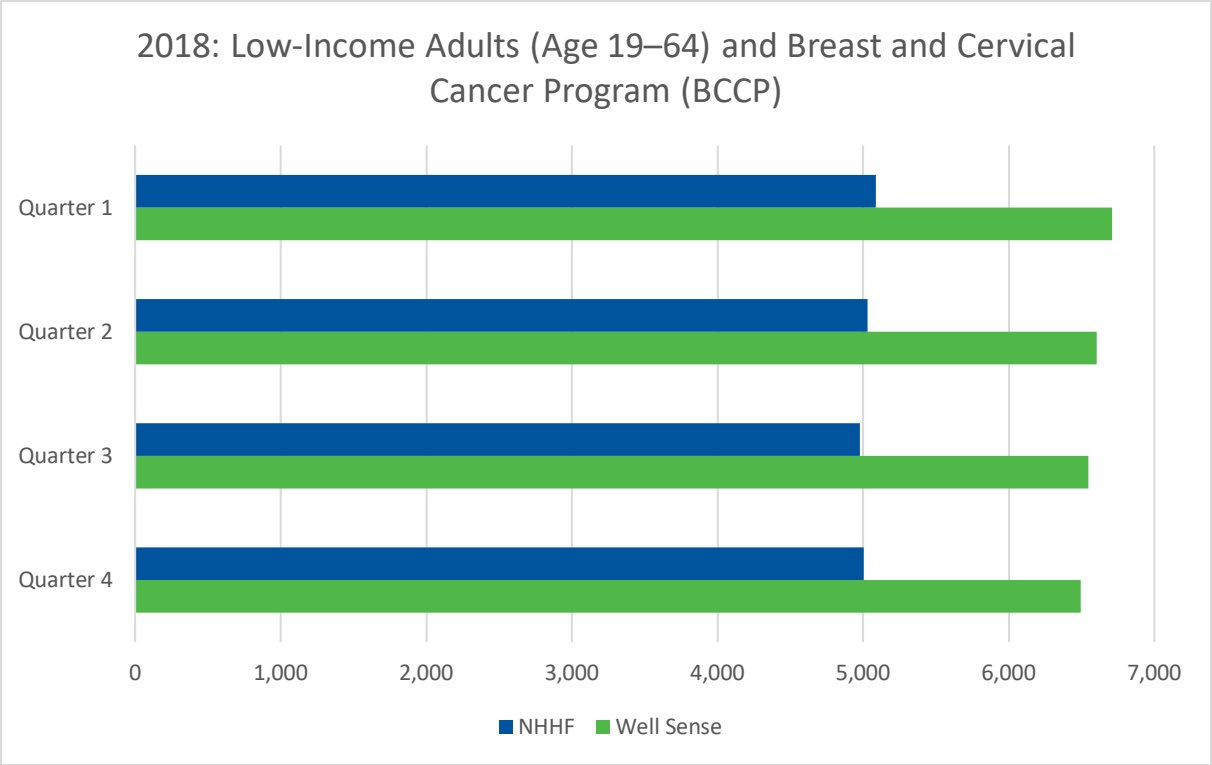
Figure C-10—Average Quarterly Enrollment for Foster Care and Adoption Subsidy Children (Ages 0–25) by MCO During 2018



Overall participation in the MCM Program by beneficiaries in foster care and with adoption subsidies included an average enrollment of 2,332 children during first quarter 2018 and an average enrollment of 2,503 children during fourth quarter 2018.

Figure C-11 displays the average quarterly enrollment for low-income adults and members in the BCCP by MCO during 2018.

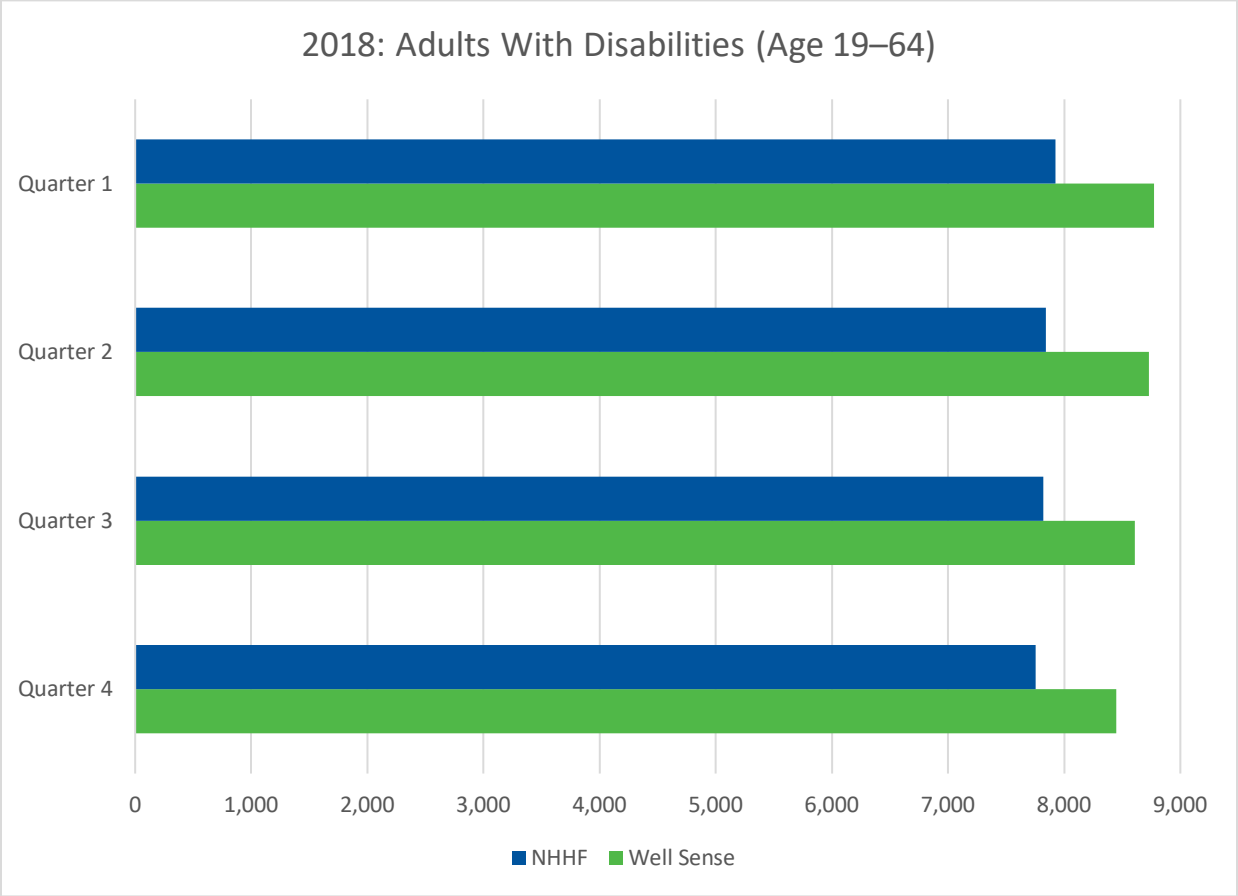
Figure C-11—Average Quarterly Enrollment for Low-Income Adults (Ages 19–64) and BCCP by MCO During 2018



The average number of low-income adults and adults in the BCCP enrolled in the MCOs during 2018 decreased slightly from 11,794 in the first quarter to 11,497 in the fourth quarter.

Figure C-12 shows the average quarterly enrollment for adults with disabilities by MCO during 2018.

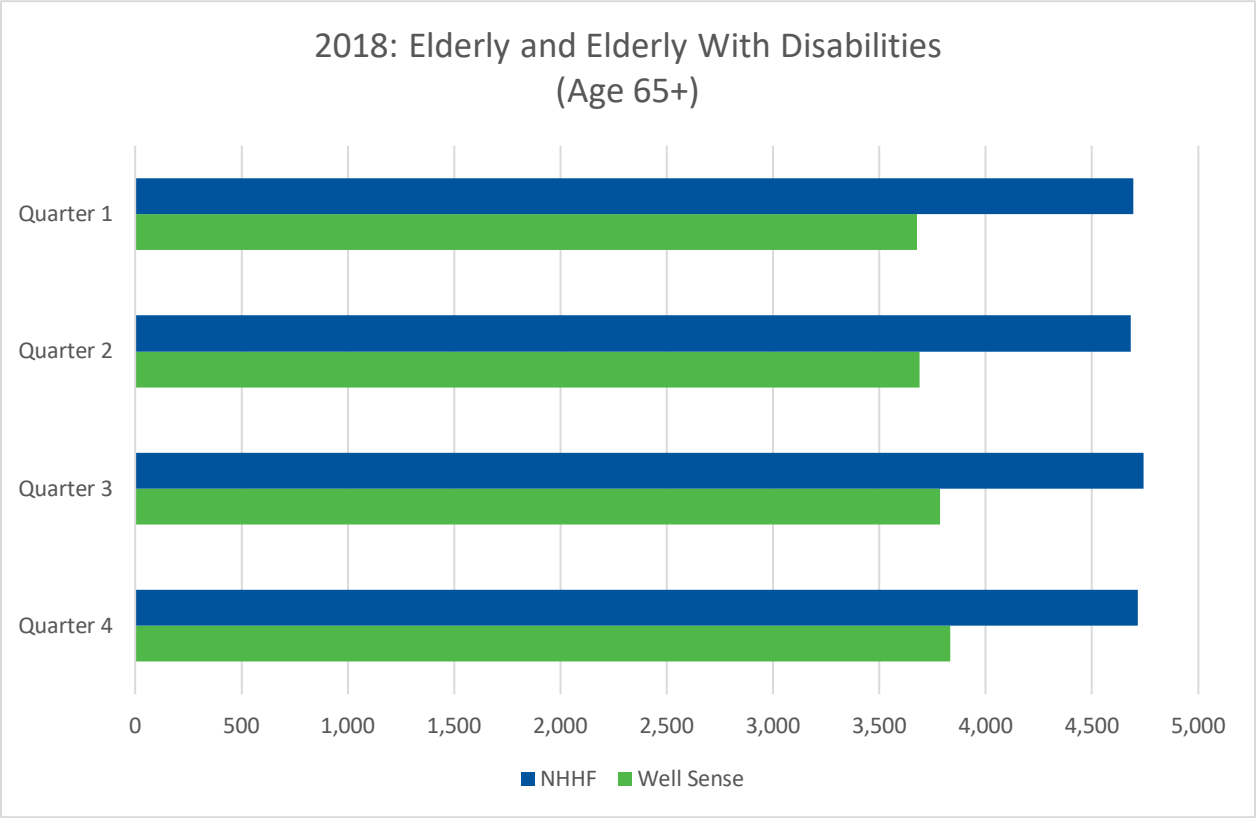
Figure C-12—Average Quarterly Enrollment for Adults With Disabilities (Ages 19–64) by MCO During 2018



The average quarterly enrollment of adults with disabilities in the New Hampshire MCM Program during 2018 decreased slightly from 16,700 in first quarter to 16,203 in fourth quarter.

Figure C-13 shows the average quarterly enrollment for the elderly/elderly with disabilities by MCO during 2018.

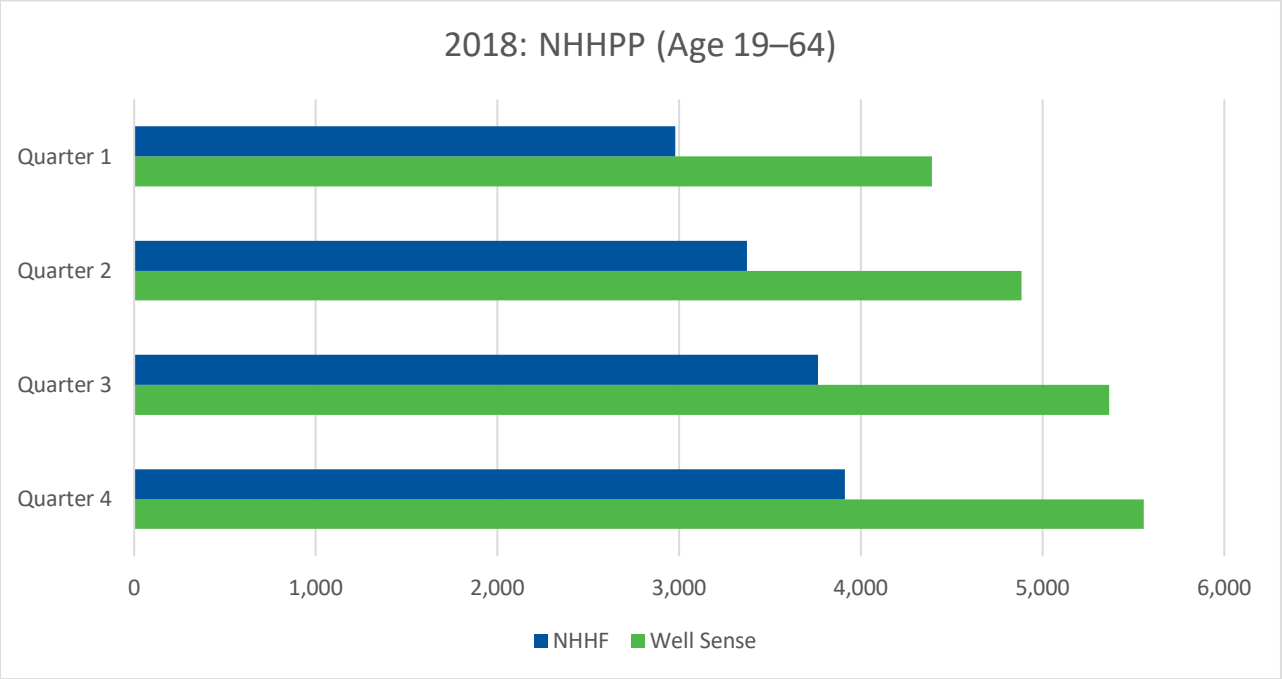
Figure C-13—Average Quarterly Enrollment for Elderly and Elderly With Disabilities (Age 65+) by MCO During 2018



The average quarterly enrollment for the elderly/elderly with disabilities increased from 8,372 in first quarter 2018 to 8,547 in fourth quarter 2018.

Senate Bill 413 created the NHHPP in 2014. The bill included the Medicaid expansion population resulting from New Hampshire's implementation of the Affordable Care Act. Enrollment in the Medicaid MCOs began in fall 2014 and continued through 2015. On January 1, 2016, members were moved from MCM or non-MCM/PAP to a QHP. NHHPP members who were medically frail could elect to remain in the Medicaid MCOs. Figure C-14 shows the average enrollment of NHHPP members by MCO for the four quarters of 2018.

Figure C-14—Average Enrollment for NHHPP (Ages 19–64) by MCO During 2018



The average quarterly NHHPP enrollment had the greatest increasing enrollment in the MCOs during 2018. Enrollment increased from 7,369 in first quarter of 2018 to 9,467 in fourth quarter.