State of New Hampshire
Department of Health and Human Services

2024 New Hampshire Dental Organization External Quality Review Technical Report

April 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Since December 1, 2013, New Hampshire Department of Health and Human Services (DHHS) has operated the Medicaid Care Management (MCM) program, which is a statewide comprehensive risk-based capitated managed care program. On July 1, 2022, New Hampshire's Governor Chris Sununu signed into law a Medicaid adult dental benefit. This legislation required DHHS to implement a comprehensive adult dental benefit by April 1, 2023. DHHS implemented the New Hampshire Smiles Adult Dental Program, a Dental Medicaid Care Management (DMCM) program, on April 1, 2023. The benefit includes diagnostic, preventive, limited periodontal, restorative, and oral surgery services, as well as care management and transportation services. Individuals who participate in the 1915(c) waivers (such as Choices for Independence [CFI], Acquired Brain Disorder [ABD], and Developmental Disabilities [DD] waivers) and nursing facility residents have an additional removable partial and full denture benefit. The Children's Dental Benefit remains in the Fee-for-Service (FFS) Program and covers Medicaid members from birth to 21 years of age.

The New Hampshire Smiles Adult Dental Program added the new group of services to the existing MCM program, with all dental services managed through a separate dental organization (DO), Delta Dental Plan of New Hampshire, Inc. (doing business as [DBA] **Northeast Delta Dental** [**NEDD**]), and its plan administrator, **DentaQuest** (**DQ**). **NEDD** and **DQ** were not considered exempt from any New Hampshire external quality review (EQR) activities.

This report is a summative account of the activities conducted by Health Services Advisory Group, Inc. (HSAG), New Hampshire's external quality review organization (EQRO) in state fiscal year (SFY) 2024. Activities conducted to evaluate the DO included audits of contract compliance, performance improvement projects (PIPs), performance measure validation (PMV), network adequacy validation (NAV), and encounter data validation (EDV). HSAG also conducted a quality study, a revealed caller provider survey, and a provider satisfaction survey for the DO.

The SFY 2024 New Hampshire Dental Organization External Quality Review Technical Report presents the rates for **NEDD/DQ** and includes conclusions and recommendations for the DO in the detailed findings section of this report. That section also contains an explanation of each task conducted in New Hampshire and offers nationally recognized comparison rates, when appropriate. The next section of the report offers a summary of strengths and recommendations for improving the quality, timeliness, and accessibility of dental services provided by the DO. An assessment of the New Hampshire Comprehensive Medicaid Quality Strategy follows. Appendices to this report list abbreviations and acronyms (Appendix A) and the methodology for conducting all activities included in the report (Appendix B).

Table 1-1 summarizes the areas providing the greatest opportunities for improvement noted in the EQR tasks described in this report for **NEDD/DQ**. Since the DO completed corrective action plans (CAPs) to remedy the elements not achieving the standard rate for the compliance reviews, targeted improvement activities for **NEDD/DQ** should focus on measures that did not meet the standards for PMV, NAV, and EDV.

Table 1-1—Opportunities for Improvement for NEDD/DQ

EQR Activity	Measure Standard	NEDD/DQ's Results	Standard
Contract Compliance Audit	Delegation and Subcontracting	55.3%	100%
	Emergency and Post-Stabilization Care	53.9%	100%
	Care Management/Care Coordination	85.0%	100%
	Member Enrollment and Disenrollment	72.2%	100%
	Member Services	76.7%	100%
	Cultural and Accessibility Considerations	80.0%	100%
	Grievances and Appeals	84.3%	100%
	Access	82.1%	100%
	Network Management	90.8%	100%
	Utilization Management	94.3%	100%
	Quality Management	42.9%	100%
	Health Information Systems	78.6%	100%
PMV	DHHS specifications for DENTAL_CLAIM.03 concerning total interest paid on dental claims received during the measurement period and not paid within 30 calendar days of receipt using the interest rate published in the Federal Register in January of each year for the Medicare program.	No established audit process to review claims that incurred interest after more than 30 days	Establish an audit process to review claims paid after 30 days
NAV	**NEDD/DQ** did not meet the 90 percent time and distance standard for one dental service type, oral maxillofacial surgery, in rural counties.	Time and Distance <90%	Time or Distance ≥90%
EDV	**Information System Review**		
	On the dental and non-emergency medical transportation (NEMT) encounters, **NEDD/DQ** should perform more data quality checks such as the following: • Reconciliation With Financial Reports: Evaluates whether the payment fields in the claims align with the financial reports from an entity. • Claim Volume by Submission Month: Evaluates the number of unique claims based on the month when the providers submitted the claims to **NEDD/DQ**. • Timeliness: Evaluates whether the source entity submits claims in a timely manner.		
	NEDD/DQ should submit reconciliation files to DHHS and HSAG when submitting its 837 Professional (P) and 837 Dental (D) encounters.		
	Ongoing Encounter Data Quality Reports		
	837P: Validity of Member Identification Number—Percent Valid	99.9%	100%

2. Overview of the DMCM Program

As of December 31, 2023, there were 88,997 adult Medicaid beneficiaries enrolled in **NEDD/DQ**'s New Hampshire dental program.[1] New Hampshire Medicaid provides diagnostic, preventive, restorative, limited periodontic, and oral surgery services to adults ages 21 and older.

A removable partial and full denture benefit is available for nursing facility residents and individuals included in the following three waiver categories: Acquired Brain Disorder (ABD), Developmental Disability (DD), and Choices for Independence (CFI). All dental services for adults ages 21 and older are administered through the dental organization in a prepaid ambulatory health plan (PAHP).

The New Hampshire DHHS has contracted with a single EQRO to meet the requirements of 42 Code of Federal Regulations (CFR) §438 Subpart E. The Department has contracted with HSAG to provide EQRO services for the DO. To comply with federal regulations, 42 CFR §438.358(b), the EQR's federally mandated scope of work for the DO includes:

- DO contract compliance reviews.
- Validation of PIPs.
- Validation of DO quality performance measures.
- Validation of DO network adequacy.
- Preparation of EQRO technical reports for the DO.

HSAG follows the U.S. Department of Health and Human Services, *Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocols, February 2023*, when conducting EQR activities.[2] In addition to the mandatory activities, HSAG also conducts voluntary activities for the DO to include EDV, provider satisfaction surveys, secret shopper surveys, and quality studies.

Exhibit O: Quality and Oversight Reporting Requirements of the New Hampshire Department of Health and Human Services Medicaid Care Management Dental Services Contract includes 78 DO performance measures. The Dental Unit of the Division of Medicaid Services provides programmatic and clinical oversight of all dental services.

[1] The data source is the Enterprise Business Intelligence (EBI) Start of Month Member Tables as of July 2, 2024 (data loaded through May 2024).

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 2, 2024.

3. Detailed Findings

Overview

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[3] HSAG is currently the EQRO in 19 states and has contracted with DHHS to perform EQR activities for New Hampshire since 2013.

The SFY 2024 New Hampshire EQR Technical Report for the DMCM program complies with 42 CFR §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 managed care organization (MCO), prepaid inpatient health plan (PIHP), or PAHP."[4] The DO is considered a PAHP. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information of any beneficiary. The current report contains findings from the EQR activities conducted during SFY 2024 (July 1, 2023–June 30, 2024).

The following section of the report presents the rates of the New Hampshire DO (i.e., **NEDD/DQ**) and includes conclusions and recommendations. The section also contains an explanation of each task conducted by the EQRO in New Hampshire for the DO and offers nationally recognized comparison rates, when appropriate.

Dental Plan Findings, Conclusions, and Recommendations

This section of the report provides information concerning the New Hampshire EQR tasks conducted by HSAG during SFY 2024. The tasks include DO contractual compliance, PIPs, PMV, NAV, EDV, a quality study, a provider satisfaction survey, and a secret shopper study.

Contractual Compliance

The purpose of the New Hampshire compliance reviews was to determine the DO's compliance with 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual

[3] 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: Dec 2, 2024.

[4] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.358 Accessed on: Dec 2, 2024.

requirements included in the DMCM Contract.[5,6,7] HSAG followed the guidelines set forth in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023,[8] to create the process, tools, and interview questions used for the reviews. As SFY 2024 was the first full year of the DO's participation in the DMCM program, this year's review for **NEDD/DQ** consisted of all the DO compliance review standards. The DO tool does not include two standards found in the New Hampshire MCO's compliance tool, Standard V—Behavioral Health and Standard XIV—Substance Use Disorder, since these standards do not apply to the DO. The standards included in the SFY 2024 compliance review are listed in Table 3-1. For additional information concerning HSAG's compliance reviews, see Appendix B. Methodologies for Conducting EQR Activities, page B-2.

Table 3-1—Standards Included in the DO New Hampshire SFY 2024 Compliance Review

Standard	42 CFR	CFR Standard Name	New Hampshire Standard Name
I.	§438.230	Subcontractual Relationships and Delegation	Delegation and Subcontracting
II.	§438.114	Emergency and Post-Stabilization Services	Emergency and Post-Stabilization Care
III.	§438.208	Coordination and Continuity of Care	Care Management/Care Coordination
IV.	NA*	NA*	Wellness/Prevention/Member Education
VI.	§438.56	Disenrollment: Requirements and Limitations	Member Enrollment and Disenrollment
VII.	§438.100 §438.224	Enrollee Rights	Member Services
		Confidentiality	
VIII.	NA*	NA*	Cultural and Accessibility Considerations
IX.	§438.228	Grievance and Appeal Systems	Grievances and Appeals
X.	§438.206	Availability of Services	Access
XI.	§438.214 §438.207	Provider Selection	Network Management
		Assurances of Adequate Capacity and Services	

5 State of New Hampshire Department of Health and Human Services. (2022). *Medicaid Care Management Dental Services Contract.* Available at: https://www.sos.nh.gov/sites/g/files/ehbemt561/files/inline-documents/sonh/09a-gc-agenda-110222.pdf. Accessed on: Dec 2, 2024.

6 Department of Health and Human Services. (2024). 42 CFR §438. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438. Accessed on: Dec 2, 2024.

7 Centers for Medicare & Medicaid Services. (2024). Medicaid Program; Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457?toc=1. Accessed on: Dec 2, 2024.

8 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 2, 2024.

Standard	42 CFR	CFR Standard Name	New Hampshire Standard Name
XII.	§438.210 §438.224	Coverage and Authorization of Services	Utilization Management
		Confidentiality	
XIII.	§438.236 §438.224 §438.330	Practice Guidelines	Quality Management
		Confidentiality	
		Quality Assessment and Performance Improvement Program	
XV.	NA*	NA*	Fraud, Waste, and Abuse
XVI.	NA*	NA*	Financial
XVII.	NA*	NA*	Third Party Liability
XVIII.	§438.242	Health Information Systems	Health Information Systems

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

The standards HSAG reviewed included requirements that affect the ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries. The review period covered calendar year (CY) 2023. To assess the DOs compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the DOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., January 31, 2024)
- The member handbook and additional documents sent to members
- The provider manual and other DO communication to providers/subcontractors
- The automated member and provider portal
- Automated provider directory
- Third-party liability (TPL) documents
- File reviews
- Narrative and/or data reports across a broad range of performance and content areas
- DO Questionnaire sent to the DO with the pre-site documents

HSAG scheduled the three-day compliance review in May 2024. DHHS and HSAG agreed to perform this year's review virtually using Microsoft Teams. The use of Teams, which supported an end-to-end encryption, allowed HSAG and the DO to securely display documents and databases discussed during the review.

Based on the overall score achieved by the DO, HSAG established a level of confidence rating for this year's compliance review as defined below:

90%–100%: High confidence in the DO's compliance with State and federal requirements
80%–89%: Moderate confidence in the DO's compliance with State and federal requirements
70%–79%: Low confidence in the DO's compliance with State and federal requirements
Under 70%: No confidence in the DO's compliance with State and federal requirements

Conclusions and Recommendations

HSAG conducted the compliance review for **NEDD/DQ** on May 14–16, 2024. Table 3-2 details the scores achieved by **NEDD/DQ** for the 16 standards included in the SFY 2024 review.

Table 3-2—SFY 2024 Compliance Review Scores for NEDD/DQ

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
I.	Delegation and Subcontracting	47	47	22	8	17	55.3%
II.	Emergency and Post-Stabilization Care	13	0	NA	NA	NA	NA
III.	Care Management/Care Coordination	10	10	8	1	1	85.0%
IV.	Wellness/Prevention/Member Education	5	5	5	0	0	100%
VI.	Member Enrollment and Disenrollment	17	9	5	3	1	72.2%
VII.	Member Services	43	43	28	10	5	76.7%
VIII.	Cultural and Accessibility Considerations	10	10	7	2	1	80.0%
IX.	Grievances and Appeals	166	146	122	2	22	84.3%
X.	Access	28	28	23	0	5	82.1%
XI.	Network Management	201	201	179	7	15	90.8%
XII.	Utilization Management	71	61	56	3	2	94.3%
XIII.	Quality Management	11	7	3	0	4	42.9%
XV.	Fraud, Waste, and Abuse	18	18	18	0	0	100%
XVI.	Financial	2	2	2	0	0	100%
XVII.	Third Party Liability	8	6	6	0	0	100%
XVIII.	Health Information Systems	7	7	5	1	1	78.6%
Overall Results		**657**	**600**	**489**	**37**	**74**	**84.58%**

* ***Partially Met*** and ***Not Met*** elements must be addressed in the CAP.
** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after non-applicable elements were removed.

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the DO's performance complied with the requirements. A designation of *Not Applicable (NA)* was used when a requirement was not applicable to the DO during the period covered by HSAG's review. This scoring methodology is consistent with the CMS EQR Protocol 3 cited earlier in this report. HSAG included any element that did not receive a score of *Met* in a CAP document distributed to the DO. Prior to the completion of the CAP process, which was approved by DHHS, the DO submitted information to bring all elements scoring *Partially Met* or *Not Met* into compliance with the State contract requirements and federal regulations. At the conclusion of the CAP process, all standards achieved a 100 percent score. The elements included in the CAPs will be reviewed during the SFY 2025 compliance review to ensure continued compliance by the DO.

The **NEDD/DQ** compliance tool included 16 standards representing 613 applicable elements. **NEDD/DQ** *Met* the requirements for 496 elements, scored a *Partially Met* for the requirements for 37 elements, and scored a *Not Met* for 80 elements. **NEDD/DQ** achieved an overall score of 83.9 percent. Of the 16 standard areas reviewed, **NEDD/DQ** achieved 100 percent compliance on four standards, demonstrating adherence to all requirements within:

- Wellness/Prevention/Member Education
- Fraud, Waste, and Abuse
- Financial
- Third Party Liability

The 16 standards included requirements that affected the ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid beneficiaries.

NEDD/DQ received *80 percent or higher compliance* on six standards, representing opportunities for improvement:

- Care Management/Care Coordination
- Cultural and Accessibility Considerations
- Grievances and Appeals
- Access
- Network Management
- Utilization Management

NEDD/DQ received *below 80 percent compliance* on six standards, representing the greatest opportunities for improvement:

- Delegation and Subcontracting
- Emergency and Post-Stabilization Care
- Member Enrollment and Disenrollment

- Member Services
- Quality Management
- Health Information Systems

This year's review included file reviews of a random sample of subcontractor agreements, appeals files, grievance files, credentialing files, and denial files. HSAG included the results from the file review in the scores for the Delegation and Subcontracting, Grievances and Appeals, Network Management, and Utilization Management standards, as applicable.

To improve the standards that scored below 100 percent, **NEDD/DQ** and its delegates must:

- Delegation and Subcontracting:
  - The DO must ensure that subcontractors receive information about the grievance and appeal system and the rights of the member as described in 42 CFR §438.10(g) at the time they enter into a contract or subcontract. The information includes:
    - The member's right to file grievances and appeals and the requirements and time frames for filing.
    - The member's right to a State fair hearing (SFH), how to obtain a hearing, and the rules that govern representation at a hearing.
    - The availability of assistance with filing.
    - The toll-free number to file oral grievances and appeals.
    - The member's right to request continuation of benefits during an appeal or SFH filing and, if the DO's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits.
    - The provider's right to appeal the DO's failure to pay for or cover a service.
  - The DO must develop a process to ensure that DHHS is notified within five business days of receiving notice from a subcontractor of its intent to terminate a subcontractor agreement.
  - The DO must notify DHHS within one business day of any material breach by the subcontractor or an agreement between the DO and the subcontractor that may result in the DO being noncompliant with or violating the DHHS contract.
  - The DO must evaluate the subcontractor's ability to perform the activities to be delegated (1) prior to any delegation; and (2) regularly and periodically, at least annually, and when there is a substantial change in the scope or terms of the subcontractor agreement.
  - The DO must ensure that if the DO identifies deficiencies or areas for improvement in the subcontractor's performance that affect compliance with the DO's Agreement with DHHS:
    - The DO notifies DHHS within seven calendar days and requires the subcontractor to develop a CAP.
    - The DO provides DHHS with a copy of the subcontractor's CAP within 30 calendar days upon DHHS' request, which is subject to DHHS' approval.
  - The DO must ensure that participating providers and subcontractors do not discriminate against eligible persons or members on the basis of their health or behavioral health history, health or

behavioral health status, their need for healthcare services, amount payable to the DO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

- Emergency and Post-Stabilization Care:
  - The DO must ensure that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities responsible for coverage and payment.
  - The DO must be financially responsible for post-stabilization services, including but not limited to the following scenarios:
    - Those obtained within or outside the DO that are not pre-approved by the participating provider or other DO representative but administered to maintain the member's stabilized condition within one hour of a request to the DO for pre-approval of further post-stabilization care services.
    - Those administered to maintain, improve, or resolve the member's stabilized condition without preauthorization if the DO does not respond to a request for pre-approval within one hour; the DO cannot be contacted; or the DO representative and the treating physician cannot reach an agreement concerning the member's care and a DO physician is unavailable for consultation. In this situation, the DO gives the treating physician the opportunity to consult with a DO physician and the treating physician may continue with the patient's care until a DO physician is reached or one of the criteria of 42 CFR §422.133(c)(3) is met.
  - The DO must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if the member obtained the services through the DO.
  - The DO must have documentation which supports that the DO's financial responsibility for post-stabilization care services, if not pre-approved, ends when the DO physician with privileges at the treating hospital assumes responsibility for the member's care, the DO physician assumes responsibility for the member's care through transfer, the DO representative and the treating physician reach agreement concerning the member's care, or the member is discharged.
- Care Management/Care Coordination:
  - Regarding conflicts of interest, care managers must remain conflict-free: Not being related by blood or marriage to a member, financially responsible for a member, or with any legal power to make financial or health-related decisions for the member. The DO must demonstrate that care managers remain conflict-free.
  - The DO must ensure that all completed Dental Risk Assessment Screenings are shared with the member's assigned primary dental provider (PDP) for inclusion in the member's dental record and within seven calendar days of completing the screening.
- Member Enrollment and Disenrollment:
  - The DO must notify DHHS within five business days when it identifies information regarding a member's circumstances that may affect the member's eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member.

  - The DO must accept for automatic reenrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two months or less.
  - The DO must ensure that it does not request disenrollment because of the member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse.
  - In requesting involuntary disenrollment, the DO must submit documentation and justification for review.
- Member Services:
  - The DO must send a letter to new members within 10 calendar days following the receipt of a valid enrollment file from DHHS, but no later than seven calendar days after the effective date of enrollment:
    - Directing the member to the provider directory on the DO's website.
    - Informing the member of the right to a printed version of the provider directory upon request.
  - The DO must develop a mechanism to help potential members understand the requirements and benefits of the plan.
  - The DO must ensure that all written member information critical to obtaining services for potential enrollees includes, at the bottom, taglines printed in a conspicuously visible font and in the non-English languages prevalent among the DMCM members to explain the availability of written translation or oral interpretation, and include the toll-free and TeleTYpewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number of the DO's member services center.
  - The DO must ensure that the large print tagline, which must be included in all member and potential member written information critical to obtaining services, is printed in a conspicuously visible font size and includes information on how to request auxiliary aids and services, including materials in alternative formats.
  - The DO must ensure that when potential enrollees request written materials in large print that are critical to obtaining services, the DO provides these materials in large print with a font size no smaller than 18 point.
  - In addition to members, the DO must make oral interpretation services available free of charge to potential members.
    - This applies to all non-English languages, not just those that DHHS identifies as languages of other major population groups.
    - Members are not charged for interpretation services.
    - The DO notifies members that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.
  - The DO must ensure that it provides auxiliary aids such as TTY/TDD and American Sign Language (ASL) interpreters free of charge to members or potential members, and that the DO considers the special needs of members or potential members with disabilities or limited English proficiency (LEP).

  - The DO must operate a 24-hour, seven-day-a-week toll-free member services telephone/hotline number and ensure that member identification (ID) cards include the 24/7 toll-free telephone number.
  - The DO must ensure that it reissues a member ID card if a member has a name change or for any other reason that results in a change to the information disclosed on the ID card.
  - The DO must ensure that it publishes and provides member information in the form of a member handbook available at the time of member enrollment in the plan, and at a minimum annually thereafter.
  - The DO must notify all members of their disenrollment rights at least annually. The DO must utilize notices that describe transition of care policies for members and potential members. The DO must ensure that, in the case of a counseling or referral service that it will not cover because of moral or religious objections, the DO informs members that the service is not covered and how members can obtain information from DHHS about how to access those services.
  - The DO must ensure that it makes available a printed hardcopy of the member handbook to new members within 10 calendar days following the DO's receipt of a valid enrollment file from the Department, but no later than seven calendar days after the effective date of enrollment.
  - The DO must ensure that it makes a welcome call or an interactive voice response (IVR) call to each new member within 30 days of the member's enrollment in the DO and provides the means for the member to request immediate live DO representative support during the welcome call.
  - The DO must ensure that provider hospital affiliations are included in the provider directory, as applicable.
  - The DO must ensure that it notifies all members, at least annually, of their right to obtain a paper copy of the provider directory.
- Cultural and Accessibility Considerations:
  - The DO must ensure that participating providers have policies and procedures in place to furnish access and accommodations to members with behavioral disabilities.
  - The DO must develop effective and appropriate methods for identifying, flagging in electronic systems, and tracking members' needs for communication assistance for health encounters, including preferred spoken language for all encounters, the need for an interpreter, and preferred language for written information.
  - The DO must ensure that if a member declines free interpretation services, it has a process in place for informing the member of the potential consequences of declination with the assistance of a competent interpreter to assure the member's understanding, as well as a process to document the member's declination. Interpreter services must be re-offered at every new contact, and every declination requires new documentation of the offer and the member's declination.
- Grievances and Appeals:
  - The DO must provide information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract, including the time frames for filing appeals and grievances and that the member may be required to pay the cost of continued services furnished while the appeal or SFH is pending. Additionally, the DO must ensure the information

about the grievance and appeal system provided to network providers aligns with New Hampshire policies and procedures.
  - The DO must make training available to providers in supporting and assisting members in the grievance system.
  - The DO must send written notice to members and providers of any changes to the Grievance System at least 30 calendar days prior to implementation.
  - The DO must have a process in place to extend the time frame for processing a grievance by up to 14 calendar days if the member requests the extension or if the DO shows a need for additional information and that the delay is in the member's interest.
  - If the DO extends the timeline for a grievance not at the request of the member, the DO must make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice within two calendar days of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with the decision.
  - If the member requests disenrollment, the DO must resolve the grievance in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month in which the member requests disenrollment.
  - The DO's documentation must ensure that members do not have the right to a SFH regarding the disposition of a grievance.
  - For termination, suspension, or reduction of previously authorized Medicaid-covered services, the DO must provide members written notice at least 10 calendar days before the date of action; however, the period of advance notice is five calendar days in cases wherein the DO has verified facts that the action should be taken because of probable fraud by the member.
- Access:
  - The DO must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) in the participating provider network to ensure timely access to services for American Indians who are eligible to receive services.
  - The DO's network must meet the standards for timely access to care and services, considering the urgency of the need for services, and ensuring the network capacity can meet the expectations for timely care. Specifically, network capacity should ensure that members can receive timely care for non-symptomatic appointments within 45 calendar days; non-urgent symptomatic appointments within 10 calendar days; and urgent, symptomatic appointments within 48 hours.
  - The DO must ensure that providers comply with timely access standards.
  - Within three calendar days prior to the effective date of the termination, the DO must have a transition plan in place for all affected members.
  - The DO must continue to provide services, notify the member in writing within seven calendar days, and develop a transition plan for members participating in an ongoing course of treatment with a provider who has terminated the contract.
- Network Management:
  - The DO must ensure that all providers have a New Hampshire Medicaid ID number.

- The DO must permit nonparticipating IHCPs to refer an American Indian/Alaska Native member to a participating provider.
- The DO must implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by participating providers were received by members and the application of such verification processes on a regular basis.
- The DO must credential general dentists within 30 days of receipt of a complete application and specialty dentists within 45 days of receipt of a complete application.
- The DO must ensure that the approval process for a provider ends on the date of the provider's written notice of network status.
- The provider's application must include the provider's New Hampshire Medicaid ID number.
- If the DO does not process a provider's clean and complete credentialing application within DHHS' established time frames, the DO must pay the provider retroactive to 30 calendar days or 45 calendar days, depending on the prescribed time frame for the provider type, after receipt of the provider's clean and complete application.
- The DO must have a dedicated contact number for DO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday except on Department-approved holidays. The DO's provider training documentation must include training specific to person-centered care management; social determinants of health (SDOH); quality, privacy, and confidentiality of certain conditions; billing and required documentation; and supporting and assisting members with grievances.
- The DO must have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent dental condition.
- If an adverse action is overturned during the DO's provider appeals process or SFH, the DO must immediately take steps to reverse the adverse action within 10 calendar days.
- The DO must have a process to extend the decision deadline by an additional 30 calendar days to allow the provider to submit evidence or supportive documentation, and for other good cause determined by the DO.
- If the DO fails to adhere to the notice and timing requirements, the DO must have a process in place to ensure that the provider is deemed to have exhausted the DO's appeal process and may initiate a SFH.
- The DO must provide written notice to the resolution of a provider appeal of 95 percent of provider appeals within 30 calendar days from either the date the DO receives the appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which the provider's evidence is received by the DO.
- The DO's resolution notice for a provider appeal must include the reason for the DO's decision and the provider's right to request a SFH.
- The DO must inform its participating provider regarding the SFH process including but not limited to how to obtain a SFH.
- The DO must ensure that parties to a SFH include the DO as well as the provider.

  - The DO must ensure that the participating provider exhausts the DO's provider appeals process before pursuing a SFH.
  - If a participating provider requests a SFH, the DO must provide to DHHS and the participating provider, upon request and within three business days, all DO-held documentation related to the provider appeal including, but not limited to, any transcripts, records, or written decisions.
  - In defense of its decisions in the SFH proceedings, the DO must provide supporting documentation, affidavits, and availability of the medical director and/or other staff as appropriate at no additional cost.
  - The DO must appear and defend its decision before DHHS' Administrative Appeals Unit (AAU). Nothing is to preclude the DO from representation by legal counsel.
  - The DO must ensure that its policies and procedures include that the DHHS AAU is to notify the DO of SFH determinations within 60 calendar days of the date of the DO's Notice of Resolution.
  - The DO must:
    - Not object to the State intervening in any appeal.
    - Be bound by the SFH determination, whether or not the SFH determination upholds the DO's final determination.
    - Take all steps to reverse any overturned adverse action within 10 calendar days.
- Utilization Management:
  - The DO must have a written policy that indicates if clinical review criteria change, the DO notifies participating providers and members at least 30 calendar days in advance of the change.
  - The DO must ensure that determinations of standard pre-service authorizations are made within a reasonable time period appropriate to the medical circumstances, not to exceed 14 calendar days.
  - The DO must ensure that an extension of up to 14 calendar days is permissible if the member or the provider requests the extension, or the DO justifies the need for additional information.
- Quality Management:
  - The DO must adopt evidence-based clinical practice guidelines (CPGs) that are based on valid and reasonable clinical evidence or a consensus of providers in a particular field, consider the needs of the DO's members, are adopted in consultation with participating providers, and are reviewed and updated periodically.
  - The DO must adopt CPGs consistent with the standards of care and evidence-based practices of specific professional specialty groups that include recommendations of the U.S. Preventive Services Task Force for the provision of primary and secondary care to adults, rated A or B. The DO may substitute generally recognized guidelines to replace recommendations of the U.S. Preventive Services Task Force, provided that the DO meets all other practice guideline requirements of the DHHS contract and that DHHS reviews these substitutions prior to implementation.
  - The DO must disseminate CPGs to DHHS and all affected providers and upon request to members and potential members. CPGs must also be available on the DO's website.
  - The DO's decisions regarding utilization management, member education, and coverage of services must be consistent with the DO's CPGs.

- Health Information Systems:
  - The DO must maintain a health information system that collects, analyzes, integrates, and reports confidential data.
  - The DO must implement an application program interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the DO. Information must be made accessible to its current members or the members' personal representatives through the API as follows:
    - Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed.
    - Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments.
    - All other encounter data, including adjudicated claims and encounter data from any subcontractors.
    - Clinical data, including laboratory results, no later than one business day after the DO received the data.
    - Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information.
  - The DO must also maintain a publicly accessible standards-based API as described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2).
- File Reviews:
  - Delegation and Subcontracting:
    - The DO must ensure that the written agreement between the DO and the subcontractor includes information about the grievance and appeal system and the rights of the member.
    - The DO must ensure that the written agreement between the DO and the subcontractor includes the requirement that the subcontractor agrees that it can be audited for 10 years from the final date of the term or from the date of any completed audit, whichever is later.
    - The DO must ensure that the written subcontractor agreements include the requirement to notify the DO within one business day of being cited by any State or federal regulatory authority.
    - The DO must ensure that the written subcontractor agreements include the requirement for subcontractors to screen their directors, officers, employees, contractors, and subcontractors monthly against each of the Exclusion Lists, report to the DO any person or entity appearing on any of these lists, and begin termination proceedings within 48 hours unless the individual is part of a federally approved waiver program.

- The DO must ensure that written subcontractor agreements require subcontractors to have a compliance plan that meets the requirements of 42 CFR §438.608 and policies and procedures that meet the Deficit Reduction Act of 2005 (DRA) requirements.
- The DO must ensure that the written subcontractor agreement includes the requirement that prohibits subcontractors from making payments or deposits for Medicaid-covered items or services to financial institutions located outside of the United States or its territories.
- The DO must ensure that the written subcontractor agreement includes the requirement for the subcontractor to comply with the Americans with Disabilities Act (ADA).

– Appeals:
  - Acknowledge the receipt of each appeal.
  - Resolve all expedited appeals within 72 hours.
  - Provide written resolution of appeals to the member, regardless of who initiated the appeal (e.g., the member, the member's authorized representative, or the provider).
  - Obtain the member's written consent for any appeal not initiated by the member.
– Grievances:
  - Acknowledge the receipt of each grievance.
  - Resolve grievances within 45 days of receipt.
– Denials:
  - The DO must resolve all standard prior authorization requests within 14 calendar days.

PIPs

HSAG, as the State's EQRO, validated the PIPs through an independent review process. HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* February 2023.[9]

In SFY 2024, DHHS initiated a new PIP for its contracted DO using HSAG's multi-year rapid-cycle PIP approach developed specifically for DHHS. The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes.

During SFY 2024, DHHS collaborated with **NEDD/DQ** to select a nonclinical PIP topic; *Dental Risk Assessment Screening—Social Determinants of Health (SDOH).* The PIP topic addresses ***quality***, ***timeliness of care***, and ***access to care***.

NEDD/DQ defined a Global Aim and Specific, Measurable, Attainable, Relevant, and Time-Bound (SMART) Aim for the PIP. The SMART Aim statement includes the population, the baseline

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 2, 2024.

percentage, a set goal for the project, and the end date. HSAG provided the following parameters to the DO for establishing the SMART Aim for the PIP:

- **Specific**: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **Measurable**: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **Attainable**: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **Relevant**: The goal addresses the problem to be improved.
- **Time-bound**: The timeline for achieving the goal.

NEDD/DQ used enrollment data received from DHHS on the 834-file and its health risk assessment database to identify the eligible population and query applicable data for the PIP. HSAG used these data and other tools identified throughout this report to validate the DO's PIP. Once the PIP is completed and Module 4 (PIP Conclusions) is submitted for validation, HSAG used its established scoring methodology to assign the overall confidence levels defined below:

HSAG determined whether **NEDD/DQ** adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results:

- *High Confidence*: The PIP was methodologically sound, at least one of the tested interventions could reasonably result in significant improvement and/or achievement of the SMART Aim goal, and the DO conducted complete and accurate data analysis and interpretation of PIP results.
- *Moderate Confidence*: The PIP was methodologically sound and at least one of the tested interventions could reasonably result in the demonstrated improvement; however, the DO did not conduct complete and accurate data analysis and/or did not accurately interpret the PIP results.
- *Low Confidence*: The PIP was methodologically sound with or without complete and accurate data analysis and interpretation of results; however, none of the interventions tested could reasonably result in demonstrated improvement.
- *No Confidence*: The DO did not adhere to an acceptable methodology for the design, data collection, and data analysis/interpretation of results of the PIP.

HSAG determined whether **NEDD/DQ** produced evidence of significant improvement.

- *High Confidence*: The PIP demonstrated statistically significant improvement and/or achievement of the SMART Aim goal.
- *Moderate Confidence*: The PIP demonstrated non-statistically significant improvement in the SMART Aim measure and the SMART Aim goal was not achieved.
- *Low Confidence:* The PIP did not demonstrate any type of improvement.

- *No Confidence*: The DO did not adhere to acceptable methodology for the SMART Aim measure baseline and/or remeasurement.

Table 3-3 includes the SMART Aim statement as stated by **NEDD/DQ** for the PIP.

Table 3-3—PIP Title and SMART Aim Statement

PIP Title	SMART Aim Statement
Dental Risk Assessment Screening—SDOH	By December 31, 2024, use key driver interventions to increase the percentage of eligible members who complete the dental risk screening within 90 days of enrollment from 4.1% to 6.0%.

Table 3-4 summarizes the progress the DO has made in completing the four PIP modules.

Table 3-4—PIP Topic and Module Status

PIP Topic	Module	Status
Dental Risk Assessment Screening—SDOH	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	The Module 3 submission achieved all validation criteria. Intervention testing currently in progress. Additional Module 3 submissions can be submitted throughout 2024.
	4. PIP Conclusions	To be submitted and validated in April 2025.

Module 1: PIP Initiation

The *Dental Risk Assessment Screening—SDOH* PIP is based on the DO's contract requirement that all members newly enrolled must have a screening completed within 90 days of enrollment. **NEDD/DQ** will use enrollment data received from DHHS on the 834-file to identify newly enrolled members. The eligible members will be outreached to complete the screening. The outreach and completed screenings will be captured in the health risk assessment database. The information contained in the database for newly enrolled members who were continuously enrolled for 90 days during the measurement period will be used to determine the numerator and denominator, and to calculate the percentage screened according to the data element specifications. Duplicate members and members who meet exclusion criteria will be removed.

NEDD/DQ met all validation criteria and received *Achieved* scores for all evaluation elements. A resubmission was not required.

Module 2: Intervention Determination

NEDD/DQ completed a cause-and-effect diagram, a Five Whys analysis, and the key driver diagram to determine the areas within its current process that demonstrated the greatest need for improvement and will have the most impact on the desired outcomes. **NEDD/DQ** identified the following prioritized areas to address with interventions:

- Awareness, purpose, and benefits of completing the dental risk assessment.
- Accurate and up-to-date member contact information
- Assisting members with access to care and alleviating barriers
- Motivating members to complete the assessment.
- Alternative methods for members to complete the assessment (e.g., web-based assessment)
- Use of a local phone number for outreach to avoid spam identification.

To address these barriers, **NEDD/DQ** documented the following potential interventions:

- Outreach to newly enrolled members for education, awareness, and benefits of completing the dental risk assessment. During outreach, member contact information will be updated in **NEDD/DQ**'s system.
- Include information on the available incentive for completing the assessment in the member welcome packet and during outreach calls.
- Mailing of a postcard with a QR code to complete the assessment.

Upon initial validation of Module 2, HSAG provided feedback that **NEDD/DQ** needed to revise how the drivers were stated in the key driver diagram. Drivers in a key driver diagram should be stated in the affirmative and not as a negative. The DO made the correction, submitted the module for final validation, and received *Achieved* scores for all evaluation elements.

Module 3: Intervention Testing

NEDD/DQ submitted two Module 3s for validation. The first intervention submitted was to provide member education on the dental risk assessment. The goal of this intervention is to educate newly enrolled members on the purpose and benefits of completing the assessment and giving them the opportunity to complete the assessment during the outreach call. The intervention effectiveness measure is described as follows:

Table 3-5—Intervention Effectiveness Measure

Dental Risk Assessment Member Education	
Intervention Measure Title	The percentage of members who complete the dental risk assessment who receive education on the dental risk assessment.
Numerator Description	The number of members from the denominator who completed the dental risk assessment.
Denominator Description	The number of newly enrolled members who were contacted via the outreach call and educated on benefits of the dental risk assessment.

Upon initial validation of Module 3, HSAG identified opportunities for improvement related to the documentation of barriers. **NEDD/DQ** made corrections and submitted the module for a final validation. All validation criteria were met and received *Achieved* scores for all evaluation elements.

The second intervention submitted was providing an incentive to members who completed the dental risk assessment. The goal of this intervention is to increase the number of newly enrolled members completing the dental risk assessment by providing a gift card. The intervention effectiveness measure is described as follows:

Table 3-6—Intervention Effectiveness Measure

Member Incentive to Complete the Dental Risk Assessment	
Intervention Measure Title	The percentage of members who receive an incentive after completing the dental risk assessment.
Numerator Description	The number of members from the denominator who completed the dental risk assessment.
Denominator Description	The number of newly enrolled members who were contracted and educated on the dental risk assessment and incentive.

NEDD/DQ received *Achieved* scores for all validation criteria, and a resubmission was not required.

Intervention Testing Check-In

HSAG conducted the first of three scheduled intervention check-ins. The check-in occurred in April 2024. **NEDD/DQ** submitted its Plan-Do-Study-Act (PDSA) worksheet and reported the DO's progress in the intervention testing process. HSAG reviewed the intervention progress update and provided written feedback. The intervention check-in progress updates are not validated.

Conclusions and Recommendations for Improvement

Based on the validation findings, **NEDD/DQ** successfully initiated a methodologically sound PIP that met all State and federal requirements. **NEDD/DQ** completed the first three modules of the rapid-cycle PIP process and is currently testing interventions for the PIP.

- HSAG recommends that **NEDD/DQ** continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. The testing methodology should allow **NEDD/DQ** to quickly gather data and make data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal or improvement over the baseline performance.
- HSAG recommends that, for the member education intervention, **NEDD/DQ** consider tracking an additional intervention effectiveness measure focused on completion rates of outreach calls. For the intervention to effectively improve the SMART Aim measure, **NEDD/DQ** will need to successfully reach and educate enough members.

- HSAG recommends that **NEDD/DQ** revisit its quality improvement (QI) tools and processes throughout the PIP process to determine new interventions to test until December 31, 2024. **NEDD/DQ** should test as many interventions as possible as this gives the DO the greatest opportunity for achieving the desired outcomes for the PIP.

PMV

HSAG conducted the validation activities in New Hampshire as outlined in the CMS EQR *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023.[10] The following section of the report describes the results of HSAG's SFY 2024 EQR activities and provides conclusions as to the strengths and areas of opportunity related to the ***quality of care***, ***timeliness of care***, and ***access to care*** provided by the New Hampshire Medicaid DO. During SFY 2024, the DO submitted rates for 15 performance measures validated during PMV. HSAG offered recommendations to the DO to facilitate continued QI in the New Hampshire DMCM program.

Based on the validation activities, HSAG determined the result achieved by the DO for the performance measures.

HSAG identifies four possible validation finding designations for performance measures, which are defined in Table 3-7.

Table 3-7—Designation Categories for Performance Measures

Report (R)	Measure was compliant with state specifications.
Do Not Report (DNR)	DO rate was materially biased and should not be reported.
Not Applicable (NA)	The DO was not required to report the measure.
Not Reported (NR)	Measure was not reported because the DO did not offer the required benefit.

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

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

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 2, 2024.

The measure was determined *Reportable*: High confidence in the DO's ability to comply with New Hampshire's technical specifications for the measure during the reporting period.

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

Table 3-8 and Table 3-9 display the findings from the PMV activities conducted for the DO in SFY 2024.

Table 3-8—Measure-Specific Review Findings and Designations for NEDD/DQ

Performance Measure	Performance Measure Description	Key Review Finding	Measure Designation
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County	No issues were identified.	R
DENTAL_CLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	No issues were identified.	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	No issues were identified.	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy	No issues were identified.	R
DENTAL_APPEALS.01	Resolution of All Member Dental Appeals Within 45 Calendar Days	No issues were identified.	R
DENTAL_APPEALS.05	Resolution of Expedited Member Dental Appeals Within 72 Hours	No issues were identified.	R
DENTAL_APPEALS.06	Member Dental Services Authorized Within 72 Hours Following a Reversed Appeal	No issues were identified.	R
DENTAL_GRIEVANCE.02	Member Dental Grievances Received	No issues were identified.	R
DENTAL_PROVAPPEAL.01	Resolution of Dental Provider Appeals Within 30 Calendar Days	No issues were identified.	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries	No issues were identified.	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	No issues were identified.	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	No issues were identified.	R
DENTAL_SERVICEAUTH.01	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Post-Delivery Requests	No issues were identified.	R

Performance Measure	Performance Measure Description	Key Review Finding	Measure Designation
DENTAL_SERVICEAUTH.02	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	No issues were identified.	R
DENTAL_SERVICEAUTH.03	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	No issues were identified.	R

Table 3-9—SFY 2024 PMV Findings

Audit Element	NEDD/DQ Score
Adequate documentation: Data integration, data control, and performance measure development	Acceptable
Claims systems and process adequacy: No nonstandard forms used for claims	Acceptable
Appropriate membership and enrollment file processing	Acceptable
Appropriate provider data systems and processing	Acceptable
Appeals data system and process findings	Acceptable
Prior authorization and case management data system and process findings	Acceptable
Performance measure production and reporting findings	Acceptable
Required measures received a *Reportable* designation	Acceptable
Level of Confidence	**High Confidence**

Table 3-10 displays the validated SFY 2024 performance measure rates as well as the validation designations for each performance measure.

Table 3-10—Measure-Specific Rates and Designations for NEDD/DQ

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Belknap County	04/01/2023	0.06%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Belknap County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Carroll County	04/01/2023	0.05%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Carroll County	07/01/2023	0.02%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Cheshire County	04/01/2023	0.06%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Cheshire County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Coos County	04/01/2023	0.05%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Coos County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Grafton County	04/01/2023	0.05%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Grafton County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Hillsborough County	04/01/2023	0.05%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Hillsborough County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Merrimack County	04/01/2023	0.06%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Merrimack County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Rockingham County	04/01/2023	0.10%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Rockingham County	07/01/2023	0.02%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Strafford County	04/01/2023	0.07%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Strafford County	07/01/2023	0.02%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Sullivan County	04/01/2023	0.03%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Sullivan County	07/01/2023	0.01%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Non-NH. Unknown Counties	04/01/2023	0.06%	R
DENTAL_ACCESSREQ.01	Requests for Assistance Accessing Dentists by County: Non-NH. Unknown Counties	07/01/2023	0.00%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	04/01/2023	100.00%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	05/01/2023	78.30%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	06/01/2023	99.70%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	07/01/2023	99.90%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	08/01/2023	99.90%	R
DENTALCLAIM.01	Timely Processing of All Clean Dental Claims: Thirty Days of Receipt	09/01/2023	99.70%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	04/01/2023	0.00%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	05/01/2023	0.00%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	06/01/2023	0.00%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	07/01/2023	0.00%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	08/01/2023	0.00%	R
DENTAL_CLAIM.03	Interest on Late Paid Dental Claims	09/01/2023	0.00%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Oral and Maxillofacial Surgery	04/01/2023	0.00%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Oral and Maxillofacial Surgery	07/01/2023	99.70%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Adjunctive	04/01/2023	92.10%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Adjunctive	07/01/2023	100.00%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Periodontics	04/01/2023	93.30%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Periodontics	07/01/2023	97.30%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Maxillofacial Prosthetics	04/01/2023	0.00%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Maxillofacial Prosthetics	07/01/2023	0.00%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Implant Services	04/01/2023	0.00%	R
DENTAL_CLAIM.05	Claims Quality Assurance: Claims Financial Accuracy: Implant Services	07/01/2023	0.00%	R
DENTAL_APPEALS.01	Resolution of All Member Dental Appeals Within 45 Calendar Days	04/01/2023	100.00%	R
DENTAL_APPEALS.01	Resolution of All Member Dental Appeals Within 45 Calendar Days	07/01/2023	100.00%	R
DENTAL_APPEALS.05	Resolution of Expedited Member Dental Appeals Within 72 Hours	04/01/2023	100.00%	R
DENTAL_APPEALS.05	Resolution of Expedited Member Dental Appeals Within 72 Hours	07/01/2023	0.00%	R
DENTAL_APPEALS.06	Member Dental Services Authorized Within 72 Hours Following a Reversed Appeal	04/01/2023	100.00%	R
DENTAL_APPEALS.06	Member Dental Services Authorized Within 72 Hours Following a Reversed Appeal	07/01/2023	100.00%	R
DENTAL_GRIEVANCE.02	Member Dental Grievances Received	04/01/2023	0.03%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_GRIEVANCE.02	Member Dental Grievances Received	07/01/2023	0.00%	R
DENTAL_PROVAPPEAL.01	Resolution of Dental Provider Appeals Within 30 Calendar Days	04/01/2023	100.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	04/01/2023	0.53%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	05/01/2023	0.46%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	06/01/2023	0.35%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	07/01/2023	0.18%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	08/01/2023	0.25%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	09/01/2023	0.45%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Verifying Member Eligibility	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	04/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	05/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	06/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	07/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	08/01/2023	0.00%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	09/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Billing/Payment	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	04/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	05/01/2023	0.14%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	06/01/2023	0.10%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	07/01/2023	0.11%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	08/01/2023	0.22%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	09/01/2023	0.13%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Service Authorization	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	04/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	05/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	06/01/2023	0.00%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	07/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	08/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	09/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Change of Address, Name, Contact Info., etc.	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	04/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	05/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	06/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	07/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	08/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	09/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Enrollment/Credentialing	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	04/01/2023	0.00%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	05/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	06/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	07/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	08/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	09/01/2023	0.00%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Complaints about Dental Organization	10/01/2023	—	—
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	04/01/2023	0.06%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	05/01/2023	0.40%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	06/01/2023	0.55%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	07/01/2023	0.71%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	08/01/2023	0.53%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	09/01/2023	0.42%	R
DENTAL_PROVCOMM.03	Dental Provider Communications: Reasons for Telephone Inquiries: Other	10/01/2023	—	—
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	04/01/2023	100.00%	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	05/01/2023	100.00%	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	06/01/2023	100.00%	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	07/01/2023	100.00%	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	08/01/2023	100.00%	R
DENTAL_TIMELYCRED.01	Timely Provider Credentialing—Primary Dental Provider	09/01/2023	100.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	04/01/2023	100.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	05/01/2023	100.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	06/01/2023	100.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	07/01/2023	100.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	08/01/2023	0.00%	R
DENTAL_TIMELYCRED.02	Timely Provider Credentialing—Specialty Dental Providers	09/01/2023	100.00%	R
DENTAL_SERVICEAUTH.01	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Post-Delivery Requests	04/01/2023	92.20%	R
DENTAL_SERVICEAUTH.01	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Post-Delivery Requests	07/01/2023	84.20%	R

Performance Measure	Performance Measure Description	Indicator	PM Rate	Measure Designation
DENTAL_SERVICEAUTH.02	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	04/01/2023	0.00%	R
DENTAL_SERVICEAUTH.02	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	07/01/2023	100.00%	R
DENTAL_SERVICEAUTH.03	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	04/01/2023	88.60%	R
DENTAL_SERVICEAUTH.03	Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	07/01/2023	96.70%	R

— Indicates that indicator data were not provided for the performance measure; therefore, no rate or measure designation is displayed.

Conclusions and Recommendations for Improvement

NEDD/DQ used a variety of methods for producing the measures under review and had staff members dedicated to quality reporting. **NEDD/DQ** produced the measures in accordance with the specifications, benchmarked appropriately based on its population/sub-populations, and had sufficient policies and procedures in place to ensure reporting accuracy. **NEDD/DQ** demonstrated knowledge of the measures and provided system demonstrations without issue during the virtual review. HSAG had no concerns with the measure production for any measure under review this year.

HSAG identified opportunities for improvement in processes related to validation of performance measure DENTAL_CLAIM.03, considering **NEDD/DQ** did not have a routine process specific to claims that incurred interest after more than 30 days. HSAG recommends implementation of a regularly scheduled internal audit process to conduct quality assurance (QA) on claims that were adjudicated over 30 days wherein interest had been applied.

NAV

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

Information Systems Capabilities Assessment (ISCA): In accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4),[11] HSAG conducted a desk review of materials that the DO submitted, supplemented with live virtual review sessions demonstrating the information systems (IS), data processing procedures, and underlying methodology that the DO utilized to support its network adequacy indicator reporting.

- **Time and distance analysis:** New Hampshire requires the DO to meet geographic access standards by providing access to a minimum number of network providers within a minimum driving distance or driving time from members' residences.[12] For each type of dental service with a standard, HSAG calculated the percentage of members able to access care within the time or distance requirements defined in the DHHS MCM Services Contract and the required reporting template.

Appendix B contains further details on the methodology.

ISCA

HSAG completed an ISCA for **NEDD/DQ** and presented findings and an assessment of any concerns related to data sources used in the NAV. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for **NEDD/DQ**. Additionally, HSAG determined that **DQ**'s data collection procedures were acceptable.

Statewide Results

NEDD/DQ cooperated fully with the ISCA process and provided HSAG with the requested access to **NEDD/DQ's** IS. Based on the results of the ISCAs combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and whether **NEDD/DQ**'s interpretation of data was accurate.

Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has *High Confidence* in **NEDD/DQ**'s data systems, methodologies, and the accuracy and reliability of reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems for **NEDD/DQ**. Overall, HSAG

[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 3, 2025.

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

recommends that **NEDD/DQ** continue to monitor member access through network adequacy assessments based on DHHS' expectations.

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **NEDD/DQ** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 3-11 summarizes HSAG's validation ratings for **NEDD/DQ**, with **NEDD/DQ** receiving *High Confidence* for the two indicator types (access and availability and time and distance).

Table 3-11—Validation Ratings for the NEDD/DQ*

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Access and Availability	100%	0%	0%	0%
Time and Distance	100%	0%	0%	0%

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

Time and Distance Analysis

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if the DO meets either the time or distance requirement. This is the first year of activity for **NEDD/DQ** in New Hampshire, and **NEDD/DQ** met the time or distance standards for 93.3 percent of the dental service types assessed for SFY 2024. Table 3-12 displays the percentage of **NEDD/DQ** members who have the access to care required by contract standards for all applicable dental service types. Red shading indicates the DO did not meet minimum time or distance standards for a specific provider service type.

Table 3-12—Percentage of Members With Required Access to Care by Dental Service Types for NEDD/DQ

	Percent of Members With Access Within Time or Distance Standards					
	Urban Counties		Middle Counties		Rural Counties	
Type of Service	Time	Distance	Time	Distance	Time	Distance
Dental Diagnostic Services	98.0%	92.6%	100.0%	96.6%	100.0%	100.0%
Dental Preventive Services	98.0%	92.3%	100.0%	96.6%	100.0%	100.0%
Dental Restorative Services	98.0%	92.3%	100.0%	96.6%	100.0%	100.0%
Dental Oral and Maxillofacial Surgery	99.3%	95.6%	96.4%	77.6%	83.9%	1.6%

	Percent of Members With Access Within Time or Distance Standards					
	Urban Counties		Middle Counties		Rural Counties	
Type of Service	Time	Distance	Time	Distance	Time	Distance
Dental Adjunctive General Services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: The time and distance standards vary by urbanicity, taking into account different driving conditions and average expected driving speeds. For example, the standard for oral and maxillofacial surgeons in rural counties is one provider within 120 minutes or 80 miles. In a rural county with average driving speeds of 55 mph, this means that a member could potentially reach a provider 110 miles from their residence in two hours. This sometimes produces fairly large differences in the percentage of members with access using the time standard versus the distance standard.

Of the 15 time and distance standards that HSAG assessed, **NEDD/DQ** met the standards for 14 (93.3 percent), For four of the five service types, **NEDD/DQ** met standards across all three urbanicities. **NEDD/DQ** did not meet either the time or distance standard for access to dental oral and maxillofacial surgery in rural counties.

Health Plan-Specific Conclusions and Recommendations

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

NEDD/DQ

HSAG recommends that **NEDD/DQ** maintain current levels of access to care and continue to address network gaps in rural counties for dental oral and maxillofacial surgery.

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

EDV

During SFY 2024, DHHS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023,[13] HSAG conducted the following two core evaluation activities for the EDV activity:

- IS review—assessment of **NEDD/DQ**'s IS and processes.
- Ongoing encounter data quality reports—assess completeness, accuracy, and timeliness of **NEDD/DQ**'s encounter data files submitted to DHHS on a monthly/quarterly basis.

[13] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 2, 2024.

The ongoing encounter data quality reports evaluated encounters submitted to DHHS between July 1, 2023, and June 30, 2024. Of note, HSAG received encounters from **NEDD/DQ** starting May 2024.

Information Systems Review

Health Plan Comparisons

The IS review component of the EDV study provided self-reported qualitative information from **NEDD/DQ**. Based on **NEDD/DQ**'s responses, below are key findings:

- **NEDD/DQ** had policies and procedures in place to document and guide the intake of claims and encounter data from dental providers and its NEMT subcontractor, validate the claims and encounter data, and submit encounter files to DHHS.
- Upon receiving response files from DHHS, **NEDD/DQ** used its data review and correction process to respond to quality issues identified by DHHS bimonthly. **NEDD/DQ** also had an internal processing policy to identify duplicate claims.
- **NEDD/DQ** had subcontracted Gainwell Technologies, LLC (Gainwell) for additional management of TPL information.
- The only notable issue is that **NEDD/DQ** did not perform any quality checks on dental claims other than Electronic Data Interchange (EDI) compliance checks.

Health Plan-Specific Conclusions and Recommendations

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

- On the dental and NEMT encounters, **NEDD/DQ** should perform more data quality checks such as the following:
  - Reconciliation With Financial Reports
  - Claim Volume by Submission Month
  - Timeliness

Ongoing Encounter Data Quality Reports

Health Plan Comparison

Through the monthly and quarterly reports, HSAG evaluated encounter data in four areas: (1) encounter submission accuracy and completeness, (2) encounter data completeness, (3) encounter data accuracy, and (4) encounter data timeliness. While the ongoing reports are produced on a monthly/quarterly basis, Table 3-13 displays aggregate compliance rates for **NEDD/DQ** in relation to the five standards within Exhibit A of the contract. The aggregate results are for encounters submitted to DHHS between July 1, 2023, and June 30, 2024. Of note, if **NEDD/DQ** fails to meet a standard, the DO can work with DHHS to determine whether **NEDD/DQ** is responsible for the missed measure and if DHHS should adjust the measure result.

Table 3-13—Aggregate Rates for Encounter Data Submission and Quality Standards¥

Evaluation Area	Standard	837D Encounters		837P Encounters	
		% Present	% Valid	% Present	% Valid
X12 EDI Compliance Edits	98.0%	100%		100%	
Validity of Member Identification Number	100%	100%	100%	100%	99.9%
Validity of Billing Provider Information	98.0%	100%	>99.9%	100%	100%
Validity of Servicing Provider Information	98.0%	100%	100%	100%	100%
Initial Submission Within 14 Days of Claim Payment	100%	100%		100%	

¥ When cells showing "% Present" and "% Valid" are merged, rates for the evaluation area are displayed.
Green text indicates rates meeting the standards.

The list below includes the findings for each standard:

- **X12 EDI Compliance Edits:** **NEDD/DQ** met the submission standard regarding the X12 EDI compliance edits, with HSAG successfully translating 100 percent of all submitted 837D/P encounters.
- **Member Identification Number:** **NEDD/DQ** populated all submitted encounters with member ID numbers for both encounter types. However, when HSAG assessed these values, **NEDD/DQ** either met the percent accurate standard of 100 percent or fell slightly below the standard by no more than 0.1 percentage points.
- **Billing Provider Information:** **NEDD/DQ** populated all submitted encounters with billing provider information for both encounter types. As for the percent valid standard of 98.0 percent, **NEDD/DQ** met the standard.
- **Servicing Provider Information:** **NEDD/DQ** populated all submitted encounters with servicing provider information for the 837D/P encounters. As for the percent valid standard of 98.0 percent, **NEDD/DQ** met the standard.
- **Initial Submission Within 14 Days of Claim Payment:** **NEDD/DQ** met the standard (100 percent) for the percentage of encounters initially submitted to DHHS within 14 calendar days of claim payment dates.

Health Plan-Specific Conclusions and Recommendations

NEDD/DQ's submitted encounters met the standards for the X12 EDI compliance edits, the accuracy for member ID numbers for 837D encounters, the accuracy for billing providers and servicing providers for all encounter types, and timely initial encounter data submissions to DHHS within 14 calendar days of the claim payment date for all encounter types.

HSAG recommends that **NEDD/DQ** submit reconciliation files to DHHS and HSAG when submitting its 837D and 837P encounters. While **NEDD/DQ**'s rate was only slightly below the standard, **NEDD/DQ** should work to improve its data accuracy for the member ID numbers for its 837P encounters.

Other EQR Activities

Quality Study

New Hampshire DHHS asked HSAG to conduct a quality study to determine the effectiveness of the DO's education to members and providers regarding the extra cleaning benefit for pregnant members during their perinatal period.

HSAG collected information for the study by sending questionnaires to the DO in New Hampshire: **Delta Dental Plan of New Hampshire, Inc.** (doing business as [DBA] **NEDD**), which subcontracts with **DQ** to administer benefits for the New Hampshire DMCM program.

Methodology

To begin the study, HSAG prepared a list of questions for the DO to answer regarding the education it provides to members and providers about the extra cleaning benefit for pregnant members. Once received, HSAG prepared follow-up questions for the DO to answer. Additionally, HSAG requested that the DO provide the number of pregnant members who received the first cleaning, the second cleaning, and the third (extra) cleaning during each month of the study period (i.e., April 2023 to May 2024). Using the information provided, HSAG investigated the effectiveness of the DO's member and provider education based on the number and percentage of members who received the extra cleaning benefit.

Findings

Table 3-14 demonstrates that there was an average of 430 pregnant members per month during the 14 months of the study. Only 17 pregnant members received one dental cleaning, one member received two dental cleanings, and no members received the additional benefit of a third cleaning. HSAG was unable to determine the total number of unique members who were pregnant during the study, so a percentage of unique members receiving the cleanings could not be calculated.

Table 3-14—Pregnant Members Who Received Dental Cleanings

Average Number of Pregnant Members per Month	Number of Members Who Received One Cleaning	Number of Members Who Received Two Cleanings	Number of Members Who received Three Cleanings
430	17	1	0

Conclusions, Limitations, and Recommendations

During the study, HSAG found that only 17 pregnant members received their first dental cleaning, one member received a second dental cleaning, and no members received the third cleaning. During any given month, fewer than 1 percent of members eligible for dental cleanings received them. While the DO educates members and providers about the third dental cleaning available for pregnant members, it appears that most pregnant members are not receiving the first and second cleanings available to all

members. Therefore, it is unlikely that they will receive the additional cleaning available to them during their pregnancy.

Limitations

HSAG requested the number of pregnant women during each month of the study from the DO. Because pregnancy typically last nine months, many members are included in the denominator multiple times. Therefore, it is difficult to know how many unique members were pregnant during the study period, when each member became eligible, and when their eligibility ended.

HSAG does not have information regarding the number and percentage of members in the DO's entire population who received the first and second cleanings. Therefore, it is unclear if the low number and percentage of pregnant members receiving those services is reflective of the entire population.

Recommendations

HSAG provides the following recommendations from the information obtained during this study for DHHS and the DO to consider:

- The DO should focus on improving the rate of members who receive their regular two cleanings during the calendar year to ensure adequate oral health.
- DHHS could require the DO to develop a performance improvement project concentrating on successful first and second cleaning completion rates.
- The DO and/or DHHS should review network adequacy and appointment availability for members to determine if access could be a barrier for members to obtain preventive dental services.
- The DO should conduct a barrier analysis to determine the reasons that members, specifically pregnant members, are not receiving the recommended dental care. The DO could use a survey or member focus group to identify potential barriers to care.
- The DO should use information obtained through the surveys, member focus groups, and barrier analysis to develop targeted interventions to reduce the barriers to obtaining dental care.
- The DO should partner with the MCOs and their case managers to ensure that pregnant women are aware of the enhanced dental services available to them.
- The DO could revise the introduction to the interactive voice response (IVR) script to entice members to listen to the entire message. After identifying who is calling by saying, "Hello, this is DentaQuest," the script could immediately inform members about an exciting, no-cost benefit available to them for the next 12 months. The members could then be connected to a live caller or be instructed to call **NEED/DQ** to learn more about the benefit.
- The DO also could consider using a live caller rather than IVR to assist members in scheduling an appointment.
- The DO could consider contacting members more than one time during their pregnancy to inform them of the benefit and importance of obtaining three recommended dental cleanings.

- The DO could consider developing an incentive (e.g., gift card) for pregnant members who receive all three dental cleanings.

Provider Satisfaction Survey

HSAG and DHHS developed a survey instrument designed to acquire provider information and gain providers' insight into **NEDD/DQ**'s performance and potential areas of performance improvement. The survey was administered to dental providers who contract with **NEDD/DQ** and provide services to adult beneficiaries. HSAG categorized the survey questions into the following six domains:

- **Overall Satisfaction**—presents providers' overall level of satisfaction with **NEDD/DQ**.
- **NEDD/DQ Processes**—presents providers' satisfaction with claims processing and obtaining non-pharmacy authorizations through **NEDD/DQ**.
- **Access to NEDD/DQ Staff and Services**—presents providers' assessment of access to utilization management staff, complex case/care managers, interpretative services, and call center staff at **NEDD/DQ**.
- **Obtaining Member Information**—presents providers' satisfaction in obtaining member information through the call center and Web portal for **NEDD/DQ**.
- **Provider Relations**—presents providers' satisfaction with provider relations for **NEDD/DQ**.
- **Covered Services at Medicaid Plan**—presents providers' assessment of getting dental medications covered and pharmacy authorizations from the Medicaid MCOs—**AmeriHealth Caritas New Hampshire, Inc.** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), and/or **WellSense Health Plan** (**WS**).

Response options were classified into one of three response categories: (1) satisfied, (2) neutral, and (3) dissatisfied. Then, HSAG calculated the proportion (i.e., percentage) of responses in each response category. As is standard in most survey implementations, "top-box" scores are defined by the proportion of positive or satisfied responses. Since all measures had fewer than 100 respondents, caution should be exercised when interpreting these results.

Table 3-15 depicts the proportion of satisfied responses (i.e., satisfied or very satisfied; usually or always; yes) for each of the provider survey domains and measures. Since 2024 was the first year **NEDD/DQ** providers were surveyed, trending results are not available.

Table 3-15—Provider Survey Results for DentaQuest

	2024 Top-Box Scores
Overall Satisfaction	
Overall Satisfaction	50.00%
NEDD/DQ Processes	
Claims Processing	72.00%

	2024 Top-Box Scores
Non-Pharmacy Authorizations	48.57%
Access to NEDD/DQ Staff and Services	
Access to Knowledgeable Utilization Management Staff	48.57%
Access to Complex Case/Care Managers	23.81%
Interpretative Services	12.50%
Call Center Staff	48.65%
Obtaining Member Information	
Call Center	66.67%
Web Portal	81.63%
Provider Relations	
Provider Relations	61.22%
Covered Services at Medicaid Plan	
Getting Dental Medications	67.86%
Pharmacy Authorizations	72.73%

Secret Shopper Provider Survey

As part of its provider network adequacy monitoring activities, DHHS requested HSAG to conduct a secret shopper survey among dental providers contracted with New Hampshire's Medicaid DO to ensure members have access to accurate provider information.

The goal of the survey was to evaluate New Hampshire's Medicaid DO network of dental locations. Specific survey objectives included the following:

- Determine the accuracy of the contact information (i.e., phone number, address) for the dental providers reported by the DO as being contracted dental providers.
- Determine whether dental locations accept patients enrolled with the DO for the New Hampshire Medicaid program and the degree to which the study's DO and program acceptance rates align with the DO's provider data.
- Determine whether dental locations accepting the DO for the New Hampshire Medicaid program accept new patients and the degree to which the study's new patient acceptance rate aligns with the DO's provider data.
- Determine appointment availability with the sampled dental locations for routine dental care.

To address the study objectives described above, HSAG used a DHHS-approved methodology (Appendix B) to conduct the SFY 2024 DO Secret Shopper Survey for **Delta Dental Plan of New Hampshire, Inc.** DBA **NEDD** and the plan administrator, **DQ**.

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

From the results of this year's plan-specific activities, HSAG summarizes the DO'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 the DO provides. The evaluations are based on the following definitions of quality, timeliness, and access:

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

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, or PAHP entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[14]
- ***Timeliness***—The National Committee for Quality Assurance (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."[15] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the DO (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).[16]

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

[14] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 2, 2024.

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

[16] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 2, 2024.

§438.364(a)(1).[17] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the ***quality***, ***timeliness***, and ***access*** to care furnished by the DO.

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

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

[17] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Dec 2, 2024.

Northeast Delta Dental

Contractual Compliance

This was the first year that HSAG completed a compliance review with **NEDD/DQ** in New Hampshire, and the DO achieved an overall score of 83.9 percent on the review. Of the 16 standards reviewed that included 613 applicable elements, **NEDD/DQ** achieved a 100 percent score in four standards. Those elements demonstrated strength in compliance with federal and State requirements for ***quality of care***, ***timeliness of care***, and ***access to care*** for the New Hampshire Medicaid DMCM beneficiaries.

NEDD/DQ demonstrated strengths in the Wellness/Prevention/Member Education standard by implementing evidence-based oral health wellness and prevention programs for its members, such as the Smiling Stork and Broken Appointment programs. The DO also implemented incentive programs for healthy behaviors for members who completed an opioid misuse risk assessment and members who received two preventive dental visits during a 12-month period. These programs contributed to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NEDD/DQ**'s members.

NEDD/DQ demonstrated strengths in the Fraud, Waste, and Abuse standard by highlighting its program integrity processes as they relate to subcontracting, provider applications, and credentialing and recredentialing. One document described the DO's process to suspend provider payments and investigate any allegations of suspected fraud. Additional documents provided the processes the DO followed after investigations were completed.

NEDD/DQ demonstrated strengths in the Financial standard by ensuring its risk-based capital ratio was more than two, and it remained in compliance with the New Hampshire Insurance Department solvency requirements. The DO also maintained a recoveries process flow confirming its responsibility and process for cost avoidance through coordination of benefits as they relate to federal and private health insurance resources. These activities may result in improved ***quality of care*** and ***timeliness of care*** for **NEDD/DQ**'s members.

NEDD/DQ demonstrated strengths by complying with requirements in the TPL standard. DO documents and staff interviews confirmed the implementation of TPL claims processing and handling of the recovery of applicable funds. The DO's process documents correctly illustrated the process used to ensure that **NEDD/DQ** coordinated payments to ensure any responsible third parties paid for services as applicable.

NEDD/DQ could strengthen the delegation and subcontracting standard to improve compliance with State and federal requirements by ensuring that subcontractors receive all required information when they enter into a contract with **NEDD/DQ**. Since the information includes informing subcontractors about the grievance and appeal system, evaluating the subcontractor's ability to perform the activities being delegated, remedies for performance deficiencies up to and including termination, non-discrimination requirements when interacting with members, and screening employees to ensure they are not excluded from participation in federal contracts could improve ***quality of care*** and ***access to care*** for **NEDD/DQ**'s members.

Compliance with the requirements for emergency and post-stabilization care could be strengthened by ensuring that the provider treating the member determines when the member is stabilized for transfer or discharge, ensuring that the DO understands the requirements and limitations associated with the financial responsibilities of post-stabilization care, and ensuring that members are not billed inappropriately for post-stabilization services. Improvement in emergency and post-stabilization care could result in improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NEDD/DQ**'s members. To improve the Emergency and Post-Stabilization Care standard, **NEDD/DQ** must ensure that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. **NEDD/DQ** also must ensure its documentation indicates the DO's financial responsibility for services for emergency and post-stabilization services and when its financial responsibility ends. Additionally, **NEDD/DQ** must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if the member obtained the services through the DO. These activities may result in improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NEDD/DQ**'s members.

To improve the Care Management/Care Coordination standard, **NEDD/DQ** must ensure care managers are not related by blood or marriage to a member, financially responsible for a member, or have any legal power to make financial or health-related decisions for the member to maintain conflict-free care management. **NEDD/DQ** must also ensure that all completed Dental Risk Assessment Screenings are shared with the member's assigned PDP for inclusion in the member's dental record within seven calendar days of completing the screening. Ensuring care managers remain conflict-free and sharing Dental Risk Assessment Screenings with members' PDPs may contribute to enhanced ***quality of care*** for Medicaid members.

To improve the Member Enrollment and Disenrollment standard, **NEDD/DQ** must notify DHHS within five business days when it identifies information regarding a member's circumstances that may affect the member's eligibility, including changes in the member's residence, out-of-state claims, or death of the member. The DO also must accept for automatic reenrollment members who were disenrolled due to a loss of Medicaid eligibility for a period of two months or less. **NEDD/DQ** also must ensure that it does not request disenrollment because of the member's misuse of substances, prescribed or illicit, and any legal consequences resulting from substance misuse. If the DO requests involuntary disenrollment, it must submit documentation and justification to DHHS for review. These activities could result in improved ***access to care*** for **NEDD/DQ**'s members.

Compliance with member services requirements could be strengthened by ensuring that the DO informs new members about accessing the automated provider directory and the right to request a printed version of the directory within 10 calendar days of **NEDD/DQ**'s receipt of enrollment information. Member information must be accessible to existing and potential members requesting assistance with written and verbal translation services, ASL, TTY/TDD services for the deaf, and large print documents for the visually impaired. These activities may result in improved ***timeliness of care*** and ***access to care*** for **NEDD/DQ**'s members.

To improve the Cultural and Accessibility Considerations standard, **NEDD/DQ** must ensure providers furnish accommodations to members with behavioral disabilities. **NEDD/DQ** must also develop effective, appropriate methods for identifying, flagging in electronic systems, and tracking members' needs for communication assistance for health encounters, including preferred spoken language for all encounters, the need for an interpreter, and preferred language for written information. Additionally, **NEDD/DQ** must have a process to inform the member of the potential consequences of declining interpretation services and offer the services at each new contact. These activities may contribute to improved ***quality of care*** for members.

To improve the Grievances and Appeals standard, **NEDD/DQ** must inform providers about the grievance and appeal system and train providers to assist members in filing a grievance or appeal. **NEDD/DQ** must have a process in place to extend the time frame for processing a grievance by up to 14 calendar days if the member requests the extension or if the DO needs additional information. If the DO extends the timeline for a grievance not at the request of the member, it must promptly notify the member orally and give the member written notice within two calendar days of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with the decision. Additionally, for termination, suspension, or reduction of previously authorized services, the DO must provide members written notice at least 10 calendar days before the date of action, except for instances outlined in federal rule. The DO must acknowledge the receipt of each grievance and appeal; resolve grievances within 45 calendar days of receipt; resolve all expedited appeals within 72 hours of receipt; provide written resolution of appeals to the member regardless of who initiated the appeal (e.g., the member, the member's authorized representative, or the provider); and obtain written consent for any appeal not initiated by the member. These activities may result in improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NEDD/DQ**'s members.

To improve the Access standard, **NEDD/DQ** must demonstrate that there are sufficient IHCPs in the participating provider network to ensure timely access to services for American Indians who are eligible to receive services. The DO's network must meet the standards for timely access to care and services, considering the urgency of the need for services and ensuring the network capacity can meet the expectations for timely care. Additionally, **NEDD/DQ** must have a process to ensure providers comply with the timely appointment standards. If a provider terminates from the network, the DO must have a transition plan in place within three business days for all affected members and continue to provide services, notify the member in writing within seven calendar days, and develop a transition plan for members participating in an ongoing course of treatment. These activities can lead to improved ***timeliness of care*** and ***access to care*** for **NEDD/DQ**'s members.

To improve the Network Management standard, **NEDD/DQ** must ensure its credentialing and recredentialing processes include all the New Hampshire requirements as outlined in the DO's contract including (1) ensuring all providers have a New Hampshire Medicaid ID number included in the provider's application, (2) credentialing general dentists within 30 days of receipt of a complete application and specialty dentists within 45 days of receipt of a complete application, (3) ensuring that the approval process for a provider ends on the date of the provider's written notice of network status, and (4) ensuring that it pays the provider retroactive to 30 calendar days or 45 calendar days (respectively) if the DO does not process a provider's complete credentialing application within DHHS'

established time frames. The DO must have a dedicated contact number for DO staff located in New Hampshire available from 8:00 a.m. to 6:00 p.m. Monday through Friday and have a process in place to handle after-hours inquiries from providers seeking a service authorization for a member with an urgent dental condition. The DO's provider training documentation must include training specific to person-centered care management; SDOH; quality, privacy, and confidentiality of certain conditions; billing and required documentation; supporting and assisting members with grievances; and provider appeals processes. These activities can contribute to improved ***quality of care***, ***timeliness of care***, and ***access to care*** for **NEDD/DQ**'s members.

To improve the Utilization Management standard, **NEDD/DQ** must ensure that determinations of standard pre-service authorizations are made within a reasonable time period appropriate to the medical circumstances, not to exceed 14 calendar days, and that an extension of up to 14 calendar days is permissible if the member or the provider requests the extension, or the DO justifies the need for additional information. Additionally, if clinical review criteria change, **NEDD/DQ** must notify participating providers and members at least 30 calendar days in advance of the change. Additionally, to improve the handling of denials of service authorizations, **NEDD/DQ** must resolve all standard prior authorization requests within 14 calendar days. These activities could result in improved ***timeliness of care*** and ***access to care*** for **NEDD/DQ**'s members.

To improve the Quality Management standard, **NEDD/DQ** must adopt evidence-based CPGs that are based on valid, reasonable clinical evidence or a consensus of providers in a particular field; consider the needs of the DO's members; are adopted in consultation with participating providers; and are reviewed and updated periodically. The DO also must adopt CPGs consistent with the standards of care and evidence-based practices of specific professional specialty groups. The DO may substitute generally recognized guidelines to replace recommendations of the U.S. Preventive Services Task Force, provided that the DO meets all other practice guideline requirements of the DHHS contract and that DHHS reviews these substitutions prior to implementation. **NEDD/DQ** also must disseminate CPGs to DHHS and all affected providers and upon request to members and potential members. CPGs also must be available on the DO's website. The DO's decisions regarding utilization management, member education, and coverage of services must be consistent with the DO's CPGs. These activities may result in improved ***quality of care*** for **NEDD/DQ**'s members.

To improve the Health Information Systems standard, **NEDD/DQ** must maintain a health information system that collects, analyzes, integrates, and reports confidential data. The DO must implement an API as specified in 42 CFR §431.60 (member access to and exchange of data). Information must be made accessible to its current members or their personal representatives through the API. Additionally, **NEDD/DQ** must maintain a publicly accessible standards-based API as described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). The process of collecting, analyzing, integrating, and reporting member information will assist the DO in improving ***quality of care*** and ***access to care*** for the New Hampshire Medicaid members.

PIPs

For the *Dental Risk Assessment Screening—SDOH* PIP, there was an opportunity to improve the ***quality of care*** and ***access to care*** for eligible members.

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

- Successfully executed a methodologically sound PIP.
- Used QI tools and processes effectively to determine barriers and develop targeted interventions.
- Tested interventions using PDSA cycles.

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

- **NEDD/DQ** should continue to use short testing periods to ensure quick and timely data collection and analyses of effectiveness for each intervention. The testing methodology should allow **NEDD/DQ** to quickly gather data and make data-driven revisions to facilitate meaningful, impactful PDSA cycles and support achievement of the SMART Aim goal or improvement over the baseline performance.
- For the member education intervention, **NEDD/DQ** should consider tracking an additional intervention effectiveness measure focused on completion rates of outreach calls. For the intervention to effectively improve the SMART Aim measure, **NEDD/DQ** will need to successfully reach and educate enough members.
- **NEDD/DQ** should revisit its QI tools and processes throughout the PIP process to determine new interventions to test until December 31, 2024. **NEDD/DQ** should test as many interventions as possible to give the DO the greatest opportunity for achieving the desired outcomes for the PIP.

PMV

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

- Implement a regularly scheduled internal audit process to conduct QA on claims that were adjudicated over 30 days wherein interest had been incurred. As it relates to processes surrounding validation of performance measure DENTAL_CLAIM.03, **NEDD/DQ** did not have a process specific to claims that incurred interest after more than 30 days. Improving this requirement will facilitate ***quality of care***.

NAV

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

Strengths

- **NEDD/DQ** had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform calculation of network adequacy standards and indicators. HSAG had no concerns with **DQ**'s data collection procedures, network adequacy methods, or network adequacy results.
- **NEDD/DQ** had sufficient policies and procedures in place to ensure that **NEDD/DQ** uses sound methods to assess the adequacy of its managed care networks as required by the State and accurately reported results to the State in the required format. HSAG has *High Confidence* in **NEDD/DQ**'s ability to produce and report accurate results to support the DO's and the State's network adequacy monitoring efforts.
- DHHS requires its contracted DOs to provide ***access to care*** to 90 percent of members within DHHS' time and distance standards. **NEDD/DQ** met the State's time and distance standards for all five dental service types in urban and middle counties and four of the five service types in rural counties. Based on these findings, members' ***access to care*** is robust for dental diagnostic services, dental preventive services, dental restorative services, and dental adjunctive general services.

Opportunities for Improvement

- HSAG did not identify any specific opportunities related to the data collection and management processes **NEDD/DQ** had in place to inform calculation of network adequacy standards and indicators.
- **NEDD/DQ** did not meet the 90 percent time and distance standard for one dental service type, dental oral and maxillofacial surgery, in rural counties.

EDV

In the IS review activity, **NEDD/DQ** had policies and procedures in place to document and guide the intake of claims and encounter data from dental providers and its NEMT subcontractor, validate the claims and encounter data, and submit encounter files to DHHS. Upon receiving response files from DHHS, **NEDD/DQ** used its data review and correction process to respond to quality issues identified by DHHS bimonthly. **NEDD/DQ** also had an internal processing policy to identify duplicate claims. **NEDD/DQ** had subcontracted Gainwell technologies for additional management of TPL information. The only notable issue was that **NEDD/DQ** did not perform any quality checks on dental claims other than EDI compliance checks.

NEDD/DQ's submitted encounters met the standards for the X12 EDI compliance edits, the accuracy for member ID numbers for 837D encounters, the accuracy for billing providers and servicing providers

for all encounter types, and timely initial encounter data submissions to DHHS within 14 days of the claim payment date for all encounter types. HSAG recommends that **NEDD/DQ** submit reconciliation files to DHHS and HSAG when submitting its 837D and 837P encounters. While **NEDD/DQ**'s rate was only slightly below the standard, **NEDD/DQ** should work to improve the data accuracy for the member ID numbers associated with 837P encounters. Without complete and accurate encounter data in DHHS' data warehouse, it could be difficult to monitor and improve ***quality of care*** and ***access to care***.

Quality Study

Since only 17 total members received the first dental cleaning and one member received the second dental cleaning during the 14 months of this study, it appears that most pregnant members are not receiving the first and second cleanings that they should receive as part of their regular benefits. While it is important for members to be aware of and receive the third cleaning during pregnancy, HSAG recommends that the DO focus on improving the rate of members who receive their regular two cleanings during the calendar year to ensure adequate oral health. Focusing on improving the rate of members who receive their two regular cleanings during the calendar year will improve member ***access to care***.

Because of the low number and percentage of pregnant members accessing dental care, HSAG recommends that the DO and/or DHHS review network adequacy and appointment availability for members to determine if access could be a barrier for members to obtain preventive dental services. It is important that the dental provider network is adequate and has available appointments to ensure ***access to care*** and ***timeliness of care*** for members.

HSAG also recommends that the DO conduct a barrier analysis to determine the reasons that members, specifically pregnant members, are not receiving the recommended dental care. The DO could accomplish this using a survey method or member focus group to identify potential barriers to care. The DO should use this information to develop targeted interventions to reduce barriers to obtaining dental care. Understanding members' barriers to receiving the recommended dental care can assist the DO in improving ***access to care*** and ***timeliness of care*** for its pregnant members.

HSAG recommends that the DO partner with the MCOs and their case managers to ensure that pregnant women are aware of the enhanced dental services available to them. If the member is working with a MCO case manager, the case manager would be a good resource to encourage the member to obtain appropriate dental care. This could help improve the DO's ***access to care*** for its members.

The DO could consider revising the introduction to the IVR script. After identifying who is calling by saying, "Hello, this is DentaQuest," the script could immediately inform members about an exciting, no-cost benefit available to them for the next 12 months. Then the members could be connected to a live caller or be instructed to call DentaQuest to learn more about the benefit. Additionally, the DO could consider contacting members more than one time during their pregnancy to inform them of the benefit and importance of obtaining three recommended dental cleanings. The DO also could consider using a live caller rather than IVR to help the member schedule an appointment. Ensuring members are aware of

the extra cleaning benefit can improve ***access to care***, ***timeliness of care***, and ***quality of care*** for pregnant members.

The DO should consider developing a program to incentivize pregnant members to obtain all three dental cleanings. Having a new baby can be expensive, and pregnant mothers may be more inclined to obtain all the recommended dental cleanings if there is an extra incentive, such as a gift card to purchase items for the baby, such as diapers. Incentives can help encourage members to obtain the appropriate dental care, thereby increasing the ***quality of care*** pregnant members receive.

Provider Satisfaction Survey

Over half of **NEDD/DQ**'s providers were not accepting new patients. Approximately 43 percent of the providers who contracted with **NEDD/DQ** reported they were accepting new patients, while approximately 57 percent reported they were not accepting new patients. Additionally, two of the providers indicated that they were not contracted with **NEDD/DQ**.

Strengths[18]

Approximately half of the providers who contracted with **NEDD/DQ** reported *high* levels of *Overall Satisfaction* (i.e., very satisfied or satisfied) with **NEDD/DQ**, which represents high ***quality of care***. Furthermore, providers reported *high* levels of experience in the following areas:

- *Claims Processing*
- *Obtaining Member Information—Call Center* ***(access to care)***
- *Obtaining Member Information—Web Portal* ***(access to care)***
- *Provider Relations* ***(quality of care)***
- *Getting Dental Medications* ***(access to care)***
- *Pharmacy Authorizations* ***(timeliness of care)***

Areas for Improvement

Providers reported *low* levels of experience for *Interpretative Services,* which represents unsatisfactory ***access to care***.

Additionally, providers were encouraged to write comments in the open-ended response portion of the survey about their experience with **NEDD/DQ**. HSAG evaluated the provider comments and summarized the reoccurring comments. Although the results indicated that providers reported *high* levels of experience across several measures, provider comments indicated other areas that have opportunities for improvement. For instance, providers commented that **NEDD/DQ**'s fee schedules are low and coverage is limited; patients reported concerns about dental procedure coverage; and

[18] Due to the low number of respondents, caution should be exercised when evaluating these results.

NEDD/DQ is disorganized, resulting in providers having difficulty navigating the plan and getting claims submitted and processed.

To address these concerns, DHHS should consider evaluating the cost of dental care as well as the coverage to ensure that it is comprehensive, and that patients have access to the care they require (e.g., expanding code coverage). Additionally, DHHS should monitor the response category proportions to ensure that significant decreases in scores over time do not occur. **NEDD/DQ** should consider reevaluating fee schedules, which may lead to providers staying in network and providing care to **NEDD/DQ** patients. **NEDD/DQ** could improve access to interpretative services and make information on how to obtain these services available to providers and patients. **NEDD/DQ** should ensure the accuracy of information relayed to providers and update Web portals, benefits, and coverage information. **NEDD/DQ** could explore ways to streamline the process for claims submission and reimbursement.

Secret Shopper Survey

The following sections provide information concerning **NEDD/DQ**'s strengths identified during the secret shopper survey and opportunities for improvement.

Strengths

- Of the cases reached, 100 percent indicated the sampled address was correct, demonstrating data quality and improved ***access to care*** for **NEDD/DQ** members.
- Of the cases reached, 100 percent indicated the location offered the requested services, demonstrating data quality and improved ***access to care*** for **NEDD/DQ** members.

Opportunities for Improvement

- **NEDD/DQ** had an overall response rate of 87.5 percent, with all unresponsive cases reaching a voicemail after three attempts to contact the office. **NEDD/DQ** should consider conducting a review of the offices' customer service processes to ensure staff members are available during business hours and office procedures do not unduly burden members in their ability to reach a provider or to gain ***access to care***.
- Among **NEDD/DQ**'s contacted locations, 88.9 percent confirmed acceptance of the requested insurance. **NEDD/DQ** should consider reviewing the processes used to ensure that it updates and maintains provider data in an accurate and timely manner. Additionally, **NEDD/DQ** should conduct outreach to its providers to ensure the providers or their offices routinely submit up-to-date insurance information for the provider location to increase data quality and ***access to care*** for its members.
- Overall, 81.0 percent of **NEDD/DQ**'s locations indicated acceptance of new patients. **NEDD/DQ** should consider reviewing provider panel capacities and the availability of providers to accept new patients relative to **NEDD/DQ**'s membership to determine whether additional provider contracts should be executed to increase ***access to care*** for its members.

- Overall, 54.0 percent of contacted locations offered an appointment, with 70.6 percent of appointments within DHHS' compliance standards. **NEDD/DQ** should work with its contracted providers to ensure sufficient appointment availability for members to improve ***access to care*** and ensure ***timeliness of care***.

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

Table 4-1—Conclusions Regarding NEDD/DQ's Strengths in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Strengths
	✓	✓	**NEDD/DQ** met the time and distance standards for all five dental service types in urban and middle counties and four of the five service types in rural counties (all except dental oral and maxillofacial surgery). Additionally, all provider offices reached during the secret shopper survey offered the requested services and had a correct address in **NEDD/DQ**'s system, ensuring that members could locate the provider and obtain the services needed. Based on these findings, members' access to dental diagnostic services, dental preventive services, dental restorative services, and dental adjunctive general services is robust.

Table 4-2—Conclusions Regarding NEDD/DQ's Weaknesses in Access, Timeliness, and Quality Domains

Quality	Access	Timeliness	Weaknesses
	✓	✓	During the secret shopper survey, only 54 percent of provider offices offered an appointment when contacted. Although **NEDD/DQ** had sufficient providers in its network according to the time and distance requirements, members may not be able to access timely appointments. Additionally, as indicated by the quality study, only 17 pregnant members received an initial dental appointment and one pregnant member received a second dental appointment. As just over half of providers could offer an appointment, this could indicate that members are unable to schedule an appointment.

5. Assessment of the New Hampshire MCM Quality Strategy

Background

DHHS developed the New Hampshire MCM Quality Strategy dated July 2, 2024, as required by 42 CFR §438.340. The final rule issued by CMS, Department of Health and Human Services, was published in the Federal Register on May 10, 2024. According to 42 CFR, the State's quality strategy must include:

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

Methodology

DHHS provided HSAG with Revision #8 of the New Hampshire MCM Quality Strategy for SFYs 2024–2027 dated July 2, 2024.[19] After receiving the document, HSAG reviewed the goals of the New Hampshire MCM Quality Strategy and defined the following information as required in 42 CFR §438.364(a)(4):

> *…recommendations for improving the quality of health care services furnished by each MCO, PIHP, or PAHP, including how the State could target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.*[20]

Findings

Goal 1 of the managed care quality program goals and objectives requires assurance of quality and appropriate care delivery to the New Hampshire Medicaid population enrolled in managed care.

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[19] New Hampshire Department of Health and Human Services. *New Hampshire MCM Quality Strategy #8 2024–2027*. Available at: Care Management Quality Strategy | NH Medicaid Quality. Accessed on: Dec 2, 2024.

[20] U.S. Government Publishing Office. 2024. *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Dec 2, 2024.

Under this goal, there is one quality measure for the DO as shown in Table 5-1 below:

Table 5-1–DO Quality Measure Goal 1

DHHS New Hampshire DO Quality Measure	Performance Baseline Percentage March 1, 2023–March 31, 2024	Performance Target Reporting Year 2026	Current Rate July 1, 2023–June 30, 2024
Dental Risk Assessment Screening (DHHS-Developed)	5.2%	11.2%	3.1%

The adult dental program in New Hampshire began in April 2023, and this is the first DO objective included in the New Hampshire quality strategy for Goal 1. Objective 1.1 of Goal 1 requires ensuring that in calendar year 2026, selected New Hampshire priority primary care and preventive care measure rates show improvement. DHHS established the performance target of 11.2 percent and reported a baseline rate of 5.2 percent in March 2024. The most current rate available from June 2024 shows a decline in the rate from 5.2 percent to 3.1 percent.

Evaluation

The contract between DHHS and **NEDD/DQ**, Section 4.10.2, requires **NEDD/DQ** to "conduct a Dental Risk Assessment Screening of all existing and newly enrolled Members within ninety (90) calendar days of the effective date of DO enrollment to identify Members who may have unmet health care needs and/or Special Health Care Needs."[21] Requirements in 42 CFR §438.208(b)(3) also provide "that the MCO, PIHP, or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful."[22]

From the 12-month period ending March 31, 2024, to the 12-month period ending June 30, 2024, the rate of completion for the dental risk assessment screenings decreased from 5.2 percent to 3.1 percent. During that time, **NEDD/DQ** had 90,000–95,000 members. A total of 4,977 members completed the screening tool during the first reporting period ending March 31, 2024, and 2,868 members completed the screening tool during the second reporting period ending June 30, 2024.

[21] State of New Hampshire Department of Health and Human Services. (2022). *Medicaid Care Management Dental Services Contract.* Available at: https://www.sos.nh.gov/sites/g/files/ehbemt561/files/inline-documents/sonh/09a-gc-agenda-110222.pdf. Accessed on: Dec 2, 2024.

[22] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.208. Accessed on: Dec 2, 2024.

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

To improve the rate of dental risk assessment screening, **NEDD/DQ** should ensure that new member packets include the screening tool, and additional screening tools could be mailed if one is not received within 30 and 60 days of enrollment from the members. Focused education and training for all employees who interact with newly enrolled members (e.g., member service staff, care managers, and outreach coordinators) would also assist in improving the screening rates.

Member education is also a key component to improving the rates of dental risk assessment screening. Flyers, recorded phone messages with an option of leaving a message requesting a return call to complete the screening, newsletters, text messages, or mailers could be used to remind members about the importance of completing the screening. Member incentives earned upon completion of the screening tool may also increase the rate of dental assessment screenings. **NEDD/DQ** could consider organizing member focus groups to receive ideas from members concerning ways to improve the completion rates for the dental risk assessment screening tools.

Conclusions

Doubling the baseline rate in two years is an aggressive performance target for the DO. Improving dental care for the adult Medicaid population in New Hampshire, however, begins with identifying the needs of each individual member. Completion of the dental risk assessment screening document is the most comprehensive way to assess new members. **NEDD/DQ** must continue to develop interventions to improve the dental risk assessment screening rate to ensure that adult Medicaid members in New Hampshire have timely access to quality dental care.

6. Follow-Up on Prior Recommendations

As SFY 2024 was the first full year of operation for the DO, this SFY 2024 New Hampshire Dental Organization External Quality Review Technical Report is the first EQR technical report to be completed. Therefore, there are no prior recommendations requiring follow-up by the DO. This section of the report will be completed beginning with the SFY 2025 New Hampshire Dental Organization External Quality Review Technical Report.

Appendix A. Abbreviations and Acronyms

Commonly Used Abbreviations and Acronyms

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

- **AAU**—Administrative Appeals Unit
- **ABD**—acquired brain disorder
- **ACNH**—AmeriHealth Caritas New Hampshire, Inc.
- **ADA**—Americans with Disabilities Act
- **API**—application program interface
- **ASL**—American Sign Language
- **BBA**—Balanced Budget Act of 1997
- **CAP**—corrective action plan
- **CASS**—Coding Accuracy Support System
- **CDT**—current dental terminology
- **CFI**—choices for independence
- **CFR**—Code of Federal Regulations
- **CHIP**—Children's Health Insurance Program
- **CM**—clinical modification
- **CMS**—Centers for Medicare & Medicaid Services
- **CPG**—clinical practice guideline
- **CPT**—current procedural terminology
- **CY**—calendar year
- **D**—dental
- **DBA**—doing business as
- **DD**—developmental disability
- **DHHS**—New Hampshire Department of Health and Human Services
- **DMCM**—New Hampshire Dental Medicaid Care Management
- **DNR**—Do Not Report
- **DO**—dental organization
- **DQ**—DentaQuest
- **DRA**—Deficit Reduction Act of 2005
- **EBI**—enterprise business intelligence

- **EDA**—encounter data accuracy
- **EDC**—encounter data completeness
- **EDI**—electronic data interchange
- **EDT**—encounter data timeliness
- **EDV**—encounter data validation
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FFS**—fee-for-service
- **HCPCS**—Healthcare Common Procedure Coding System
- **HSAG**—Health Services Advisory Group, Inc.
- **ICD**—International Classification of Diseases
- **ID**—identification
- **IHCP**—Indian Health Care Provider
- **IS**—information systems
- **ISCA**—Information Systems Capabilities Assessment
- **ISCAT**—Information Systems Capabilities Assessment Tool
- **IVR**—interactive voice response
- **LEP**—limited English proficiency
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MMIS**—Medicaid Management Information System
- **NA**—not applicable
- **NAV**—network adequacy validation
- **NCQA**—National Committee for Quality Assurance
- **NEDD**—Northeast Delta Dental
- **NEMT**—non-emergency medical transportation
- **NHHF**—New Hampshire Healthy Families
- **NR**—Not Reported
- **P**—professional
- **PAHP**—prepaid ambulatory health plan
- **PDP**—primary dental provider
- **PDSA**—Plan-Do-Study-Act
- **PIHP**—prepaid inpatient health plan
- **PIP**—performance improvement project

- **PMV—**performance measure validation
- **PSV—**primary source verification
- **QA—**quality assurance
- **QI—**quality improvement
- **R—**Report
- **SAC—**submission accuracy and completeness
- **SDOH—**social determinants of health
- **SFH—**State fair hearing
- **SFTP—**secure file transfer protocol
- **SFY—**state fiscal year
- **SMART—**specific, measurable, attainable, relevant, and time-bound
- **TPL—**third-party liability
- **TTY/TDD—**TeleTYpewriter/Telecommunications Device for the Deaf
- **WS—**WellSense

Appendix B. Methodologies for Conducting EQR Activities

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

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

  Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, or PAHP entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[23]
- ***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."[24] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the DO (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).[25]

[23] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 2, 2024.

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

[25] U.S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Dec 2, 2024.

Contractual Compliance

Objectives

The purpose of the compliance reviews, one of the mandatory EQR activities defined in 42 CFR §438.358(b)(1)(iii),[26] is to evaluate the ***quality of care***, ***timeliness of care***, and ***access to care*** and services the DO furnishes to members. The evaluation includes determining DO compliance with 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements included in the New Hampshire Medicaid Dental Services Contract.[27,28,29] HSAG follows the guidelines set forth in the CMS EQR Protocol 3, cited earlier in this report, to create the process, tools, and interview questions used for the compliance reviews. The results of the compliance reviews assist in identifying, implementing, and monitoring interventions to drive performance improvement for the New Hampshire DMCM program.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 3 defines the five activities included in the review of compliance with Medicaid and CHIP managed care regulations. Table B-1 displays the activities and indicates the process HSAG uses to ensure compliance with those requirements.

[26] U.S. Government Printing Office. (2019). *Activities related to external quality review.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b3461a8c76280ca265d93ee04a872844&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Dec 2, 2024.

[27] State of New Hampshire Department of Health and Human Services. (2022). *Medicaid Care Management Dental Services Contract.* Available at: https://www.sos.nh.gov/sites/g/files/ehbemt561/files/inline-documents/sonh/09a-gc-agenda-110222.pdf. Accessed on: Dec 2, 2024.

[28] Department of Health and Human Services. (2016). 42 CFR §438. Available at: https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-part438.pdf. Accessed on: Dec 2, 2024.

[29] Centers for Medicare & Medicaid Services. (2018). Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf. Accessed on: Dec 2, 2024.

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

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

Activity 3:	Conduct the Compliance Review
	• Conduct an opening conference that includes introductions, HSAG's overview of the compliance review process and schedule, the DO's overview of its structure and processes, and a discussion concerning any changes needed to the agenda and general logistical issues • Conduct interviews with the DO's staff to obtain complete information concerning the DO's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the pre-site documents, and increase HSAG reviewers' overall understanding of the DO's performance • Collect additional documents required for the compliance review including, but not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas • Discuss the organization's IS data collection process and reporting capabilities related to the standards included in the review • Summarize findings at a closing conference to provide the DO's staff members and DHHS with a high-level summary of HSAG's preliminary findings • Provide information concerning next steps and the projected date the DO will receive the draft compliance report
Activity 4:	**Compile and Analyze Findings**
	• Complete compliance tools with findings from interviews and documents received during the site review • Evaluate and analyze the DO's performance complying with the requirements in each of the standards contained in the review tool • Delineate findings and designate scores (e.g., *Met*, *Partially Met*, *Not Met*, or *Not Applicable*) to document the degree the DO complies with each of the requirements • Calculate a percentage of compliance rate for each individual standard and an overall percentage of compliance score across all standards
Activity 5:	**Report Results to the State**
	• Prepare a draft report describing HSAG's compliance review findings to include: – Scores assigned for each element within each standard – Assessments of the DO's strengths and areas requiring corrective action – Identification of best practices to share with DHHS – Suggested ways to further enhance the DO's performance • Forward the draft report to DHHS for review and comment • Receive approval of the draft report from DHHS • Send the draft report to the DO for comment • Respond to any comments made by the DO • Issue a final report that includes an appendix with the compliance tool and an appendix with elements included in the CAP • Collaborate with the DO to correct all elements scoring below 100 percent compliance until the revisions meet the requirements

Description of Data Obtained

To assess the DO's compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by the DO, including, but not limited to, the following for the SFY 2024 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., January 31, 2024)
- The member handbook and additional documents sent to members
- The provider manual and other DO communication to providers/subcontractors
- The automated member and provider portal
- Automated provider directory
- TPL documents
- File reviews
- Narrative and/or data reports across a broad range of performance and content areas
- DO Questionnaire sent to the DO with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with the DO's key staff members.

How Conclusions Were Drawn

HSAG uses scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the DO's performance complies with the requirements. HSAG uses a designation of *NA* when a requirement is not applicable to the DO during the period covered by HSAG's review. The scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as either of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the rates assigned for each of the requirements, HSAG calculates a total percentage-of-compliance rate for the standards and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

While the focus of a compliance review is to evaluate if the DO correctly implement the required federal and State requirements, the results of the review can also determine areas of strength and weakness for the DO related to ***quality of care***, ***timeliness of care***, or ***access to care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met, Partially Met*, and *Not Met* to determine how the elements relate to the three domains as defined on page B-1. At that point, HSAG draws conclusions for the DO concerning ***quality of care***, ***timeliness of care***, or ***access to care*** from the results of the compliance review.

HSAG determines the overall percentage-of-compliance score across the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements). HSAG also assists in reviewing the CAPs from the DO to determine if its proposed corrections will meet the intent of the requirements that were scored *Partially Met* or *Not Met*. The CAP continues until all items achieve a *Met* status.

HSAG established a level of confidence rating for the compliance review based on the overall score as shown below:

90%–100%: High confidence in the DO's compliance with State and federal requirements
80%–89%: Moderate confidence in the DO's compliance with State and federal requirements
70%–79%: Low confidence in the DO's compliance with State and federal requirements
Under 70%: No confidence in the DO's compliance with State and federal requirements

SFY 2024 Compliance Review Results

HSAG conducts the compliance review for all standards over a three-year period. However, as this was the first full SFY for the DMCM program in New Hampshire, HSAG conducted a compliance review for all standards. Table B-2 presents information concerning the compliance reviews conducted in SFY 2024. The table displays the CFR reference, the standard name as listed in 42 CFR §438, the name of the standards as listed in the New Hampshire DMCM program contract with the DO, and the rates achieved during the compliance review. In future compliance reviews, HSAG will spread its review of the standards over a three-year period.

Table B-2 includes the rates achieved by **NEDD/DQ** during SFY 2024.

Table B-2—Standards and Scores Achieved by NEDD/DQ in the Compliance Review for SFY 2024

	42 CFR	Standard Name	2024
		§438.358(b)(iii)	
I.	§438.230	Subcontractual Relationships and Delegation Delegation and Subcontracting	55.3%
II.	§438.114	Emergency and Post-Stabilization Care	NA
III.	§438.208	Coordination and Continuity of Care Care Management/Care Coordination	85.0%
IV.	NA	Wellness/Prevention/Member Education	100%
V.	NA	Behavioral Health	NA
VI.	§438.56	Disenrollment: Requirements and Limitations Member Enrollment and Disenrollment	72.2%
VII.	§438.100 §438.224	Enrollee Rights Member Services	76.7%
VIII.	NA	Cultural and Accessibility Considerations	80.0%
IX.	§438.228	Grievances and Appeals Systems	84.3%
X.	§438.206	Availability of Services Access	82.1%
XI.	§438.214 §438.207	Provider Selection Assurances of Adequate Capacity and Services Network Management	90.8%
XII.	§438.210 §438.224	Coverage and Authorization of Services Utilization Management	94.3%

	42 CFR	Standard Name	2024
		§438.358(b)(iii)	
XIII.	§438.236 §438.224 §438.330	Practice Guidelines	42.9%
		Confidentiality	
		Quality Assessment and Performance Improvement Program	
		Quality Management	
XIV.	NA	Substance Use Disorder	NA
XV.	NA	Fraud, Waste, and Abuse	100%
XVI.	NA	Financial	100%
XVII.	NA	Third Party Liability	100%
XVIII	§438.242	Health Information Systems	78.6%
Overall Results			**84.58%**
Confidence Level			**Moderate**

PIPs

Validation of PIPs, as set forth in 42 CFR §438.358(b)(1)(i),[30] is one of the mandatory EQR activities. HSAG's PIP validation process includes evaluation of the technical structure of the PIP to ensure that **DQ** designed, conducted, and reported the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's evaluation determines whether the PIP design (e.g., Aim statement, population, indicator[s], and data collection methodology) is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and indicators used have the capability to achieve statistically significant and sustained improvement.

Evaluation of the Implementation of the PIP

Objectives

The purpose of conducting PIPs, as required in 42 CFR §438.330(b)(1),[31] is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical and nonclinical focus areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

[30] U.S. Government Printing Office. (2019). *Activities related to external quality review.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Dec 2, 2024.
[31] Ibid.

The primary objective of PIP validation is to determine **NEDD/DQ**'s compliance with requirements set forth in 42 CFR §438.330(d)(2), including:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. HSAG used the CMS EQR Protocol 1 cited earlier in this report.

At the request of DHHS, HSAG used a rapid-cycle PIP approach and developed the PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[32] For the rapid-cycle framework, HSAG developed four modules with an accompanying reference guide. Prior to issuing each module, HSAG holds technical assistance sessions with the DO to educate about the application of each module. The four modules are defined as:

Module 1—PIP Initiation: Module 1 outlines the framework for the project. The framework includes the topic and narrowed focus description and rationale, supporting baseline data, description of baseline data collection methodology, setting Aims (Global and SMART), and setting up a run chart for the SMART Aim measure.

Module 2—Intervention Determination: In Module 2, the DO uses specific QI tools to determine interventions that have the potential to impact the SMART Aim. The DO will use a step-by-step process to identify and prioritize interventions that will be tested using PDSA cycle(s).

Module 3—Intervention Testing: In Module 3, the DO defines the Intervention Plan for the intervention to be tested. The DO will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.

Module 4—PIP Conclusions: In Module 4, key findings, comparisons of successful and unsuccessful interventions, and outcomes achieved are summarized. The DO will synthesize all data collection, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement going forward.

[32] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: https://www.ihi.org/resources/Pages/Publications/ImprovementGuidePracticalApproachEnhancingOrganizationalPerformance.aspx. Accessed on: Dec 2, 2024.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the DO's module submission forms. Following HSAG's rapid-cycle PIP process, the DO submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the DO can seek technical assistance from HSAG and has the opportunity to resubmit the module for a final validation.

For the PIP, **NEDD/DQ** used enrollment data from the 834-file obtained from DHHS and data queried from its health risk assessment database specific to the SMART Aim measure. The numerator is divided by the denominator to produce the percentages reported.

How Conclusions Were Drawn

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that any reported improvement is related to the QI strategies and activities conducted by the DO during the PIP. HSAG's scoring methodology evaluates whether the DO executed a methodologically sound improvement project and confirms that any improvement achieved could be reasonably linked to the QI strategies implemented by the DO.

For the SFY 2024 validation of modules 1 through 3 (PIP Initiation, Intervention Determination, and Intervention Testing) confidence levels were determined as follows:

- *High confidence in reported PIP results: 100 percent of all module evaluation elements were Achieved across all steps validated.*
- *Moderate confidence in reported PIP results: 80 to 99 percent of all module evaluation elements were Achieved across all steps validated.*
- *Low confidence in reported PIP results: 60 to 79 percent of all module evaluation elements were Achieved across all steps validated.*
- *No confidence: Reported PIP results are not credible: Less than 60 percent of all module evaluation elements were Achieved across all steps validated.*

When Module 4 is submitted for validation (PIP Conclusions), HSAG will use its standardized scoring methodology and will assign two levels of confidence as described below:

1. HSAG determined whether the DO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results:
   - *High Confidence*: The PIP was methodologically sound, at least one of the tested interventions could reasonably result in significant improvement and/or achievement of the SMART Aim goal, and the DO conducted complete and accurate data analysis and interpretation of PIP results.
   - *Moderate Confidence*: The PIP was methodologically sound and at least one of the tested interventions could reasonably result in the demonstrated improvement; however, the DO did not conduct complete and accurate data analysis and/or did not accurately interpret the PIP results.

- *Low Confidence*: The PIP was methodologically sound with or without complete and accurate data analysis and interpretation of results; however, none of the interventions tested could reasonably result in demonstrated improvement.
- *No Confidence*: The DO did not adhere to an acceptable methodology for the design, data collection, and data analysis/interpretation of results of the PIP.

2. HSAG determined whether the DO produced evidence of significant improvement.
   - *High Confidence*: The PIP demonstrated statistically significant improvement and/or achievement of the SMART Aim goal.
   - *Moderate Confidence*: The PIP demonstrated non-statistically significant improvement in the SMART Aim measure and the SMART Aim goal was not achieved.
   - *Low Confidence*: The PIP did not demonstrate any type of improvement.
   - *No Confidence*: The DO did not adhere to acceptable methodology for the SMART Aim measure baseline and/or remeasurement.

While the focus of **NEDD/DQ**'s PIP may be to improve performance related to healthcare quality and timeliness of care, or access to care, PIP validation activities are designed to evaluate the validity, reliability, and quality of the DO's process for conducting valid PIPs. Therefore, HSAG can draw conclusions about the ***quality of care*** domain from all PIPs. HSAG may also draw conclusions about the remaining domains of care and services—***timeliness of care*** and ***access to care***—depending on the specific PIP topics and interventions selected by the DO.

Table B-1—Timeline for the SFY 2024 PIP Activity

MCE	Collecting Data	Conducting Validation	Writing Report	Finalizing Report
NEDD/DQ	07/01/23–12/31/24	09/06/23–05/16/25	05/20/25–06/20/25	07/07/25–07/17/25

PMV

Objectives

Validation of performance measures, as set forth in 42 CFR §438.358(b)(1)(ii),[33] is one of the mandatory EQR activities. The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measures data collected.
- Determine the extent to which the specific performance measures calculated by the DO followed the specifications established for calculation of the performance measures.

[33] U.S. Government Printing Office. (2020). *Activities related to external quality review.* Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.358. Accessed on: Dec 2, 2024.

- Identify overall strengths and areas for improvement in the performance measure process.

Table B-3 presents the 15 state-selected performance measures for the SFY 2024 validation activities in New Hampshire. HSAG completed the reports for this activity in May 2024.

Table B-3—DO Performance Measures Audited by HSAG for SFY 2024

Performance Measures
DENTAL_ACCESSREQ.01; Requests for Assistance Accessing Dentists by County
DENTALCLAIM.01; Timely Processing of All Clean Dental Claims: Thirty Days of Receipt
DENTAL_CLAIM.03; Interest on Late Paid Dental Claims
DENTAL_CLAIM.05; Claims Quality Assurance: Claims Financial Accuracy
DENTAL_APPEALS.01; Resolution of All Member Dental Appeals Within 45 Calendar Days
DENTAL_APPEALS.05; Resolution of Expedited Member Dental Appeals Within 72 Hours
DENTAL_APPEALS.06; Member Dental Services Authorized Within 72 Hours Following a Reversed Appeal
DENTAL_GRIEVANCE.02; Member Dental Grievances Received
DENTAL_PROVAPPEAL.01; Resolution of Dental Provider Appeals Within 30 Calendar Days
DENTAL_PROVCOMM.03; Dental Provider Communications: Reasons for Telephone Inquiries
DENTAL_TIMELY CRED.01; Timely Provider Credentialing—Primary Dental Provider
DENTAL_TIMELYCRED.02; Timely Provider Credentialing—Specialty Dental Providers
DENTAL_SERVICEAUTH.01; Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Post-Delivery Requests
DENTAL_SERVICEAUTH.02; Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests
DENTAL_SERVICEAUTH.03; Dental Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS EQR Protocol *2* cited earlier in this report.

Table B-4—Timeline for the SFY 2024 PMV Activity

MCE	Review Period	Collecting Data	Conducting Review	Writing Report	Finalizing Report
DQ	04/01/23–10/31/23	08/07/23–12/15/23	01/22/24	02/27/24–03/28/24	04/15/24–05/09/24

HSAG used the following process for the DO PMV conducted in New Hampshire by HSAG. The process included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed DO responses to the Information Systems Capabilities Assessment Tool (ISCAT); and (2) virtual review activities such as interviews with staff members, PSV, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the DO's IS capabilities for accurate reporting. The review team focused specifically on aspects of the DO's systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data; membership data; provider data; and data integration and measure calculation. If HSAG noted an area of noncompliance with any validation component listed in the CMS EQR Protocol 2, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

Each measure verified by the HSAG review team received an audit result consistent with one of the three designation categories listed in Table B-5.

Table B-5—Designation Categories for Performance Measures Audited by HSAG

Report (R)	Measure was compliant with state specifications.
Do Not Report (DNR)	DO rate was materially biased and should not be reported.
Not Applicable (NA)	The DO was not required to report the measure.
Not Reported (NR)	Measure was not reported because the DO did not offer the required benefit.

Description of Data Obtained

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

- Completed responses to the ISCAT by the DO.
- Source code, computer programming, and query language (if applicable) used by the DO to calculate the selected measures.

- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Final performance measure rates.

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

How Conclusions Were Drawn

Based on the acceptable level achieved by the DO per measure, HSAG establishes an overall level of confidence for the performance validation review based on the DO following state-specific measure guidelines as defined below:

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

After completing the validation process, HSAG prepared a final report for the DO detailing the PMV findings and any associated recommendations. DHHS and the DO received copies of the report. The results of the validation process also determined areas of strength and recommendations for the DO related to ***quality of care***, ***timeliness of care***, or ***access to care***. Once HSAG completed the validation process, the reviewers evaluated the designation category (i.e., R, DNR, NA, NR) for each performance measure to determine how the elements related to the three domains of care as defined on page B-1. At that point, HSAG drew conclusions for the DO concerning ***quality of care***, ***timeliness of care***, or ***access to care*** from the results of the PMV activity.

NAV

This section describes the DHHS-approved methodology for the SFY 2024 NAV activities, including HSAG's NAV analysis and its ISCA-specific methodology and activities.

Table B-6 outlines the timeline of the SFY 2024 NAV activities.

Table B-6—Timeline for the SFY 2024 NAV Activities

MCO	Collecting Data	Conducting Review	Writing Report	Finalizing Report
DQ	03/15/24–06/28/24	05/08/24–08/30/24	08/30/24–09/30/24	09/30/24–11/21/24

ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the DO, HSAG obtained all DHHS-defined network adequacy standards and indicators that DHHS requires for validation.

HSAG prepared and submitted a document request packet to the DO outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the DO's IS and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents that HSAG requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the DO to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the DO, such as network data files or directories and member enrollment files, through a single documentation request packet that HSAG provided to the DO.

HSAG hosted a webinar focused on providing technical assistance to the DO to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **IS underlying network adequacy monitoring**: HSAG conducted an ISCA by using the DO's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the DO tracks providers over time, across multiple office locations, and through changes in participation in the DO's network. HSAG used the ISCAT to assess the ability of the DO's IS to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the DO's IT system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Validate network adequacy logic for calculation of network adequacy indicators**: HSAG required the DO to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG identified whether the required variables were in alignment with the DHHS-defined indicators used to produce the DO's indicator calculations. If the DO did not use

computer programming language to calculate the performance indicators, HSAG requested that it submit documentation describing the steps the DO took for indicator calculation.

- **Validate network adequacy data and methods**: HSAG assessed data and documentation from the DO that included, but was not limited to, network data files or directories, member enrollment data files, and appointment availability surveys. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results**: HSAG assessed the DO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support DO and DHHS network adequacy monitoring results. HSAG validated network adequacy reporting against DHHS-defined indicators. HSAG assessed whether the results were valid, accurate, and reliable, and if the DO's interpretation of the data was accurate.
- **Supporting documentation**: HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with the DO. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key DO staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- **Review of the ISCAT and supporting documentation:** HSAG designed this session to be interactive with key DO staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing the DO's IS required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.
- **Evaluation of underlying systems and processes:** HSAG evaluated the DO's IS, focusing on the DO's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; DO oversight of external IS, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors,

and other front-line staff members familiar with network adequacy monitoring and reporting activities.

- **Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the DO produced the analytics files to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated the DO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support DO and DHHS network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the DO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table B-7.

Table B-7—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and whether the DO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that the DO used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table B-8. HSAG assigned a rating once it calculated the validation score for each indicator.

Table B-8—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*

Validation Score	Validation Rating
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Table B-9 presents an example of a validation rating determination based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table B-10 presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table B-9—Example Validation Rating Determination—No Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	16	*Moderate Confidence*
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* elements determined to have significant bias on the results	0	

Table B-10—Example Validation Rating Determination—Includes Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	15	*No Confidence*
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* elements determined to have significant bias on the results	1	

HSAG determined significant bias based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the DO provide a root cause analysis of the finding.
- Working with the DO to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Tasking HSAG's NAV Oversight Review Committee with reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.

- Tasking HSAG's NAV Oversight Review Committee with finalizing a bias determination based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or HSAG was unable to quantify the impact and therefore determined the potential for significant bias.

NAV Methodology

Technical Methods of Data Collection and Analysis

To conduct the NAV analysis, HSAG requested data from DHHS and the DO.

Member Data

HSAG requested Medicaid member files from DHHS and from the DO. HSAG submitted a detailed member data requirements document to DHHS and the DO and offered a technical assistance call to review the data request in detail and clarify any questions regarding the data request. HSAG requested data for members actively enrolled in the DO as of February 29, 2024, including these key data elements: member's street address, city, state, ZIP Code, date of birth, dates of enrollment, and DO affiliation.

Provider Data

HSAG requested Medicaid provider files from DHHS reflecting all providers enrolled in the State's Medicaid program. From the DO, HSAG requested provider files reflecting all active providers serving Medicaid members. HSAG requested the following key data elements: provider name, National Provider Identifier, address, provider type, specialty, and taxonomy codes.

DO Provider Network Reports

Table B-11 lists the annual and ad hoc network adequacy reports and data that the DO submitted to DHHS, along with their respective reporting dates. HSAG requested these reports from both the DO and DHHS.

Table B-11—Required Network Reports and Reporting Periods

Report Name and Entity Submitting	Report Frequency	Template	Data Period	Date Submitted to DHHS
DO				
Comprehensive Dental Provider Network and Equal and Timely Access Annual Filing[1]	Annual, and monthly	2023.08.22 DENTAL_Network.01	2/1/2024–2/29/2024	4/12/2024

Report Name and Entity Submitting	Report Frequency	Template	Data Period	Date Submitted to DHHS
Corrective Action Plan to Restore Dental Provider Network Adequacy	Ad hoc if necessary	DENTAL_Network.02	As applicable	45 days after end of measurement period
Access to Dental Care Provider Survey	Annual	DENTAL_Network.03	4/1/2023–3/31/2024	5/15/2024

[1] The Dental Annual Network Report covers the data period of April 1, 2023, through June 30, 2024. However, the DO conducted monthly network reporting during the first year of the contract, which commenced in April 2023. For this analysis, HSAG used the monthly file covering February 2024.

Methods of Analysis and How Conclusions Were Drawn

Time and Distance

For the DO, HSAG calculated the percentage of members with required access to care according to the time and distance standards, and evaluated whether 90 percent of members met either the time or distance standard. HSAG used Quest Analytics software to calculate the travel time and physical distance between the addresses of specific members for all provider categories identified in the analysis. HSAG also visually compared its results to DO-submitted results included in the Dental Network.01 Reports for general consistency and reasonability.

EDV

Table B-12—Timeline for the SFY 2024 EDV Activity

DO	Activity	Review Period	Collecting Data	Conducting Review	Writing Report	Finalizing Report
NEDD/DQ	IS Review	03/11/24–04/05/24	03/11/24–04/05/24	04/08/24–06/11/24	06/06/24–07/31/24	08/01/24–08/30/24
	Ongoing Encounter Data Quality Reports	07/01/23–06/30/24	Weekly	Monthly/Quarterly	Not applicable	Not applicable

During SFY 2024, DHHS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR *Protocol 5* cited earlier in this report, HSAG conducted the following two core evaluation activities for the DO:

- IS review—assessment of DHHS' and/or the DO's IS and processes. The goal of this activity is to examine the extent to which DHHS' and the DO's IS infrastructures are likely to collect and process complete and accurate encounter data.
- Ongoing encounter data quality reports—assess completeness, accuracy, and timeliness of the DO's encounter data files submitted to DHHS on a monthly/quarterly basis.

The ongoing encounter data quality reports evaluated encounters submitted to DHHS between July 1, 2023, and June 30, 2024. Of note, HSAG received encounters from **NEDD/DQ** starting May 2024. The following sections describe the methodology for each activity.

IS Review

Objectives

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the DO to DHHS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. This activity corresponds to *Activity 2: Review the MCO's Capability* in the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DHHS. Documents for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and DHHS' current encounter data submission requirements, among others. The information obtained from this review is important for developing a targeted questionnaire to address important topics of interest to DHHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the DO's ISCAT collected through the CMS EQR Protocol 2 cited earlier in this report. HSAG then developed a questionnaire customized in collaboration with DHHS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DHHS and DO information technology personnel to clarify any questions from the questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Description of Data Obtained

Representatives from the DO completed the DHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the DO's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

How Conclusions Were Drawn

HSAG made conclusions based on the CMS EQR Protocol 5, the DO contract, DHHS' data submission requirements (e.g., companion guides), and HSAG's experience working with other states regarding the IS review. HSAG calculated results from the study and drew conclusions associated with ***access to care*** and also ***quality of care*** since determining quality can be challenging if the DO does not submit accurate and timely encounter data.

Ongoing Encounter Data Quality Reports

Objectives

The objective of the ongoing encounter data quality reports is to assess monthly and quarterly the completeness, accuracy, and timeliness of the DO's encounter data files submitted to DHHS. This activity corresponds to *Activity 3: Analyze Electronic Encounter Data* in the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

HSAG uses the same general process and files as DHHS' fiscal agent, Conduent, when collecting and processing encounter data for the monthly/quarterly encounter data quality reports. For example, daily or weekly, the DO prepares and translates claims and encounter data into the 837D and 837P (NEMT) 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 DO's 837D/P 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) the DO's overall compliance with submission requirements (e.g., filename confirmation); and (2) key encounter data quality elements (e.g., data field compliance and completeness). Additionally, while failure to pass certain edits during Conduent's processing may lead to rejection and resubmission of files/encounters by the DO, HSAG's edit processing is used for reporting only.

Once HSAG successfully translates the 837D/P files, the files are loaded into HSAG's data warehouse. HSAG then runs a secondary set of edits. These edits are used for reporting only and are designed to identify potential issues related to encounter data quality.

In general, the ongoing encounter data quality reports assess measures in four domains such as submission accuracy and completeness (SAC), encounter data completeness (EDC), encounter data accuracy (EDA), and encounter data timeliness (EDT). Of note, HSAG received DO encounters starting May 2024.

For the SFY 2024 study, DHHS focused on the following measures:

- **Study Indicator SAC.2—**Percentage of confirmed plan file submissions

Measure Element	Specification
Numerator	Number of files attested by the plans through reconciliation reports
Denominator	Total number of files submitted within a month
File Type	Paid and denied encounters
Reporting Frequency	Monthly, but with weekly results
Reporting Level(s)	File-Level—by encounter type

- **Study Indicator SAC.4**—Percentage of 837D and 837P records passing X12 EDI compliance edits

Measure Element	Specification
Numerator	Number of 837D and 837P records passing X12 EDI compliance edits
Denominator	Total number of 837D and 837P records submitted within a month
File Type	Paid and denied 837D and 837P encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type

- **Study Indicator EDA.1**—Percentage of records with values present for key data element (see Table B-13)

Measure Element	Specification
Numerator	Number of records with values present for a specific data element
Denominator	Total number of records passing X12 EDI compliance edits during measurement period
File Type	Final paid encounters
Reporting Frequency	Monthly

Measure Element	Specification
Reporting Level(s)	Record-Level—by encounter type

- **Study Indicator EDA.2**—Percentage of records with valid values for key data element (see Table B-13).

Measure Element	Specification
Numerator	Number of records with valid values for a specific data element
Denominator	Number of records with values present for a specific data element
File Type	Final paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type

Table B-13 highlights the key data elements evaluated for the Percent Present metric presented in Study Indicator EDA.1, as well as the validity criteria used to calculate the Percent Valid metric in Study Indicator EDA.2.

Table B-13—Key Data Elements for Indicators EDA.1 and EDA.2

Key Data Elements	Professional	Dental	Criteria for Validity
Beneficiary ID	✓	✓	In beneficiary file
Billing Provider Number	✓	✓	In provider file
Rendering Provider Number	✓	✓	In provider file
Primary Diagnosis Code	✓	✓	In national International Classification of Diseases, Tenth Revision, Clinical Modification (International Classification of Diseases [ICD-10-Clinical Modification [CM]) diagnosis code sets
Current Procedural Terminology (CPT)/Current Dental Terminology (CDT)/Healthcare Common Procedure Coding System (HCPCS) Code(s)	✓	✓	In national CPT, CDT, and HCPCS code sets
Tooth Number		✓	In standard tooth number code set defined by American Dental Association

- **Study Indicator EDT.2**—Percentage of initial encounters submitted to DHHS within 14 calendar days of claim payment date.

Measure Element	Specification
Numerator	Number of initial encounters (i.e., the unique number of *ClaimNo*) submitted to DHHS within 14 calendar days of the latest claim payment date
Denominator	Total number of initial encounters (i.e., the unique number of *ClaimNo*) passing X12 EDI compliance edits and submitted during the measurement period
File Type	Initial paid encounters
Reporting Frequency	Monthly
Reporting Level(s)	Record-Level—by encounter type

- **Study Indicator EDC.6 (DO Only)**—Number/Percentage of detail lines by the DO subcategory based on procedure codes for each submission month.

Measure Element	Specification
Numerator	Percentage of detail lines in each subcategory based on procedure codes for each submission month[1]
Denominator	Number of final paid detail lines for each submission month
File Type	Final paid DO encounters after EDI translation
Reporting Frequency	Quarterly

[1] Submission months are reported for a rolling six months.

- **Study Indicator EDA.3**—Number of unique final paid claims and total plan paid amounts as listed in the final quarterly reconciliation report template.

Measure Element	Specification
Metrics	a. Number of unique final paid claims paid in a quarter and submitted to DHHS within two months from the end of the quarter (i.e., the first quarterly results for the EDA.3 measure will include encounters paid between April 1, 2023, and June 30, 2023, and submitted to DHHS by August 31, 2023) b. Total plan paid amount in a quarter and submitted to DHHS within two months from the end of the quarter (i.e., the first quarterly results for the EDA.3 measure will include encounters paid between April 1, 2023, and June 30, 2023, and submitted to DHHS by August 31, 2023)
File Type	Final paid claims and claim lines
Reporting Frequency	Quarterly
Reporting Level(s)	Record-Level—by encounter type and vendor (if appropriate)

Description of Data Obtained

Although HSAG prepared the ongoing reports monthly and quarterly for DHHS to monitor the DO's performance, this technical report shows the aggregate rates for encounter files received from the DO with dates of service between July 1, 2023, and June 30, 2024. These results are based on the data stored in HSAG's data warehouse; and for indicators EDA.1, EDA.2, and EDC.6, HSAG determined the final encounters as of July 1, 2024.

How Conclusions Were Drawn

HSAG calculated the study indicators for the DO and then compared the DO's rates with the following standards within Exhibit B of the DO contract:[34]

- Standard 5.1.3.34.2.1 specifies that "Ninety-eight percent (98%) of the records in a DO's encounter batch submission shall pass X12 EDI compliance edits and the Medicaid Management Information System (MMIS) threshold and repairable compliance edits."
- Standard 5.1.3.34.2.2 requiring that "One-hundred percent (100%) of member identification numbers shall be accurate and valid."
- Standard 5.1.3.34.2.3 requiring that "Ninety-eight percent (98%) of billing provider information will be accurate and valid."
- Standard 5.1.3.34.2.4 requiring that "Ninety-eight percent (98%) of servicing provider information will be accurate and valid."
- Standard 5.1.3.34.3.1 states that "Encounter data shall be submitted weekly, within fourteen (14) calendar days of claim payment."

HSAG calculated results from the study and drew conclusions associated with ***access to care*** and ***quality of care*** since determining quality can be challenging if the DO does not submit accurate and timely encounter data.

Quality Study

Table B-14—Timeline for the Quality Study

MCE	Review Period	Collecting Data	Writing Report	Finalizing Report
NEDD/DQ	04/01/23–05/31/24	06/01/24–09/16/24	09/17/24–11/20/24	12/06/24–01/03/25

[34] New Hampshire Department of Health and Human Services. (2022). Medicaid Care Management Dental Services. Available at: https://www.sos.nh.gov/sites/g/files/ehbemt561/files/inline-documents/sonh/09a-gc-agenda-110222.pdf. Accessed on: Dec 2, 2024.

Objectives

The goal of the study was to understand the scope and frequency of education offered to providers and members. In addition, HSAG incorporated a review of a report of the benefit utilization pre- and post-education obtained from the DO. The time frame for the benefit utilization report was from April 1, 2023, to May 31, 2024. HSAG followed the guidelines set forth in the CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity,* February 2023,[35] to create the process, tools, and interview questions used for the quality study. The review period covered SFY 2022 and SFY 2023. The goals of the study included the following:

- Determine the process the DO used to be notified of a member's pregnancy.
- Determine the timing and process of education the DO offered to providers regarding the benefit.
- Determine the process and timing of education the DO offered to members regarding the benefit.
- Determine the criteria and timeline of pregnant member eligibility the DO uses to process the benefit.
- Report the findings of utilization of the additional pregnancy benefit pre- and post-education.

Technical Methods of Data Collection and Analysis

HSAG used an 11-step process to conduct the DO Quality Study that included the technical methods of data collection and analysis. HSAG conducted the study from June–October of 2024, and the process included two questionnaires and a report of the utilization pre- and post-member and provider education.

Table B-15—Process to Conduct the Service Authorization Study

Step 1:	**Meet with DHHS**
	HSAG will meet with DHHS to define the study parameters.
Step 2:	**Send a questionnaire to the DO**
	HSAG will work with DHHS to develop a questionnaire for the DO to respond to the study parameters and goals.
Step 3:	**Receive and review questionnaire responses from the DO**
	Once the DO returns the questionnaire, HSAG will review the document to ensure that the DO answered all the questions on the form.
Step 4:	**Compile the DO responses**
	HSAG will evaluate the responses and determine if the DO's submitted answers adequately address the scope and frequency of education offered to providers and members.

[35] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9: Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Dec 2, 2024.

Step 5:	**Meet with DHHS to review responses from the questionnaire**
	HSAG will meet with DHHS to review the information submitted by the DO on the questionnaire and determine if additional clarification will be needed concerning the responses.
Step 6:	**Determine if a second questionnaire or meeting is needed**
	If additional information is needed from the DO, HSAG and DHHS will determine if the DO should send written responses or if a meeting with the DO to obtain the necessary information for the study is sufficient.
Step 7:	**Continue gathering information until complete information is obtained from the DO**
	HSAG will continue to work with DHHS and the DO until complete information is obtained from the DO concerning the scope and frequency of education offered to providers and members.
Step 8:	**Compile information received from the DO concerning the number of members who used the extra benefit**
	HSAG will request the additional benefit information from the DO and compile the information.
Step 9:	**Prepare a final document with all responses by the DO**
	After receiving the final responses from the DO, HSAG will prepare a document showing all responses received from the DO. The summary will clarify the scope and frequency of education offered to providers and members.
Step 10:	**Write the report**
	HSAG will prepare a report providing details of the information obtained during the study. The report will include an evaluation of the effectiveness of the education offered to providers and members as well as conclusions and recommendations for improving utilization of the extra cleaning benefit for pregnant women.
Step 11:	**Receive DHHS approval of the draft report**
	HSAG will send a draft report to DHHS for approval. After approval of the information contained in the draft report, HSAG will send a finalized version of the report to DHHS.

Description of Data Obtained

To begin the study, HSAG prepared a list of questions for the DO to answer regarding the education it provides to members and providers about the extra cleaning benefit for pregnant members. Once received, HSAG prepared follow-up questions for the DO to answer. Additionally, HSAG requested that the DO provide the number of pregnant members who received the first cleaning, the second cleaning, and the third (extra) cleaning during each month of the study period (i.e., April 2023 to May 2024). Using the information provided, HSAG investigated the effectiveness of the DO's member and provider education based on the number and percentage of members who received the extra cleaning benefit.

How Conclusions Were Drawn

After reviewing the questionnaires and information received from the DO, HSAG drew conclusions and formulated recommendations for DHHS to improve the ***quality***, ***timeliness***, and ***access to care*** for the New Hampshire Medicaid members.

Provider Satisfaction Survey

Objective

The objective of the Provider Satisfaction Survey was to provide feedback to DHHS and **NEDD/DQ** about providers' perceptions of the DO.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the New Hampshire Provider Satisfaction Survey, which sampled all 175 eligible providers. Providers eligible for sampling included those who provided services to **NEDD/DQ** members as of February 29, 2024, and had the following credentials: Doctor of Medicine in Dentistry (DMD) or Doctor of Dental Surgery (DDS). A DMD or DDS is defined as a participating dental provider who has the responsibility for supervising, coordinating, and providing dental care to members; initiating referrals for specialist care; and maintaining the continuity of member care. The survey was administered using a mail-only methodology for data collection. **NEDD/DQ** providers received an initial questionnaire and cover letter in English. The providers were instructed to complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope. All nonrespondents received an email reminder, followed by a second survey mailing, and a second email reminder. The survey was administered from June to August 2024. In addition to a general comments section, the survey administered to **NEDD/DQ** providers included 16 questions on a broad range of topics.

The New Hampshire Provider Satisfaction Survey results were presented on the following six domains of satisfaction:

- **Overall Satisfaction**—presents providers' overall level of satisfaction with **NEDD/DQ**.
- **NEDD/DQ Processes**—presents providers' satisfaction with claims processing and obtaining non-pharmacy authorizations through **NEDD/DQ**.
- **Access to NEDD/DQ Staff and Services**—presents providers' assessment of access to utilization management staff, complex case/care managers, interpretative services, and call center staff at **NEDD/DQ**.
- **Obtaining Member Information**—presents providers' satisfaction in obtaining member information through the call center and Web portal for **NEDD/DQ**.
- **Provider Relations**—presents providers' satisfaction with provider relations for **NEDD/DQ**.

- **Covered Services at Medicaid Plan**—presents providers' assessment of getting dental medications covered and pharmacy authorizations from the Medicaid MCOs—**ACNH**, **NHHF**, and **WS**.

Response options to each question within the six domains were classified into response categories to calculate the proportion (i.e., percentage) of responses. For each measure, the percentage of satisfied responses were calculated. Responses that fell into a satisfied response category were assigned a value of 1, while all others were assigned a value of 0. The proportion of the most positive response categories (i.e., "Satisfied Response") with a score value of one divided by all responses is defined as the top-box score. HSAG did not limit the analysis to providers who indicated they were currently accepting new patients in Question 3 of the survey. For example, if a provider indicated that he/she was not accepting new patients at this time in Question 3, his/her responses to subsequent questions would still be included in the results. Therefore, providers may have rated **NEDD/DQ** on a survey question even if they were not currently accepting new patients. Since no measures met the minimum reporting threshold of at least 100 respondents, HSAG included all results for each measure.

Table B-16 presents how the response categories were assigned.

Table B-16—Response Category Assignments

Response Option	Response Category Assignment
Satisfaction	
Very Dissatisfied	Dissatisfied Response
Dissatisfied	Dissatisfied Response
Neutral	Neutral Response
Satisfied	Satisfied Response
Very Satisfied	Satisfied Response
Frequency	
Never	Dissatisfied Response
Sometimes	Neutral Response
Usually	Satisfied Response
Always	Satisfied Response
Binary	
No	Dissatisfied Response
Yes	Satisfied Response

Description of Data Obtained

The survey asked providers to report on and evaluate their experience with **NEDD/DQ**'s performance and potential areas of performance improvement. The survey covered topics important to providers, such as processing claims or pharmacy authorizations. DHHS, in collaboration with HSAG, administered the survey to providers contracted with **NEDD/DQ**. The survey response rate is the total

number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least one question in the survey instrument was answered. Eligible providers included the entire sample minus any providers who could not be surveyed due to incorrect contact information and any providers who did not have a contract with **NEDD/DQ** (i.e., undeliverable and not contracted).

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the DO, HSAG assigned each of the measures to one or more of three domains. This assignment to domains is depicted in Table B-17.

Table B-17—Assignment of Provider Survey Topics to the Quality of, Timeliness of, and Access to Services Domains

Provider Survey Topic	Quality	Timeliness	Access
Overall Satisfaction	✓		
Claims Processing	NA	NA	NA
Non-Pharmacy Authorizations		✓	
Access to Knowledgeable Utilization Management Staff			✓
Access to Complex Case/Care Managers			✓
Interpretative Services			✓
Call Center Staff	✓		
Obtaining Member Information—Call Center			✓
Obtaining Member Information—Web Portal			✓
Provider Relations	✓		
Pharmacy Authorizations		✓	
Getting Dental Medications			✓

NA—Indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

HSAG conducted the Provider Satisfaction Survey during SFY 2024 as indicated in Table B-18.

Table B-18—Timeline for the SFY 2024 Provider Satisfaction Survey Activity

DO	Collecting Data	Conducting Review	Writing Report	Finalizing Report
NEDD	06/18/24–08/20/24	08/20/24–10/04/24	10/04/24–12/23/24	01/22/25

Secret Shopper Survey

The goal of the survey was to evaluate New Hampshire's Medicaid DO network of dental locations. Specific survey objectives included the following:

- Determine the accuracy of the contact information (i.e., phone number, address) for the dental providers reported by the DO as being contracted dental providers.
- Determine whether dental locations accept patients enrolled with the DO for the New Hampshire Medicaid program and the degree to which the study's DO and program acceptance rates align with the DO's provider data.
- Determine whether dental locations accepting the DO for the New Hampshire Medicaid program accept new patients and the degree to which the study's new patient acceptance rate aligns with the DO's provider data.
- Determine appointment availability with the sampled dental locations for routine dental care.

Using the DHHS-approved sample frame creation instructions, the DO identified providers potentially eligible for survey inclusion and submitted the data files to HSAG. HSAG assembled the sample frame using records from all dental provider service locations identified by the DO. To minimize duplicate provider records, HSAG standardized the providers' address data to align with the United States Postal Service Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. HSAG retained the original provider address data values for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county). HSAG excluded records from the sample frame that:

- Did not accept new patients and identified new patient acceptance from an indicator in the DO's data submission to HSAG.
- Did not accept patients for routine dental services (e.g., orthodontists).
- The DO indicated were not in the online directory or for providers who covered services at the specified location rather than accepting appointments to see patients at the location.

HSAG generated a unique survey case list[36] by deduplicating the DO's sample frame submission. HSAG conducted the revealed caller survey on the following timeline.

Table B-19—Timeline for the SFY 2024 Secret Shopper Survey

MCE	Collecting Data	Conducting Review	Writing Report	Finalizing Report
NEDD/DQ	05/28/24–06/21/24	06/24/24–07/19/24	07/22/24–08/30/24	09/04/24–09/23/24

[36] To minimize the number of repeat phone calls to providers, HSAG selected unique cases based on locations as identified by unique phone numbers. If a phone number was associated with multiple addresses within the DO, HSAG randomly assigned the number to a single standardized address.

Technical Methods of Data Collection and Analysis

Using the DHHS-approved sample frame creation instructions, the DO identified providers potentially eligible for survey inclusion and submitted the data files to HSAG. The eligible population included actively contracted service locations associated with dental providers offering routine care (i.e., teeth cleaning) services for the DO at the time the data file was created, to serve individuals enrolled in the New Hampshire Medicaid program. HSAG also included service locations contracted with the New Hampshire DO that had addresses in states other than New Hampshire in the eligible population.

Upon receiving the DO provider data, HSAG applied a series of quality control examinations to the DO's dental provider data to ensure alignment with the DHHS-approved sample frame creation instructions.

Description of Data Obtained

Survey callers collected survey responses using a standardized script approved by DHHS. Callers conducted the survey as though they had recently moved to the area and were trying to arrange an appointment for themselves. Survey callers requested appointment availability for only the sampled location. Due to the nature of the secret shopper calls, callers improvised during actual calls as needed. Callers did not leave voicemail messages or schedule appointments.

Survey callers made up to three attempts to contact each survey case during standard business hours (i.e., 9:00 a.m.–5:00 p.m. Eastern Time).[37] If the office put the caller on hold at any point during the call, the caller remained on hold for five minutes before ending the call. If an answering service or voicemail answered a call attempt during normal business hours, the caller made additional attempts on a different day and at a different time of day. HSAG considered a survey case nonresponsive if the interviewer could not speak with office personnel during the call attempts (e.g., the call went to voicemail or to a call center that prevented the interviewer from speaking with the office staff).

How Conclusions Were Drawn

After completion of the calls, the data were tabulated electronically, and HSAG employees analyzed the information obtained during the telephone calls. HSAG reviewed the answers to the survey questions and drew conclusions based on the provider locations' responses. Recommendations from the report included items to improve ***quality of care***, ***timeliness of care***, and ***access to care***.

[37] HSAG did not consider a call attempted when the caller reached an office outside of the office's usual business hours. For example, if the caller reached a recording that stated the office was closed for lunch, the call attempt did not count toward the three attempts to reach the office. The caller attempted to contact the office up to three times outside of the known lunch hour.