



State of New Hampshire  
Department of Health and Human Services

**Independent Assessment of New  
Hampshire's Section 1915(b) Waiver  
for Mandatory Managed Care for State  
Plan Services for Currently Voluntary  
Populations**

*November 2019*

*—Draft Copy for Public Comment—*



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## 1. Executive Summary

### Introduction

New Hampshire has operated a comprehensive statewide Medicaid managed care program since December 1, 2013. On March 23, 2018, the Centers for Medicare & Medicaid Services (CMS) approved the New Hampshire Department of Health and Human Services' (DHHS') renewal application for a Section 1915(b) Waiver for Mandatory Managed Care for State Plan Services for Currently Voluntary Populations (referred to as the Section 1915(b) Waiver throughout this report). The Section 1915(b) Waiver granted DHHS the ability to mandate voluntary populations enroll in a Managed Care Organization (MCO).

Pursuant to Title 42 CFR §431.55(b)(4), CMS requires that a contractor or agency independent of the state Medicaid agency complete an assessment evaluating access to care, quality of care, and cost-effectiveness of the program 90 days before the expiration of the approved waiver program.

DHHS contracted with Health Services Advisory Group, Inc. (HSAG), an independent external quality review organization (EQRO), to complete the independent assessment of the Section 1915(b) Waiver renewal. DHHS also contracted with Milliman, Inc. (Milliman), an independent actuarial firm, to complete the assessment of the waiver's cost-effectiveness. This independent assessment presents HSAG's findings as they relate to the access to and quality of care for the Section 1915(b) Waiver population. Additionally, the results of Milliman's cost-effectiveness assessment are included.

### Summary of Overall Independent Assessment Findings

For all areas HSAG reviewed in this independent assessment, DHHS demonstrated clear expectations for the implementation, monitoring, and oversight of the MCOs, indicating overall positive results in all areas assessed related to the Section 1915(b) Waiver renewal application. While HSAG provided minor program improvement recommendations throughout the report, no items were identified that would impede DHHS from continuing implementation of mandatory managed care for the Section 1915(b) Waiver population. Additionally, Milliman's review of the actual expenditures to projected expenditures for the Section 1915(b) Waiver indicated that the waiver program appeared to be cost-effective according to CMS established standards. Table 1-1 displays a summary of all areas reviewed and HSAG's determination of whether the information included in the references and data sources met the assurances as outlined in the Section 1915(b) Waiver renewal application.

**Table 1-1—Section 1915(b) Waiver Independent Assessment Results**

Topic	Met Assurances	Did Not Meet Assurances
<b><i>Access to Care Assessment</i></b>		
Compliance Reviews	X	
Marketing and Communication	X	
Enrollment and Disenrollment	X	
Call Centers	X	
Member Materials	X	
Member Interviews	X	
Utilization Performance Measures	X	
Network Adequacy and Capacity	X	
Secret Shopper Survey	X	
Health Effectiveness Data and Information Set (HEDIS®) Performance Measures <sup>1-1</sup>	X	
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys <sup>1-2</sup>	X	
Behavioral Health Satisfaction Survey	X	
Access-Related Member Appeals and Grievances	X	
<b><i>Quality of Care Assessment</i></b>		
Quality Assessment and Performance Improvement Annual Evaluations	X	
Colorectal Cancer Screening Quality Improvement Project (QIP)	X	
HEDIS Performance Measures	X	
National Committee for Quality Assurance (NCQA) MCO Accreditation	X	
Provider Terminations	X	
CAHPS Surveys	X	
Behavioral Health Satisfaction Survey	X	
Quality-Related Member Grievances	X	
Fraud, Abuse, and Waste	X	
<b><i>Cost-Effectiveness Assessment</i></b>		
Service and Administrative Expenditures	X	
Retrospective Waiver Expenditures	X	
Renewal Cost Comparisons	X	
Adjustments, Targets, and Projections	X	

As seen in Table 1-1, DHHS met all of the assurances outlined in the Section 1915(b) Waiver renewal application.

<sup>1-1</sup> HEDIS® is a registered trademark of the NCQA.

<sup>1-2</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

## Access to Care

As all areas reviewed related to access to care met the assurances in the Section 1915(b) Waiver renewal application, these recommendations are noted as options to be considered for potential program improvement:

- **Compliance Reviews:** HSAG recommends DHHS and the MCOs investigate the areas identified as opportunities for improvement during the state fiscal year (SFY) 2019 Compliance Reviews for specific impact to the Section 1915(b) Waiver members, identifying corrective action plan (CAP) effectiveness, and consider implementing improvement strategies to ensure these members are not adversely affected moving forward.
- **Marketing and Communication:** HSAG recommends DHHS notify the MCOs that their respective websites do not appear to comply with DHHS' Marketing and Communications Guidelines related to notifying users when they leave the MCO's website and are redirected to another webpage of this finding and provide a time frame by which the MCOs must meet this requirement.
- **Member Materials:** HSAG recommends DHHS ensure the MCOs update their provider directories and websites to indicate if a provider has completed the required cultural competence training.
- **Member Interviews:** HSAG suggests DHHS do further investigation into the recommendations provided by Horn Research to determine if they are widespread among the Section 1915(b) Waiver population and consider implementing additional requirements in the MCO contract, if determined necessary, based on the additional investigation findings.
- **Utilization Performance Measures:** HSAG recommends DHHS continue to monitor utilization of outpatient and emergency services to ensure that utilization rates return to normal levels after the influx of the New Hampshire Health Protection Program (NHHPP) Premium Assistance Program (PAP) Section 1115 Demonstration Project members into the Medicaid Care Management (MCM) program in first quarter (Q1) 2019.
- **HEDIS Performance Measures:** Going forward, HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve access to care.
- **Access-Related Member Appeals and Grievances:** HSAG recommends DHHS and the MCOs investigate the root cause of transportation appeals and grievances to ensure there are no transportation barriers related to accessing services.

## Quality of Care

As all areas reviewed related to quality of care met the assurances in the Section 1915(b) Waiver renewal application, these recommendations are noted as options to be considered for potential program improvement:

- **HEDIS Performance Measures:** HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve the quality of care.

- **CAHPS Surveys:** HSAG recommends DHHS and the MCOs consider investigating the adult and children with chronic conditions (CCC) rates that fell below the national average and implement improvement strategies as monitored by DHHS through the annual Quality Assurance and Performance Improvement (QAPI) submissions, to ensure the quality of care and services provided to Section 1915(b) Waiver members are adequate.
- **Behavioral Health Satisfaction Survey:** HSAG recommends DHHS and the MCOs review the results of the surveys to identify any potential areas of concern related to the quality of behavioral healthcare and services. HSAG further recommends DHHS and NHHF investigate the difference in the rates among the MCOs and consider implementing improvement strategies to ensure the NHHF members' perception of their quality of care is comparable to those individuals enrolled in Well Sense.

### ***Cost-Effectiveness***

HSAG does not have any cost-effectiveness recommendations for DHHS' consideration related to program improvement of the Section 1915(b) Waiver.

### New Hampshire MCM Program

DHHS began operating a comprehensive statewide MCM program on December 1, 2013, for all Medicaid enrollees. MCOs provide medical services to members and are responsible for coordinating and managing care through dedicated staff and a network of qualified providers. During this time period, members within the Section 1915(b) Waiver population still could receive services via a fee-for-service (FFS) system if they opted out of the MCM program. All members continue to receive dental services and long-term supports and services (LTSS) through FFS.

On August 15, 2014, New Hampshire adopted and implemented the Medicaid expansion, with 18,000 previously uninsured or underinsured citizens enrolling in Medicaid in the first three months of expansion.<sup>2-1</sup>

In 2015, CMS approved the Section 1915(b) Waiver where populations who previously had the option of enrolling in the MCM program (e.g., dual-eligibles) were required to start receiving the majority of their state plan services through the program.

The MCM program provides services to approximately 99 percent of eligible Medicaid members. As of August 31, 2019, 127,126 New Hampshire citizens were enrolled in the MCM program.<sup>2-2</sup> Approximately 70 percent of MCM program members were low income eligible females, children, and adolescents.

### Section 1915(b) Waiver

In September 2015, CMS approved DHHS' application for a Section 1915(b) Waiver for Mandatory Managed Care for State Plan Services for Currently Voluntary Populations. The Section 1915(b) Waiver granted DHHS the flexibility to not comply with the freedom of choice Medicaid law outlined in Section 1902, thereby mandating enrollment with an MCO to receive state plan services for the Medicaid members identified in 42 CFR §438.50(d). The initial waiver was effective September 1, 2015, to August 1, 2017, with three temporary extensions permitted through March 31, 2018. CMS granted DHHS' request on March 23, 2018 for a two-year renewal of the Section 1915(b) Waiver, effective April 1, 2018, to March 31, 2020. The following populations are included under the Section 1915(b) Waiver:

- Members who are eligible for Medicaid and Medicare (i.e., dual-eligible).

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<sup>2-1</sup> Health Insurance.org. *New Hampshire and the ACA's Medicaid Expansion*. Available at: <https://www.healthinsurance.org/new-hampshire-medicaid/>. Accessed on: Oct 1, 2019.

<sup>2-2</sup> New Hampshire Department of Health and Human Services. *New Hampshire Medicaid Enrollment Demographic Trends and Geography*. Available at: <https://www.dhhs.nh.gov/ombp/medicaid/documents/medicaid-enrollment-08312019.pdf>. Accessed on: Sept 19, 2019.

- Federally recognized Indian tribe members eligible for Medicaid.
- Children under the age of 19 who are:
  - Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act (SSA) (i.e., blind or disabled individuals who demonstrate financial need);
  - Eligible under Section 1902(e)(3) of the SSA (i.e., individuals that are disabled under Section 1614(a), are determined by DHHS to require facility-level care and it is appropriate to receive such care outside of the facility, and who would be eligible for medical assistance if he/she were in a medical institution);
  - Receiving services through grant funds under Section 501(a)(1)(D) of Title V of the SSA (i.e., to provide, promote, and facilitate a family-centered, community-based, coordinated care system for children with special healthcare needs) and are defined by DHHS in terms of program participation or special healthcare needs;
  - Receiving foster care or adoption assistance; or
  - In foster care or out-of-home placement.

Through enrollment of the 1915(b) population in the managed care program, DHHS seeks to:

- Ensure services and supports are driven by person-centered planning processes and principles.
- Coordinate care across medical, behavioral health, psychosocial, and LTSS settings.
- Improve the quality of healthcare, including the member's experience and the overall population.
- Achieve improved cost-effectiveness through reducing cost growth and better managing healthcare costs.

## New Hampshire MCM Quality Strategy

DHHS established a quality strategy to align the goals and objectives of the organizations that provide services to Medicaid members. Additionally, the quality strategy serves as an opportunity to assure stakeholders that MCOs are compliant with regulations, including having ample resources for internal monitoring, quality improvement activities, and improvement of the healthcare of vulnerable citizens. The most recent draft of the New Hampshire MCM Quality Strategy was released in July 2019.<sup>2-3</sup> The MCM Quality Program includes the following goals:

- Assure the quality and appropriateness of care delivered to the New Hampshire Medicaid population enrolled in managed care.
- Assure New Hampshire Medicaid members have access to care and a quality experience of care.
- Assure MCO contract compliance.

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<sup>2-3</sup> New Hampshire DHHS Bureau of Quality Assurance and Improvement. *New Hampshire MCM Quality Strategy, State Fiscal Year 2020*. Available at: <https://www.dhhs.nh.gov/ombp/quality/documents/mcm-quality-strategy-d1.pdf>. Accessed on: Oct 2, 2019.

- Assure MCO quality program infrastructure.
- Assure the quality and validity of MCO data.
- Manage continuous performance improvement.
- Conduct targeted population quality activities.

DHHS' Bureau of Quality Assurance and Improvement (BQAI) Medicaid Quality Program partners with organizations to implement the goals and strategies of the MCM Quality Program (i.e., DHHS BQAI Data Analytics and Reporting group, DHHS Bureau of MCM Operations, EQRO, and MCO QAPI programs).

To meet the goals and objectives outlined in the New Hampshire MCM Quality Strategy, DHHS collects and monitors over 200 performance measures and encounter and enrollment data, from the MCOs through the DHHS Medicaid Management Information System (MMIS) that are publicly displayed by population on the New Hampshire Medicaid Quality website (<https://medicaidquality.nh.gov/>). As part of its oversight of the MCOs, DHHS requires MCOs to submit multiple qualitative plans and tables and evidence of meeting additional requirements related to ensuring members receive quality service (e.g., obtaining and maintaining NCQA accreditation, implementing QAPI programs, comparing performance to other MCOs). As DHHS' EQRO, HSAG conducts program evaluation activities (e.g., contract compliance review) for DHHS and the MCOs.

DHHS implements several initiatives and programs to incentivize MCOs to improve the healthcare for members (e.g., performance improvement projects [PIPs], quality withhold and incentive program, alternative payment models, member incentive plans, liquidated damages).

To promote quality improvement, DHHS identified performance measures in SFY 2020 that have historically shown low performance, with the objective that these measures will rank at or above the national Medicaid 75th percentile by the end of SFY 2022. Additionally, DHHS monitors the access to care and quality of care for members with behavioral health conditions and substance use disorders (SUDs) and aims to improve the MCOs' care coordination.

Further, the New Hampshire MCM Quality Strategy outlines the monitoring plan for the Section 1915(b) Waiver population, including collecting data quarterly (e.g., utilization, grievances, appeals) and annually (e.g., member focus group).

## 3. Assessment Methodology

### Analysis Methodology

In completing the independent assessment for DHHS, HSAG followed the guidelines set forth in the *Section 1915(b) Waiver Program Independent Assessments: Guidance to States* document published by the Health Care Financing Administration (HCFA) in December 1998. Additionally, HSAG reviewed MCO and statewide performance in the domains of access to care, quality of care, and cost-effectiveness as they were outlined in DHHS' renewal proposal of the Section 1915(b) Waiver.

Documentation was secured and reviewed by HSAG and Milliman to determine the extent to which the implementation of the Section 1915(b) Waiver is cost-effective, efficient, and consistent with the access to care and quality of care requirements outlined in Title 42 CFR §438. The overall findings as they relate to the performance of the MCM program are provided within each domain and include recommendations for improvement, where appropriate.

### References and Data Sources

HSAG reviewed the information from the references and data sources below to complete the independent assessment. When available, HSAG assessed performance across waiver periods beginning from the implementation of the Section 1915(b) Waiver (i.e., September 1, 2015) through the most recently available data (i.e., August 2019).

- Independent Assessment of New Hampshire Medicaid Managed Care Program—1915(b) Population, August 2017
- New Hampshire Department of Health and Human Services MCM Contract Exhibit A—Amendment 12
- MCM Services Contract Exhibit A—Scope of Services
- SFY 2017–SFY 2019 EQRO Compliance Review reports
- New Hampshire MCM Quality Strategy for SFY 2019 and SFY 2020
- MCO CAHPS survey results
- MCO Behavioral Health Satisfaction Survey reports
- SFY 2015 Primary Care Provider (PCP) Secret Shopper Report
- New Hampshire MCM Qualitative Survey Summary Report Year Five, Spring 2018
- MCO HEDIS results
- Utilization of services data by 1915(b) Medicaid eligibility group (MEG)
- Enrollment and disenrollment processes and reports
- MCO NCQA accreditation reports

- Marketing plans and marketing materials
- Informational and educational materials for new and existing members
- Call center volumes and dispositions by month
- MCO quarterly service authorization reports
- Network adequacy and capacity standards and reports
- Provider termination reports
- MCO QAPI plans
- MCO *Colorectal Cancer Screening* QIP results
- Grievance and appeal reports
- MCO program integrity processes and reports related to fraud, waste, and abuse
- Actuarial firm's assessment of the predicted and actual costs for the Section 1915(b) Waiver population

## 4. Access to Care Assessment

### Results

This section includes an evaluation of DHHS and MCO performance as they relate to the requirements for member access to the MCM program and to all medically-covered services. The evaluation of the access to care included findings pertaining to access to marketing materials and communications, enrollment and disenrollment, member materials, customer service support, and other information about the MCM program. Additionally, the evaluation addressed MCO compliance, member perception of access, coordination of services, and access to and utilization of services.

### Contract Monitoring Activities

#### Compliance Reviews

As the EQRO for New Hampshire, HSAG conducted a three-year cycle of reviewing one-third of the elements in all the standards each year to determine the level of MCO compliance with the standards in 42 CFR §438. Additionally, HSAG evaluated whether the MCOs met DHHS’ contractual requirements included in the New Hampshire MCM Contract (referred to throughout this report as the MCO contract).<sup>4-1</sup> Table 4-1 and Table 4-2 display the overall scores of the standards reviewed for SFY 2017 to SFY 2019 for each of the compliance review standards for NHHF and Well Sense. Further, the tables show the total percentage of elements *Met*, *Partially Met*, or *Not Met*. Elements that received a determination of *Partially Met* or *Not Met* required the MCO to submit a CAP to DHHS. Of note, elements that required a CAP in the prior year were subsequently reviewed to ensure the policies and procedures submitted in the CAP were operationalized by the MCO.

**Table 4-1—Compliance Review Standards—NHHF**

Standard	Standard Name	SFY 2017 Score	SFY 2018 Score	SFY 2019 Score
I.	Delegation and Subcontracting	100%	78.6%	—
II.	Plans Required by the Contract	87.5%	100%	100%
III.	Emergency and Post-Stabilization Care	100%	100%	—
IV.	Care Management/Care Coordination	90.0%	96.4%	100%
V.	Wellness and Prevention	100%	100%	—
VI.	Behavioral Health	100%	100%	100%
VII.	Member Enrollment and Disenrollment	87.5%	90.0%	91.7%
VIII.	Member Services	100%	100%	100%

<sup>4-1</sup> State of New Hampshire Department of Health and Human Services. (2014). *Amendment #12 to the MCM Contract*. Available at: <https://www.dhhs.nh.gov/ombp/caremgmt/contracts.htm>. Accessed on: Sept 18, 2019.

Standard	Standard Name	SFY 2017 Score	SFY 2018 Score	SFY 2019 Score
IX.	Cultural Considerations	100%	100%	100%
X.	Grievances and Appeals	100%	100%	100%
XI.	Access Standards	100%	100%	91.7%
XII.	Network Management Standards	100%	100%	88.9%
XIII.	Utilization Management	100%	100%	100%
XIV.	Quality Management	95.0%	100%	100%
XV.	Substance Use Disorder	—	—	64.3%
<b>Overall Score</b>		<b>97.3%</b>	<b>98.0%</b>	<b>95.7%</b>
<b>Percent Met (No Action Required)</b>		<b>95.5%</b>	<b>96.1%</b>	<b>93.3%</b>
<b>Percent Partially Met (Action Required)</b>		<b>3.6%</b>	<b>3.9%</b>	<b>4.8%</b>
<b>Percent Not Met (Action Required)</b>		<b>0.9%</b>	<b>0.0%</b>	<b>1.9%</b>

— indicates the standard was not reviewed.

For NHHF, the MCO demonstrated strength by meeting the requirements reviewed in SFY 2019 within the Plans Required by the Contract, Care Management/Care Coordination, Behavioral Health, Member Services, Cultural Considerations, Grievances and Appeals, Utilization Management, and Quality Management standards.

Conversely, opportunities for improvement were identified, as NHHF was required to implement CAPs in SFY 2019 for requirements not met within Member Enrollment and Disenrollment, Access Standards, Network Management Standards, and Substance Use Disorder.

**Table 4-2—Compliance Review Standards—Well Sense**

Standard	Standard Name	SFY 2017 Score	SFY 2018 Score	SFY 2019 Score
I.	Delegation and Subcontracting	100%	85.7%	—
II.	Plans Required by the Contract	100%	90.0%	100%
III.	Emergency and Post-Stabilization Care	100%	100%	—
IV.	Care Management/Care Coordination	96.7%	100%	100%
V.	Wellness and Prevention	100%	100%	—
VI.	Behavioral Health	100%	100%	91.7%
VII.	Member Enrollment and Disenrollment	100%	100%	100%
VIII.	Member Services	100%	100%	100%
IX.	Cultural Considerations	100%	100%	100%
X.	Grievances and Appeals	100%	100%	100%
XI.	Access Standards	100%	100%	100%
XII.	Network Management Standards	95.0%	100%	88.9%

Standard	Standard Name	SFY 2017 Score	SFY 2018 Score	SFY 2019 Score
XIII.	Utilization Management	100%	100%	92.9%
XIV.	Quality Management	95.5%	100%	100%
XV.	Substance Use Disorder	—	—	71.4%
<b>Overall Score</b>		<b>98.6%</b>	<b>98.8%</b>	<b>96.2%</b>
<b>Percent Met (No Action Required)</b>		<b>97.3%</b>	<b>97.7%</b>	<b>93.3%</b>
<b>Percent Partially Met (Action Required)</b>		<b>2.7%</b>	<b>2.3%</b>	<b>5.7%</b>
<b>Percent Not Met (Action Required)</b>		<b>0.0%</b>	<b>0.0%</b>	<b>1.0%</b>

— indicates the standard was not reviewed.

For Well Sense, the MCO demonstrated strength by meeting the requirements reviewed in SFY 2019 within the Plans Required by the Contract, Care Management/Care Coordination, Member Enrollment and Disenrollment, Member Services, Cultural Considerations, Grievances and Appeals, Access Standards, and Quality Management standards.

Conversely, opportunities for improvement were identified, as Well Sense was required to implement CAPs in SFY 2019 for requirements not met within Behavioral Health, Network Management Standards, Utilization Management, and Substance Use Disorder.

Based on the findings listed above and within the SFY 2019 Compliance Review reports of the MCOs, HSAG recommends DHHS and the MCOs investigate the areas identified as opportunities for improvement for specific impact to the Section 1915(b) Waiver members, identifying CAP effectiveness, and consider implementing improvement strategies to ensure these members are not adversely affected moving forward.

## Access to MCOs

### Marketing and Communication

DHHS required the MCOs to follow marketing and communication federal and state guidelines, as well as those outlined in the MCM Services Agreement. Within the Section 1915(b) Waiver renewal application, DHHS assured compliance with the marketing requirements in Section 1932(d)(2) of the Act and 42 CFR §438.104 and that the CMS Regional Office reviewed and approved the MCO contracts related to the marketing requirements. Additionally, DHHS monitored and approved MCO website content and marketing materials (i.e., any communication to a potential member of the MCO to try and influence the member to either enroll with the MCO, not enroll with another MCO, or disenroll from another MCO) in advance of posting or distributing. As required in the New Hampshire MCM Quality Strategy, if any marketing or communication materials contained inaccurate or misleading information, the MCOs were subject to liquidated damages per violation.

DHHS’ marketing and communication materials (e.g., open enrollment announcement, frequently asked questions, how to get help in your language, making an informed decision) were accurate; easily

understood; available to eligible citizens with disabilities and language barriers; and did not appear to mislead, confuse, or defraud. Additionally, the Bureau of Developmental Services and Bureau of Special Medical Services, along with New Hampshire Family Voices, provided resources to dual-eligibles and families of children with special healthcare needs to assist with the enrollment process and management of the healthcare system through standardized materials.

The MCOs' websites were clear and easy to navigate and appeared to contain current information in an easily digestible format. Of note, the MCO websites did not appear to comply with DHHS' Marketing and Communications Guidelines related to notifying users when they leave the MCO's website and are redirected to another webpage;<sup>4-2</sup> therefore, HSAG recommends DHHS notify the MCOs of this finding and provide a time frame by which the MCOs must meet this requirement.

### Enrollment and Disenrollment

As part of the Section 1915(b) Waiver renewal application, DHHS assured compliance with the disenrollment requirements outlined in Section 1932(a)(4) of the Act and 42 CFR §438.56 and that the CMS Regional Office reviewed and approved the MCO contracts related to the disenrollment requirements. Further, DHHS assured that it satisfies the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy standards, as outlined in 45 CFR Parts 160 and 164. DHHS contracted with an independent contractor to conduct enrollment activities and had an easily accessible online process to enroll in managed care, NH EASY Gateway to Services (<https://nheasy.nh.gov/#/>), which included frequently asked questions, information about services and qualification requirements, a link to the official New Hampshire government website, and customer support available via telephone or email.

DHHS permitted members to select the MCO of their choice during the initial 60 days of eligibility. If a member did not select an MCO, members were auto-assigned equally between the MCOs. DHHS allowed members who were auto assigned to request disenrollment during the first 12 months of eligibility if they had an established relationship with a provider outside of their MCO network. Members were able to request disenrollment from an MCO with cause at any time and members could change MCOs during open enrollment periods. Members were mailed a letter with the necessary information to change MCOs during open enrollment periods. Of note, members were automatically re-enrolled with the same MCO if no action was taken and if there was a gap in coverage of less than two months.

Table 4-3 displays the enrollment and disenrollment counts for NHHF and Well Sense across the last quarter (i.e., January 1, 2018–March 31, 2018) of the initial Section 1915(b) Waiver period and the first five quarters of the renewal period (i.e., April 1, 2018–June 30, 2019), the most recent data available.

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<sup>4-2</sup> New Hampshire DHHS MCM Program, Division of Medicaid Services. *Marketing and Communications Guidelines*. Reference Number: 19-0001; 2019.

**Table 4-3—Section 1915(b) Waiver Population Enrollment Profile—NHHF and Well Sense**

Time Period	Enrolled		Disenrolled	
	NHHF	Well Sense	NHHF	Well Sense
January 2018	11,696	11,900	329	363
February 2018	11,675	11,886	382	402
March 2018	11,690	11,847	333	373
April 2018	11,678	11,862	361	302
May 2018	11,676	11,912	355	361
June 2018	11,734	11,994	312	329
July 2018	11,778	11,987	328	389
August 2018	11,828	12,036	242	280
September 2018	11,834	12,072	248	264
October 2018	11,768	12,011	289	324
November 2018	11,738	12,067	250	263
December 2018	11,746	12,017	297	296
January 2019	11,912	12,146	325	305
February 2019	11,975	12,222	358	329
March 2019	11,134	11,252	260	251
April 2019	12,041	12,340	312	310
May 2019	12,079	12,391	298	282
June 2019	12,121	12,450	304	295

The enrollment and disenrollment counts for both NHHF and Well Sense remained stable across Section 1915(b) Waiver periods, except for a drop in enrollment for March 2019. Members were disenrolled from the MCO for no longer being eligible for Medicaid, no longer in managed care but still a Section 1915(b) Waiver population member, and still enrolled with managed care but no longer considered part of the Section 1915(b) Waiver population.

Based on the assessment findings, HSAG concluded that the enrollment and disenrollment procedures and resources were adequate and has no recommendations.

### Access to Information

#### Call Centers

As noted in the Section 1915(b) Waiver renewal application, DHHS collected and analyzed member service call center data and implemented CAPs for performance outside of standards. The MCOs operated a member service call center Monday through Friday, meeting the required operational hours

outlined in the MCO contract (i.e., at least two days a week from 8:00 a.m. to 5:00 p.m. and three days a week from 8:00 a.m. to 8:00 p.m. Eastern Time). Translation services were available for telephonic communication and to request written materials and Teletypewriting Device for the Deaf/teletypewriter (TDD/TTY) available for the hearing impaired. MCO member service call center information was included in the MCOs’ respective member handbooks. Both MCOs also operated a Nurse Advice Line available 24 hours a day. DHHS implemented the Customer Service Center to provide general assistance, which included translation and TTY services available Monday through Friday from 8:00 a.m. to 4:00 p.m. Eastern Time. The MCO member service call centers must be coordinated with the DHHS Customer Service Center and have a warm transfer protocol in place. As outlined in the New Hampshire MCM Quality Strategy, failure to comply with the member service requirements may have resulted in daily liquidated damages for the MCO.

The member service call centers were required to meet the standards in the MCO contract, including an average speed of answer within 30 seconds for 90 percent of calls, an average abandonment rate less than 5 percent, and voicemails returned no later than the next business day.

Figure 4-1 displays the aggregated call center results for the percentage of calls answered within 30 seconds for January 2018 to July 2019. Please note the data below were not limited to the Section 1915(b) Waiver population. Of note, more than 51,000 members were transferred from Quality Health Plans (QHPs) to the MCM program on January 1, 2019, due to the end of the NHHPP PAP Section 1115 Demonstration Project. This influx of members contributed to an increase in call volume for Q1 2019, resulting in a delay in answering calls and an increase in abandoned calls.

**Figure 4-1—Member Communications—Percentage of Speed to Answer Within 30 Seconds—Statewide**

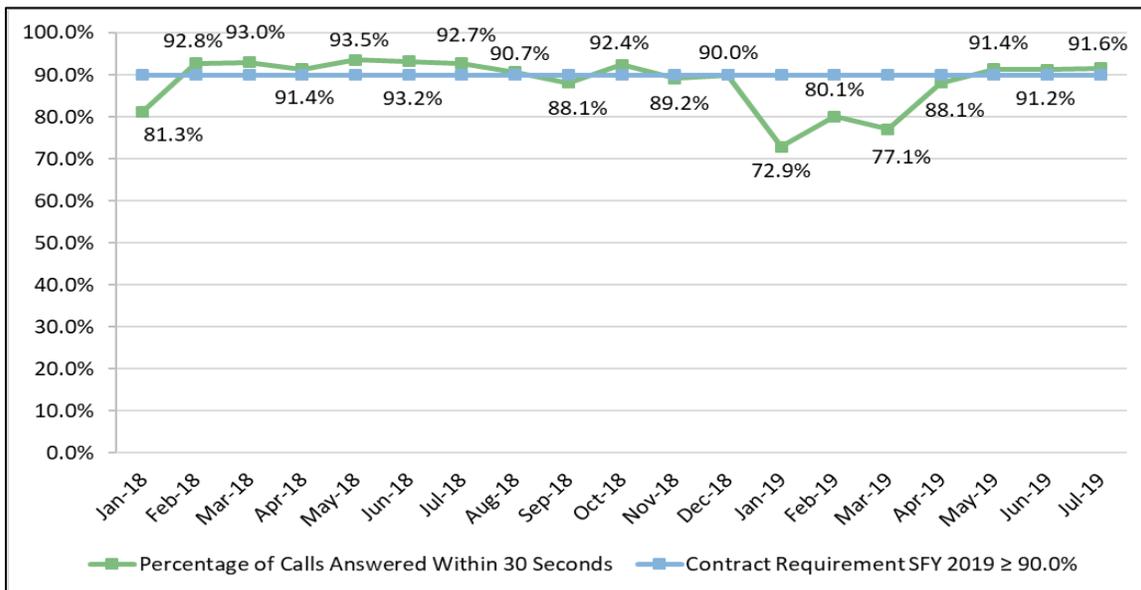


Figure 4-1 shows that the percentage of calls answered within 30 seconds standard (i.e., for at least 90 percent of calls) was not met for seven of 19 (36.8 percent) months, including the first four months of

2019 when the MCM program expanded due to the end of the NHHPP PAP Section 1115 Demonstration Project.

Figure 4-2 displays the aggregated call center results for the percentage of abandoned calls for January 2018 to July 2019. Please note the data below were not limited to the Section 1915(b) Waiver population.

**Figure 4-2—Member Communications—Percentage of Calls Abandoned—Statewide**

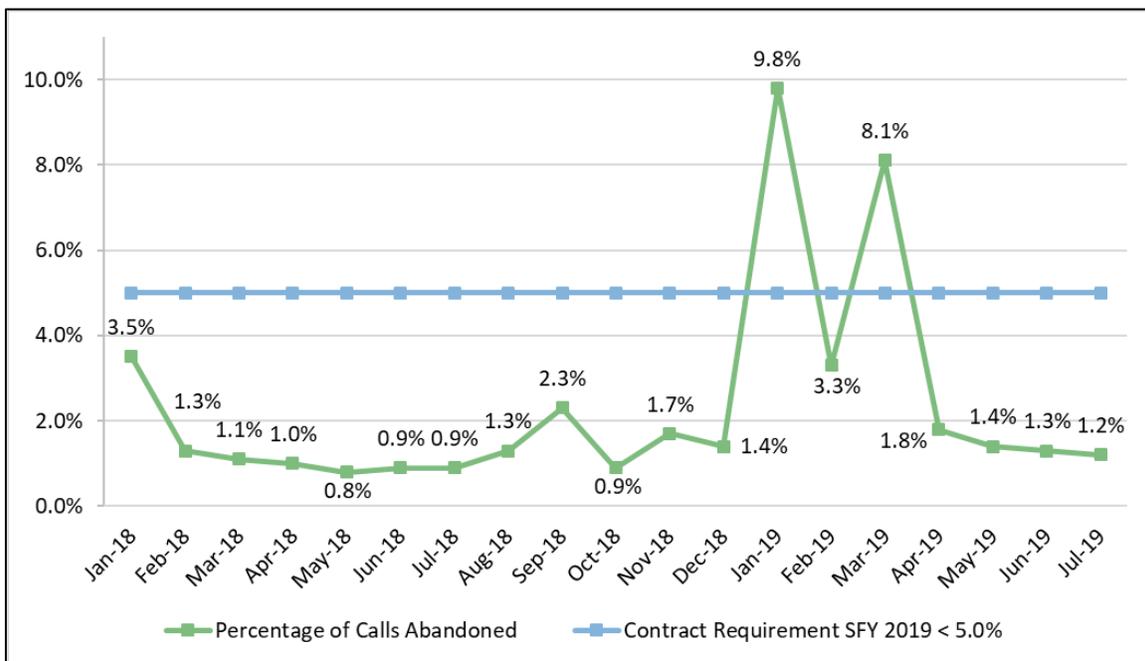


Figure 4-2 shows that the percentage of calls abandoned was more than the 5 percent standard for two of 19 (10.5 percent) months, indicating positive performance for this area.

DHHS’ contractor, MAXIMUS Health Services, operates the statewide DHHS Customer Service Center that provided enrollment information about the MCM program and services and assistance through the enrollment process. DHHS monitored several facets weekly (e.g., longest delay, transfer rate to Medicaid client services, customer satisfaction) against pre-determined minimum standards. Review of the data available from April 2018 to August 2019 indicated that there were no weeks that had a call abandonment rate more than 5 percent and that only one week (i.e., December 3, 2018–December 7, 2018) had a speed to answer within 30 seconds rate of less than 90 percent (i.e., 55.64 percent), which appears to be due to a very high volume of calls within one day.

As a result of the review of the call center policies and data, HSAG does not have any recommendations for program improvement related to the support for Section 1915(b) Waiver members.

## Member Materials

Once enrollment into the New Hampshire MCM program was complete, each MCO mailed members a printed copy of the respective MCO's *New Hampshire MCM Program Member Handbook*, which was also available online and in non-English languages and alternate formats (e.g., braille, large print) if requested.<sup>4-3,4-4</sup> HSAG reviewed the information included in both MCOs' member handbooks, which included a thorough explanation of benefits, how to obtain appropriate services and assistance (e.g., pharmacy services, urgent/emergent care, non-emergency transportation, customer service), and information for how to identify and report various offenses (e.g., fraud, waste, abuse, discrimination). Member materials included in the member handbooks were also available on the MCOs' websites and were thorough and easy to understand and navigate.

New members received a hard copy membership card for obtaining medical services and prescription drug access and resources for how to replace the membership card. Welcome calls, with language translation and alternate formats if needed, were conducted to familiarize members with the MCO and assist with the selection of the member's PCP. MCOs provided members access to a provider directory, online or via mail if requested, to assist in the selection of the members' assigned PCPs, as well as the process for changing a PCP. Additionally, DHHS required the MCOs to conduct a health needs assessment (HNA) survey to help determine the level of care coordination necessary for each member. Members received periodic explanation of benefits notices and were provided with their rights and responsibilities as a member of the MCO.

DHHS' website (<https://www.dhhs.nh.gov/index.htm>) contained ample information about the department, the MCM program, presentations and public notices, and policy updates for consumer review. DHHS' website was easy to navigate and offered immediate translation of information into several languages.

During the SFY 2019 Compliance Reviews, HSAG found that neither of the MCOs had implemented the requirement that the MCOs' provider directories and websites must indicate if a provider has completed the required cultural competence training. As a result of this finding, HSAG recommends DHHS ensure NHHF and Well Sense have updated their provider directories and websites accordingly.

## Member Interviews

Horn Research, on behalf of HSAG, conducted interviews with members in the MCM program to gain perspective on four areas: experience with MCO, access to care, quality of care management, and suggestions for improvement. In March and April 2018, Horn Research collected data from 28

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<sup>4-3</sup> New Hampshire Healthy Families. *New Hampshire MCM Program Member Handbook*. 2019. Available at: <https://www.nhhealthyfamilies.com/content/dam/centene/NH%20Healthy%20Families/Medicaid/pdfs/NH-Healthy-Families-Model-Handbook-FINAL-CLEAN-20190731.pdf>. Accessed on: Sept 26, 2019.

<sup>4-4</sup> Well Sense. *New Hampshire MCM Program Well Sense Health Plan Member Handbook*. 2019. Available at: <https://www.wellsense.org/members/-/media/0bd616da208b4929b4cc50a57f13b817.ashx>. Accessed on: Sept 26, 2019.

participants that were either dual-eligible members or parents or caregivers of children with disabilities or in foster care.

For the experience with MCO topic, more than half expressed understanding of their MCO, with most having their needs met and being unconcerned about any lack of knowledge. For the access to care topic, only two people interviewed stated that there were not enough PCPs available and nearly half indicated they had challenges accessing specialist care (i.e., a lack of mental health providers, a lack of dental providers, preferred providers out of network, and PCPs not providing referrals). Access to medications and therapy services appeared adequate based on participant responses. Related to the quality of care management topic, overall participants indicated they had positive relationships with PCPs and those who received care management services were largely satisfied. The suggestions for improvement topic indicated that participants would appreciate more information from the MCO about benefits, policy coverage, and specific conditions and treatments.

Horn Research cautioned that the results from the 28 participants should not be considered representative of the entire Section 1915(b) Waiver population. However, based on the results from the interviews, Horn Research provided the following recommendations: increase the number of specialist providers (e.g., mental health and dental), provide more comprehensive information about providers (e.g., provider experience working with special needs children), expand coverage (e.g., expand provider network, permit out-of-network care with reimbursement), and provide clearer benefit and coverage information in a variety of formats (e.g., one-sheet summaries, videos, group trainings).

Additionally, as outlined in the MCO contract, NHHF and Well Sense were required to conduct meetings with members (in-person or via interactive technology) to solicit feedback regarding the MCM program (e.g., quality improvement, changes, decisions). As a result, both MCOs hold several Member Advisory Council meetings each year and submit annual reports related to the discussion and actions taken to DHHS.

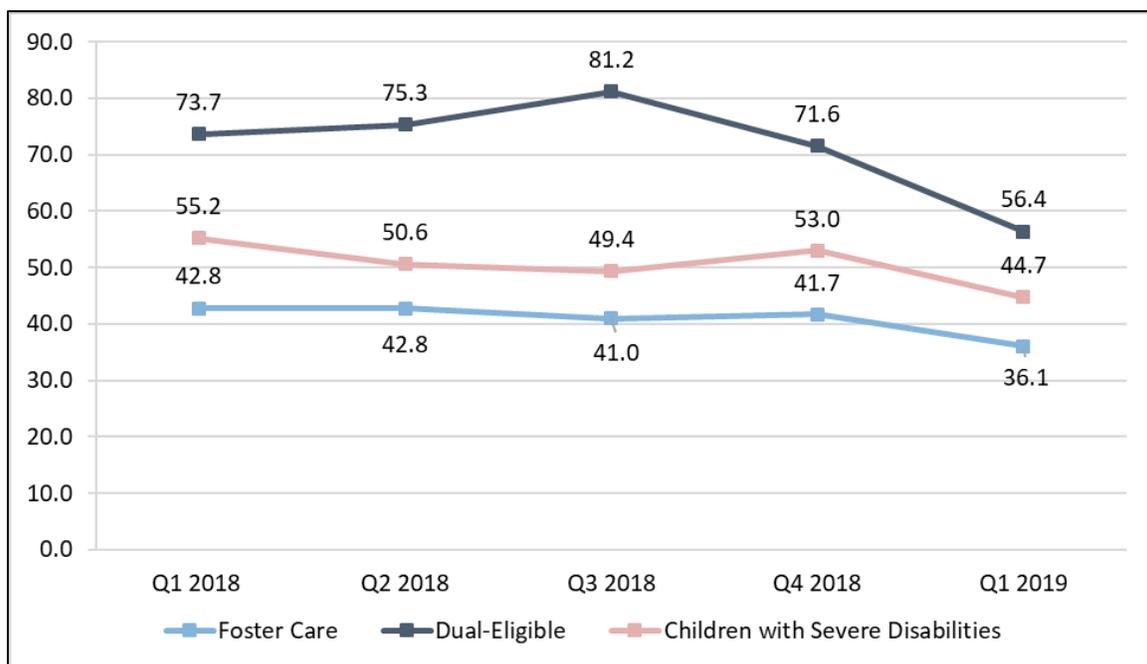
While DHHS had adequate mechanisms in place to meet the assurances of the Section 1915(b) Waiver renewal application, based on the 2018 interviews conducted by Horn Research, HSAG suggests that DHHS do further investigation into the recommendations to determine if they are widespread among the Section 1915(b) Waiver population and consider implementing additional requirements in the MCO contract, if determined necessary, based on the additional investigation findings.

## Availability of Providers and Services

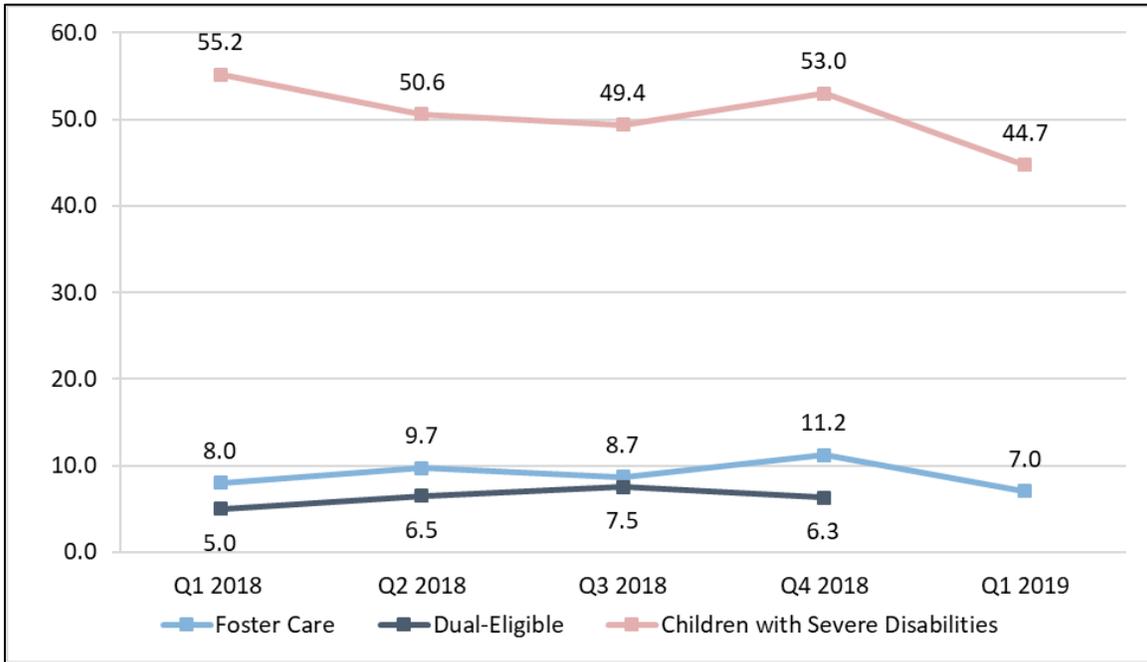
### Utilization Performance Measures

As noted in the Section 1915(b) Waiver renewal application and the New Hampshire MCM Quality Strategy, DHHS collected data from the MCOs related to the use of services. DHHS aggregated and reviewed the use of services data to monitor performance over time and identified any outliers in performance by MCO or statewide. If any outliers in performance were identified, DHHS followed-up with the MCO to address the issue with a CAP, as necessary. The figures below (i.e., Figure 4-3, Figure 4-4, Figure 4-5, and Figure 4-6) include the emergency department utilization data available specific to the Section 1915(b) Waiver population (i.e., foster care children, dual-eligibles, and children with severe disabilities) for the last quarter (i.e., January 1, 2018–March 31, 2018) of the initial Section 1915(b) Waiver period and the first four quarters of the renewal period (i.e., April 1, 2018–March 31, 2019), the most recent data available.

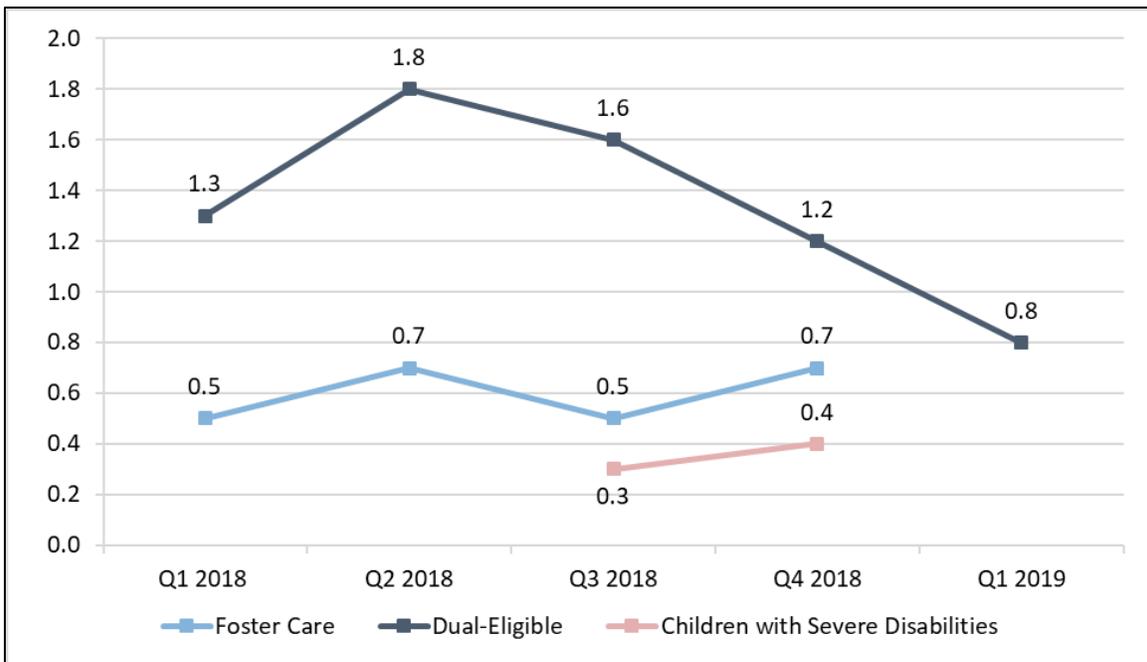
**Figure 4-3—Emergency Department Visits—Medical Conditions**



**Figure 4-4—Emergency Department Visits—Mental Health Conditions**



**Figure 4-5—Emergency Department Visits—Substance Use Disorder Conditions**



**Figure 4-6—Emergency Department Visits—Potentially Treatable in Primary Care**

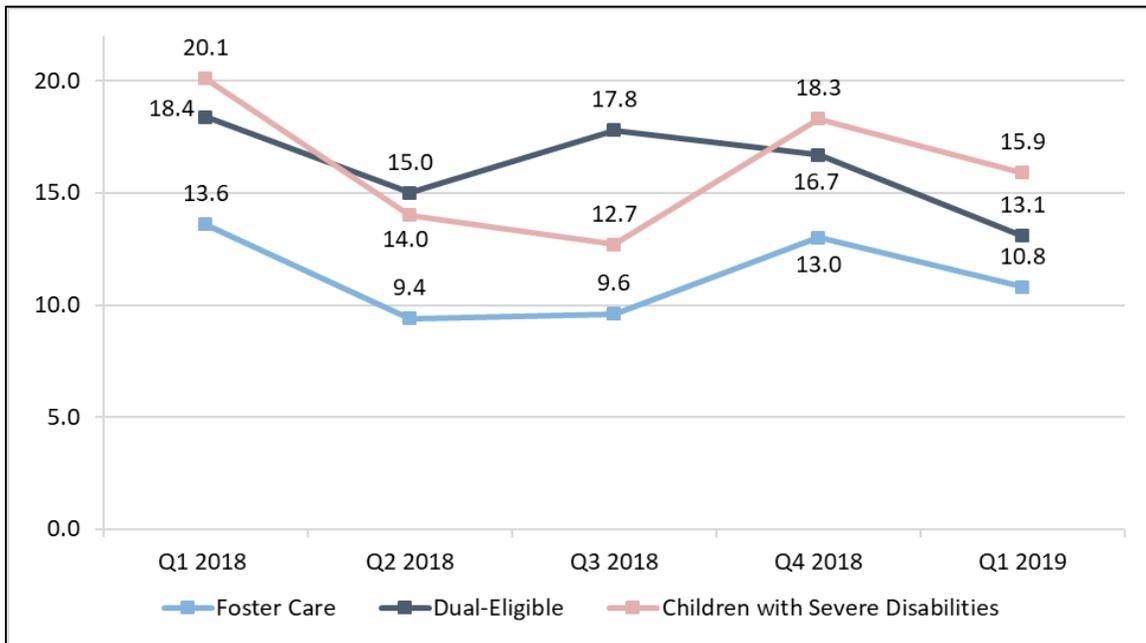
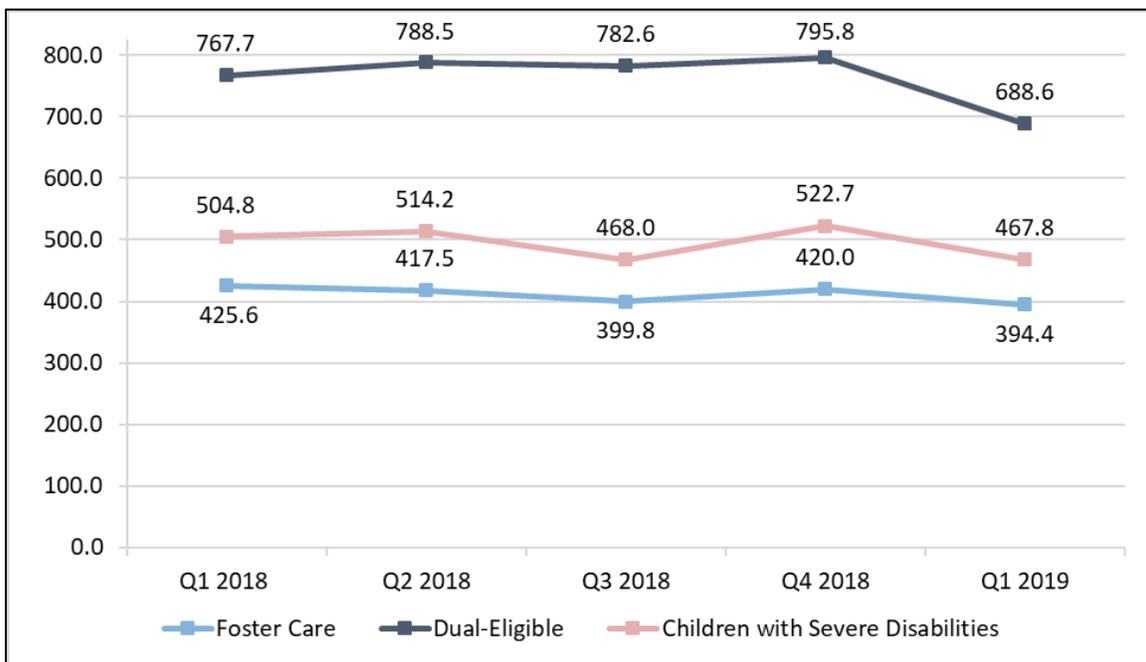


Figure 4-7 displays the office and clinic utilization data available specific to the Section 1915(b) Waiver population (i.e., foster care children, dual-eligibles, and children with severe disabilities) for the last quarter (i.e., January 1, 2018–March 31, 2018) of the initial Section 1915(b) Waiver period and the first four quarters of the renewal period (i.e., April 1, 2018–March 31, 2019), the most recent data available.

**Figure 4-7—Office/Clinic Visits**



For the emergency department and office/clinic visits, the utilization of services from Q4 2018 (i.e., October 1, 2018–December 31, 2018) to Q1 2019 (i.e., January 1, 2019–March 31, 2019) decreased for all populations with available data. With more than 51,000 members transferring from QHPs to the MCM program on January 1, 2019, following the end of the NHHPP PAP Section 1115 Demonstration Project, the decrease in utilization of services from Q4 2018 to Q1 2019 appears to be related to this influx of members.

Although not specific to the Section 1915(b) Waiver population, DHHS previously found that members using Community Mental Health Center (CMHC) services have higher emergency department utilization and that the Delivery System Reform Incentive Payment (DSRIP) waiver includes measures related to this utilization tied to the integrated delivery network (IDN) for the behavioral health population. Additionally, the new MCO contract, effective July 1, 2019, includes additional measures to monitor and address this higher utilization for the behavioral health population.

Following review of the utilization performance measures, HSAG recommends DHHS continue to monitor utilization of outpatient and emergency services to ensure that utilization rates return to normal levels after the influx of the NHHPP PAP Section 1115 Demonstration Project members into the MCM program in Q1 2019.

### Network Adequacy and Capacity

As outlined in the Section 1915(b) Waiver renewal application and in the New Hampshire MCM Quality Strategy, DHHS required the MCOs to meet standards related to network and access monitoring. DHHS evaluates data on a quarterly basis. MCOs were required to ensure members had access to the following care:

- Preventive care visits (e.g., well-care visits, childhood immunizations, annual gynecological examinations) with assigned provider within 45 calendar days
- Routine care (e.g., non-urgent symptomatic visit) within 10 calendar days
- Urgent care (e.g., urgent symptomatic visit) within 48 hours
- Emergency services, SUD care, and psychiatric care seven days a week, 24 hours a day
- Behavioral health services within six hours for non-life-threatening emergency services, 48 hours for urgent care, and 10 business days for routine care
- Transitional care with a provider or at home (with nurse or licensed counselor) within seven days of discharge from inpatient/institutional care for behavioral health disorders or SUD treatment program

The MCOs also were required to meet various guidelines related to the time and distance from members' residences to providers and facilities (e.g., must have two PCPs within 40 minutes or 15 miles).

The provider manuals on both NHHF's and Well Sense's websites included language requiring timely care for members, as required by DHHS and outlined above. Additionally, the provider manuals included various monitoring and quality improvement activities (e.g., HEDIS, CAHPS).

From the results of the 2017 MCO Provider Survey, DHHS identified potential issues with long wait times for urgent and routine appointments with specialists. DHHS indicated they would investigate the potential impact on different specialist types (e.g., pediatric, adult) using the 2018 MCO Provider Survey. Although not specific to the Section 1915(b) Waiver population, DHHS also found that, in 2018, both MCOs had network adequacy issues related to specialists and behavioral health providers and implemented new pediatric specialist reporting and standard contract criteria for requesting network adequacy exceptions in late fall 2018. Based on the fact that DHHS has taken adequate action to address the issues previously identified, HSAG has no additional recommendations for DHHS related to network adequacy and capacity.

### Secret Shopper Survey

As outlined in the Section 1915(b) Waiver renewal application, DHHS stated that it complied with Section 1932(c)(2) of the Act and 42 CFR §438 Subpart E, contracting with an EQRO (i.e., HSAG) to conduct access to care and services reviews. Following the expansion of Medicaid coverage through the ACA, members were transitioned from the NHHPP (FFS system) into the MCM program in late 2014. Since the NHHPP reimbursement rates for providers were higher, HSAG conducted a secret shopper telephone survey for SFY 2015 of providers’ offices to evaluate if the members in managed care received comparable appointment times to those in the FFS system. HSAG selected a sample of 516 PCPs that were associated with both the NHHPP and MCM programs and then randomly assigned 50 percent to an appointment type (i.e., preventive appointments or routine/episodic appointments). The final sample size was reduced for each type of appointment for various reasons, including invalid telephone numbers, providers leaving practices, and PCPs not providing services to both programs. Table 4-4 and Table 4-5 display the results of the secret shopper calls to schedule preventive appointments (e.g., annual check-up) and routine/episodic appointments (e.g., sore throat with congested nose) for new members within the standard time frame. Of note, the standard to schedule a preventive appointment in SFY 2015 was 30 days and subsequently has been revised to 45 days. Additionally, the results of the secret shopper survey were not limited to the Section 1915(b) Waiver population.

**Table 4-4—Preventive Appointment Results**

Program	Final Sample	Unable to Schedule Appointment		Able to Schedule Appointment		Appointments Scheduled Within 30 Days	
		Number	Percent	Number	Percent	Number	Percent
MCM	178	141	79.2%	37	20.8%	13	35.1%
NHHPP	150	124	82.7%	26	17.3%	9	34.6%
<b>Total</b>	<b>328</b>	<b>265</b>	<b>80.8%</b>	<b>63</b>	<b>19.2%</b>	<b>22</b>	<b>34.9%</b>

**Table 4-5—Routine or Episodic Appointment Results**

Program	Final Sample	Unable to Schedule Appointment		Able to Schedule Appointment		Appointments Scheduled Within 10 Days	
		Number	Percent	Number	Percent	Number	Percent
MCM	190	180	94.7%	10	5.3%	7	70.0%
NHHPP	151	144	95.4%	7	4.6%	7	100%
<b>Total</b>	<b>341</b>	<b>324</b>	<b>95.0%</b>	<b>17</b>	<b>5.0%</b>	<b>14</b>	<b>82.4%</b>

The results of the secret shopper survey indicated little variation between scheduling an appointment within the NHHPP and MCM programs; however, very few calls actually resulted in an appointment. Of note, many providers were unable to schedule an appointment with the secret shopper due to a lack of patient-specific data (e.g., mock Medicaid ID). Currently, HSAG is conducting a secret shopper survey for SFY 2020 for DHHS to evaluate the time frame for scheduling an appointment with a PCP for new members of the MCOs. Due to the limitations of the SFY 2015 secret shopper survey, HSAG encourages DHHS to evaluate the SFY 2020 secret shopper survey results to ensure members have appropriate access to care. From the review of the SFY 2015 secret shopper survey, HSAG does not have any program improvement recommendations specific to the Section 1915(b) Waiver members.

**HEDIS Performance Measures**

HEDIS is a standardized set of nationally recognized indicators used in measuring performance of managed care plans. According to NCQA, HEDIS is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service.<sup>4-5</sup> DHHS required the MCOs to generate performance measure rates and to contract with independent certified HEDIS compliance auditors (CHCAs) to validate and confirm the rates. The MCOs submitted various HEDIS process, outcome, and appropriate utilization measures related to acute and chronic care. The HEDIS 2019 (calendar year [CY] 2018) measure rates were compared to NCQA’s Quality Compass® national Medicaid health maintenance organization (HMO) averages as an indicator of performance per the New Hampshire MCM Quality Strategy.<sup>4-6</sup> Prior to SFY 2019, the External Quality Review (EQR) Technical Reports compared the measure rates to NCQA’s Audit Means and Percentiles. Moving forward, DHHS has revised the comparison of performance measure rates to the Quality Compass national Medicaid 75th percentile. Of note, the access-related performance measure results in Table 4-6 display the rates and comparison to national averages for the entire managed care population, as Section 1915(b) Waiver population-specific data were not yet available for all of these measures. DHHS, in conjunction with HSAG, determined which required HEDIS performance measures were deemed access-related as part of the EQRO activities. Rates that performed above the national average are in bold.

<sup>4-5</sup> National Committee for Quality Assurance. (n.d.). *HEDIS & Quality Measurement*. Available at: [http://store.ncqa.org/index.php/performance-measurement.html?\\_SID=U](http://store.ncqa.org/index.php/performance-measurement.html?_SID=U). Accessed on: Dec 28, 2018.

<sup>4-6</sup> Quality Compass® is a registered trademark of NCQA.

**Table 4-6—HEDIS 2019 (CY 2018) Performance Measure Results**

Measure	NHMF	Well Sense
<b>Prevention</b>		
<b>Prenatal and Postpartum Care</b>		
<i>Timeliness of Prenatal Care</i>	<b>82.48%</b>	<b>81.91%</b>
<i>Postpartum Care</i>	<b>66.18%</b>	59.04%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>		
<i>Ages 12 to 24 Months</i>	<b>96.90%</b>	<b>97.26%</b>
<i>Ages 25 Months to 6 Years</i>	<b>91.52%</b>	<b>92.56%</b>
<i>Ages 7 to 11 Years</i>	<b>95.10%</b>	<b>95.70%</b>
<i>Ages 12 to 19 Years</i>	<b>93.63%</b>	<b>93.19%</b>
<b>Adults' Access to Preventive/Ambulatory Health Services</b>		
<i>Total</i>	<b>89.11%</b>	<b>88.69%</b>
<b>Behavioral Health</b>		
<b>Follow-Up After Hospitalization for Mental Illness</b>		
<i>7-Day Follow-Up—Total</i>	<b>64.62%</b>	<b>54.72%</b>
<i>30-Day Follow-Up—Total</i>	<b>78.02%</b>	<b>71.24%</b>
<b>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</b>		
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	79.23%	<b>81.45%</b>
<b>Diabetes Monitoring for People With Diabetes and Schizophrenia</b>		
<i>Diabetes Monitoring for People With Diabetes and Schizophrenia</i>	<b>71.74%</b>	65.85%
<b>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</b>		
<i>Initiation Phase</i>	<b>59.96%</b>	39.12%
<i>Continuation and Maintenance Phase</i>	<b>69.15%</b>	48.59%
<b>Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment</b>		
<i>Initiation of AOD Treatment—Total</i>	37.89%	<b>44.00%</b>
<i>Engagement of AOD Treatment—Total</i>	<b>13.68%</b>	<b>20.95%</b>

Rates that performed above the national average are represented in **bold**.

For the access-related performance measures related to preventive care, both NHMF and Well Sense demonstrated strength, with only one rate falling below the national average (Well Sense's *Prenatal and Postpartum Care—Postpartum Care*). Additionally, the HEDIS 2018 performance measure results included in the 2018 New Hampshire EQR Technical Report for the Prevention domain showed that both MCOs' rates generally remained stable compared to HEDIS 2019, except Well Sense demonstrated

a decrease of more than 5 percentage points for the *Postpartum Care* indicator (from 65.50 percent to 59.04 percent), indicating overall strength for the Medicaid population.

Performance for the overall Medicaid population for the behavioral health access-related measures indicated opportunities for improvement, with NHHF and Well Sense falling below the national average for two of eight (25.0 percent) and three of eight (37.5 percent) rates, respectively. Of note, despite more than a 5-percentage point increase from the prior year (60.00 percent to 65.85 percent), Well Sense still fell below the national average for the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure.

DHHS should work with NHHF and Well Sense to investigate the cause of the rates falling below the national average and implement improvement strategies related to increasing the access to postpartum care visits, diabetic screening and monitoring of members with behavioral health conditions, follow-up care for members on ADHD medications, and the initiation of treatment for members with AOD.

The figures below display the available access-related performance measures for CY 2017 and CY 2018 that were specific to the Section 1915(b) Waiver population.

**Figure 4-8—Follow-Up Care for Children Prescribed ADHD Medication Measure Results**

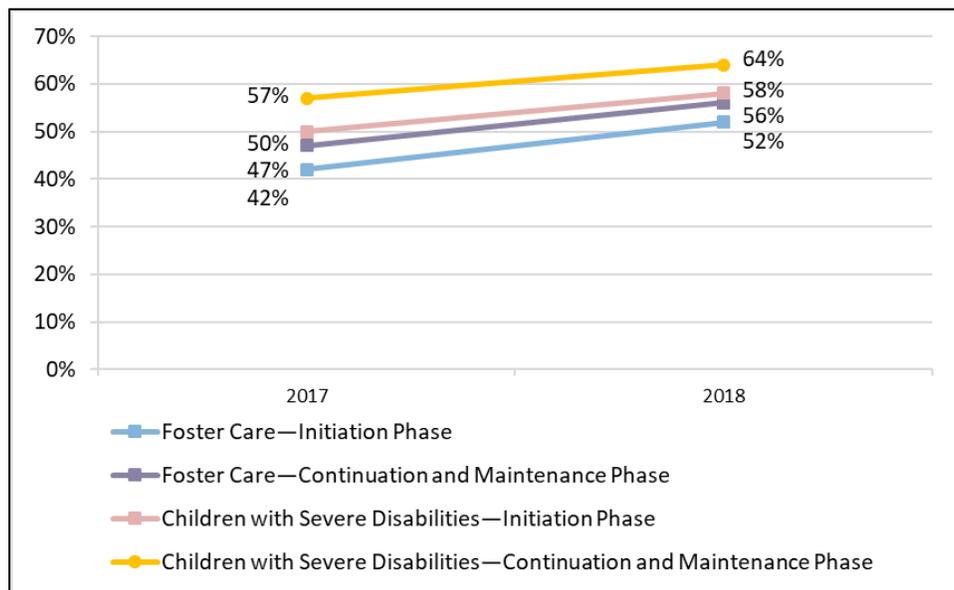
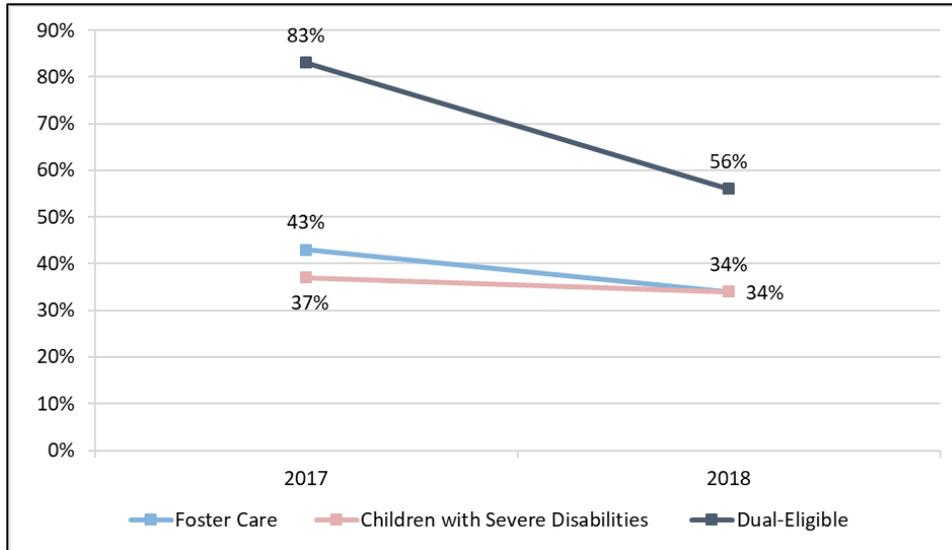


Figure 4-8 indicates strength in this measure for the foster care and children with severe disabilities members, as all rates related to *Follow-Up Care for Children Prescribed ADHD Medication* demonstrated improvement from the prior year. Of note, both the *Initiation Phase* and *Continuation and Maintenance Phase* indicators for the children with severe disabilities population exceeded the 75th percentile nationally in 2018.

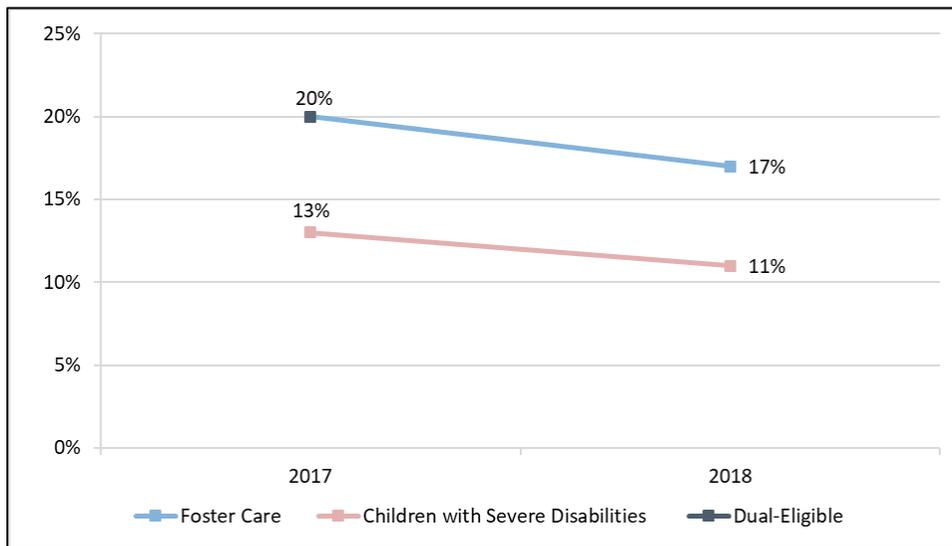
**Figure 4-9—Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment Measure Results**



*The 2018 rate for the foster care population has a small denominator (less than 30); therefore, exercise caution when reviewing results.*

Although the rates for all three populations declined from 2017 to 2018, the figure shows the 2018 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* rate for the dual-eligible population still exceeded the 95th percentile, indicating strength for this population. Conversely, the rate for the children with severe disabilities fell below the 25th percentile for 2018, indicating an opportunity to improve the access-related care for these members with AOD.

**Figure 4-10—Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment Measure Results**



*The 2018 rate for the foster care population has a small denominator (less than 30); therefore, exercise caution when reviewing results. Additionally, the 2018 dual-eligible rate had a denominator less than 20 and has been suppressed.*

Figure 4-10 shows that the *Engagement of AOD Treatment* indicator declined slightly from 2017 to 2018 for the children with severe disabilities population, falling below the 50th percentile, indicating an opportunity to increase the number of AOD services or medication treatment for these child members.

Going forward, in addition to continuing to monitor and follow-through on the previously identified measure-specific general areas of opportunity, HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population (e.g., *Children and Adolescents' Access to Primary Care Practitioners*) to monitor and improve the access to care.

## **Member Perception of Access to Providers and Services**

### **CAHPS Surveys**

Per the Section 1915(b) Waiver renewal application and the MCO contract, MCOs were required to conduct an annual survey to report member perception of access to providers and services. MCOs contracted with a licensed vendor, following NCQA data collection protocols, to administer the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult members and the CAHPS 5.0H Child Medicaid Health Plan Survey (with CCC measurement set) to parents or caretakers of child members. Of note, the CAHPS results were not limited to the Section 1915(b) Waiver population; however, the CCC results may be more indicative of MCO performance as they relate to child Section 1915(b) Waiver members because these members may have a chronic condition (i.e., eligible for SSI). CAHPS measure rates were compared to NCQA's Quality Compass CAHPS adult and general child Medicaid national averages as an indicator of performance as outlined in the New Hampshire MCM Quality Strategy. DHHS aggregated and reviewed CAHPS data to monitor performance over time and identified any outliers in performance by MCO or statewide. If any outliers in performance were identified, DHHS followed-up with the MCO to address the issue.

Table 4-7 and Table 4-8 display the available CAHPS results for the adult and CCC populations for two access-related CAHPS composite measures that examine member experiences with attempting to get care, tests, or treatment; appointments for routine checks and with specialists; and receiving care when it is needed right away (i.e., *Getting Needed Care* and *Getting Care Quickly*). Additionally, Table 4-8 displays the access-related 2018 CAHPS composite measure results for the CCC population that examine member experiences with attempting to get access to specialized services, prescription medicines, and answers to questions from providers (i.e., *Access to Specialized Services*, *Access to Prescription Medicines*, and *Family Centered Care [FCC]: Getting Needed Information*). Of note, bold rates indicate performance was above the national average.

**Table 4-7—Adult Medicaid CAHPS Results—CY 2016–2018**

Measure	2016		2017		2018	
	NHHF	Well Sense	NHHF	Well Sense	NHHF	Well Sense
<b>Composite Measures</b>						
<i>Getting Needed Care</i>	<b>85.3%</b>	<b>85.8%</b>	<b>84.7%</b>	<b>84.2%</b>	<b>82.9%</b>	<b>86.1%</b>
<i>Getting Care Quickly</i>	<b>84.0%</b>	<b>86.1%</b>	<b>88.2%</b>	<b>84.3%</b>	<b>85.9%</b>	<b>84.4%</b>

Rates that performed above the national average are represented in **bold**.

**Table 4-8—Child Medicaid With CCC Measurement Set CAHPS Results—CY 2018**

Measure	2018	
	NHHF	Well Sense
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	<b>86.9%</b>	<b>90.8%</b>
<i>Getting Care Quickly</i>	<b>95.6%</b>	<b>93.8%</b>
<i>Access to Specialized Services</i>	76.5%	77.4%+
<i>Access to Prescription Medicines</i>	88.0%	<b>92.6%</b>
<i>FCC: Getting Needed Information</i>	<b>93.4%</b>	<b>93.6%</b>

Rates that performed above the national average are represented in **bold**.

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

For the adult and child populations, the MCOs were above the national average for the two access to care measures related to getting needed care and getting care quickly, indicating strength. Additionally, the *FCC: Getting Needed Information* composite measure rates were above the 2018 national average, demonstrating that family members were able to get their questions answered by their child’s providers. Conversely, both NHHF and Well Sense fell below the national average for *Access to Specialized Services*, indicating an opportunity for DHHS and the MCOs to improve access to special medical equipment, therapy, and counseling for CCC. Further, NHHF was below the national average for the *Access to Prescription Medicines* measure suggesting opportunities to improve access to prescription medicines.

HSAG found the CAHPS survey processes and results were sufficient to meet the assurances in the Section 1915(b) Waiver renewal application. HSAG has no recommendations for program improvement in this area.

### Behavioral Health Satisfaction Survey

The MCOs were required to administer the Behavioral Health Satisfaction Survey annually to gain perception of the access to providers and services for those members who seek treatment for mental health and SUD conditions, as indicated in the Section 1915(b) Waiver renewal application. Of note, the results for this survey were not limited to the Section 1915(b) Waiver population; however, the survey

questions provide MCM program members’ perspectives on behavioral health services received in the last 12 months. DHHS aggregated and reviewed the behavioral health survey data to monitor performance over time and identified any outliers in performance by MCO or statewide. If any outliers in performance were identified, DHHS followed up with the MCO to address the issue. Table 4-9 and Table 4-10 display the results of the 2018 Behavioral Health Satisfaction Survey for NHHF and Well Sense for the questions related to access to care. Six response choices were available to members (i.e., Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree, Not Applicable), and HSAG aggregated the Strongly Agree and Agree responses to show the percentage of positive responses of members.

**Table 4-9—Adult Behavioral Health Satisfaction Survey Results—2018**

Measure	2018	
	NHHF	Well Sense
<b>Access to Care</b>		
<i>The location of services was convenient (parking, public transportation, distance, etc.).</i>	70.48%	81.95%
<i>Staff were willing to see me as often as I felt it was necessary.</i>	74.53%	83.33%
<i>Staff returned my call in 24 hours.</i>	63.81%	75.76%
<i>Services were available at times that were good for me.</i>	76.42%	86.36%
<i>I was able to get all the services I thought I needed.</i>	75.47%	76.69%
<i>I was able to see a psychiatrist when I wanted to.</i>	47.62%	60.15%

**Table 4-10—Child Behavioral Health Satisfaction Survey Results—2018**

Measure	2018	
	NHHF <sup>+</sup>	Well Sense
<b>Access to Care</b>		
<i>The location of services was convenient for us.</i>	84.09%	88.89%
<i>Services were available at times that were convenient for us.</i>	85.23%	85.19%
<i>My family got the help we wanted for my child.</i>	83.91%	83.70%
<i>My family got as much help as we needed for my child.</i>	70.45%	79.10%
<i>Staff spoke with me in a way that I understood.</i>	93.10%	95.56%

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

Although no national benchmarks were available for comparison to the behavioral health survey, DHHS and the MCOs should review the results of the surveys to identify any potential areas of concern for access to care to behavioral health services.

HSAG found the Behavioral Health Survey processes and results were sufficient to meet the assurances in the Section 1915(b) Waiver renewal application. Of note, HSAG recommends DHHS consider

investigating the difference in performance between the MCOs, as six of 11 (54.5 percent) of NHHF’s rates were at least 5 percentage points lower than Well Sense’s rates.

**Access-Related Member Appeals and Grievances**

NHHF and Well Sense were required to develop, implement, and maintain a system in which members, or providers acting on their behalf, can request a review of any action taken by the MCO (i.e., appeal) and may challenge the denial of medical services (i.e., grievance). Members must also have access to the state fair hearing system. As outlined in the Section 1915(b) Waiver, DHHS analyzed appeals and grievances, investigated those that were not within the standard of the MCO contract, and assigned CAPs as needed. Additionally, DHHS assured within the renewal application that the State complies with Section 1932(b)(4) of the Act and 42 CFR §438 Subpart F regulations and that the CMS Regional Office has reviewed and approved the MCO contract for compliance.

HSAG reviewed the processes for members regarding filing an appeal or grievance within each MCO’s member handbook. The policies and procedures include, as required, descriptions of the appeal and grievance processes and provide members, and providers acting on their behalf, with access to a State Fair Hearing with the DHHS Administrative Appeals Unit. Additionally, NHHF and Well Sense earned 100 percent during HSAG’s compliance reviews for the requirements reviewed within the Grievances and Appeals standard for SFY 2017 through SFY 2019.

Table 4-11 and Table 4-12 display the statewide access-related member appeals and grievances processed for the quarter prior to the Section 1915(b) Waiver renewal (i.e., January 1, 2018–March 31, 2018) and additionally through Q1 of 2019 (i.e., April 1, 2018–March 31, 2019) for both the 1915(b) and non-1915(b) populations.

**Table 4-11—Access-Related Member Appeals**

Time Period	Appeals Filed		Appeals Denied	
	1915(b)	Non-1915(b)	1915(b)	Non-1915(b)
Q1 2018	22	118	9	54
Q2 2018	44	137	22	63
Q3 2018	34	97	16	34
Q4 2018	44	122	21	51
Q1 2019	43	117	19	43

A noticeable increase was demonstrated in the number of statewide appeals from the initial Section 1915(b) Waiver period to the renewal period; however, the statewide appeals volume has been relatively stable for the 1915(b) population. Of note, nearly a quarter of the appeals submitted from Q1 2018 to Q1 2019 were related to non-emergency medical transportation (NEMT). The appeals time period evaluated in the previous Independent Assessment (i.e., February–August 2016) indicated that there were no appeals related to NEMT.

**Table 4-12—Access-Related Member Grievances**

Category	Q1 2018		Q2 2018		Q3 2018		Q4 2018		Q1 2019	
	1915(b)	Non-1915(b)								
Access	1	1	0	0	0	5	1	4	0	5
Billing/Financial	0	5	3	7	0	7	4	11	1	14
Coverage/Benefits	1	3	2	2	0	0	0	1	0	6
Customer Service	18	18	6	23	10	29	17	30	16	37
Website	0	0	0	0	0	0	0	0	0	1
<b>Total</b>	<b>20</b>	<b>27</b>	<b>11</b>	<b>32</b>	<b>10</b>	<b>41</b>	<b>22</b>	<b>46</b>	<b>17</b>	<b>63</b>

The access-related member grievances fluctuated slightly for the Section 1915(b) Waiver population; however, the number of grievances remained low. Of note, an increase was demonstrated over time for the non-1915(b) population. Approximately 60 percent of the Section 1915(b) Waiver access-related member grievances were related to coordinated transportation solutions (CTS), indicating an opportunity for improvement.

As a result of the review of access-related member appeals and grievances, HSAG recommends DHHS and the MCOs investigate the root cause of the transportation appeals and grievances to ensure there are no transportation barriers related to accessing services.

## Conclusions

HSAG reviewed references and data sources related to the access to care and services for Section 1915(b) Waiver members, as outlined in the assurances in the Section 1915(b) Waiver renewal application. DHHS has rigorous standards in place and demonstrated appropriate monitoring and oversight of this population and the overall MCM program. Additionally, the MCOs implemented the standards as outlined by DHHS and the renewal application. Minor feedback and recommendations for potential program improvement were noted in the Access to Care Assessment section; however, HSAG does not have any concerns that would impede DHHS from continuing implementation of mandatory managed care for the Section 1915(b) Waiver population.

## Recommendations

As all areas reviewed related to access to care met the assurances in the Section 1915(b) Waiver renewal application, these recommendations are noted as options to be considered for potential program improvement:

- **Compliance Reviews:** HSAG recommends DHHS and the MCOs investigate the areas identified as opportunities for improvement during the SFY 2019 Compliance Reviews for specific impact to the Section 1915(b) Waiver members, identifying CAP effectiveness, and consider implementing improvement strategies to ensure these members are not adversely affected moving forward.
- **Marketing and Communication:** HSAG recommends DHHS notify the MCOs that their respective websites do not appear to comply with DHHS' Marketing and Communications Guidelines related to notifying users when they leave the MCO's website and are redirected to another webpage of this finding and provide a time frame by which the MCOs must meet this requirement.
- **Member Materials:** HSAG recommends DHHS ensure the MCOs update their provider directories and websites to indicate if a provider has completed the required cultural competence training.
- **Member Interviews:** HSAG suggests DHHS do further investigation into the recommendations provided by Horn Research to determine if they are widespread among the Section 1915(b) Waiver population and consider implementing additional requirements in the MCO contract, if determined necessary, based on the additional investigation findings.
- **Utilization Performance Measures:** HSAG recommends DHHS continue to monitor utilization of outpatient and emergency services to ensure that utilization rates return to normal levels after the influx of the NHHPP PAP Section 1115 Demonstration Project members into the MCM program in Q1 2019.
- **HEDIS Performance Measures:** Going forward, HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve access to care.
- **Access-Related Member Appeals and Grievances:** HSAG recommends DHHS and the MCOs investigate the root cause of transportation appeals and grievances to ensure there are no transportation barriers related to accessing services.

## 5. Quality of Care Assessment

### Results

This section includes an evaluation of DHHS and MCO performance as they relate to the quality of care provided to MCM program members. The evaluation of the quality of care included findings pertaining to the MCOs' QAPIs, provider terminations, and MCO accreditation status. Additionally, the evaluation addresses program integrity, member perception of the quality of care and services, and the quality improvement performance measures and monitoring.

### *Quality Assessment and Performance Improvement Projects*

Per the MCO contract and 42 CFR §438.330(b) and State Medicaid Manual (SMM) 2091.7, the MCOs were required to have ongoing QAPI programs in place for the operations and services provided to members. The MCOs were instructed to approach these activities using the Continuous Quality Improvement (CQI)/Total Quality Management (TQM) principles for clinical and non-clinical aspects of operations and services. As part of the quality management requirements, MCOs try to improve and/or maintain, as appropriate, the healthcare status of members. Additionally, the MCOs were required to implement PIPs and QIPs.

### *Quality Assessment and Performance Improvement Annual Evaluations*

The MCOs were required to submit annual evaluation summaries of the QAPI program activities. The annual evaluation summaries included a description of the QAPI program, its purpose, structure, goals, accomplishments, and barriers/opportunities for improvement. Additionally, the annual evaluation summaries included the interventions for the three PIPs and the *Colorectal Cancer Screening QIP*.

NHHF reviewed, as part of its 2017 evaluation, the cultural and linguistic competency of members; provider availability; access to routine and emergency services and specialists; member experience of care; provider satisfaction; member services and responsibilities; provider credentialing; patient safety; and quality of and safety of care. Through this review, the MCO identified barriers for members, such as knowledge gaps for providers related to accessibility standards, and implemented improvement strategies (e.g., provider newsletters and reminder fax blasts with accessibility standards, monitoring access-related member complaints). Additionally, the quality goals for NHHF included improving the care for diabetics and those with behavioral health conditions, increasing cancer screenings, and improving medication adherence. For 2018, NHHF identified opportunities to improve member customer service experience, medication compliance for members with depression, and diabetic care and treatment compliance and to increase well-care visits for children.

NHHF implemented three PIPs during 2017 to improve the performance of their HEDIS measures: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications*. Interventions to increase the rates for these

performance measures included member outreach (e.g., diabetic report card mailings, financial incentives) and provider outreach (e.g., on-site meetings, provider report cards, care gap reports).

Well Sense reviewed, as part of its 2017 evaluation, the cultural and linguistic competency of members; hospital readmissions; member experience of care; prescription drug monitoring; the special needs program; the LTSS program; antipsychotic medications; and several preventive, acute and chronic condition, and behavioral health areas using HEDIS and CAHPS results. Through this review, the MCO identified barriers for members, such as knowledge gaps for members regarding the importance of preventive care, and implemented improvement strategies (e.g., reminder mailings, educational outreach via mail and phone). For 2018, Well Sense identified continued opportunities to monitor areas of care (e.g., women's preventive health, diabetes) and retired the prescription drug monitoring program because all goals were met.

Well Sense implemented three PIPs during 2017 to improve the performance of two HEDIS measures (i.e., *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Chlamydia Screening in Women*) and reduce the number of hospital readmissions. Interventions included member outreach (e.g., birthday card mailings with reminders about well-care visits and immunizations, quality outreach coordinator educational calls about preventive screenings) and provider outreach (e.g., incentive program for provider compliance, care gap reports).

Based on review of the MCOs' annual evaluation summaries and DHHS oversight of the MCOs' QAPI programs, the assurances of the Section 1915(b) Waiver renewal application are met and HSAG does not have any program improvement recommendations related to improving the quality of care for Section 1915(b) Waiver members.

### **Colorectal Cancer Screening Quality Improvement Project**

In 2016, the MCOs were required to implement a QIP for members receiving LTSS to evaluate and improve the *Colorectal Cancer Screening* rates. The MCO contract required the integration of LTSS into the QAPI program. Previous measurement of screening for colorectal cancer indicated opportunities to improve the care for the LTSS population (i.e., HEDIS rates fell below the national average). LTSS members receiving services under the New Hampshire Developmental Disabilities (DD) Waiver and New Hampshire Acquired Brain Disorder (ABD) Waiver were eligible for inclusion. Of note, these members were not specific to the Section 1915(b) Waiver population.

DHHS established the QIP in 10 stages, with design, implementation, and outcome phases. NHHF and Well Sense collaborated in the development and implementation of the QIP, working with 10 area agencies. The MCOs developed internal flow processes and reports to identify area agencies and providers with gaps in care, along with developing educational materials (i.e., Colorectal Cancer Screening Tool Kit) for area agency staff, providers, home care providers, stakeholders, among others. Educational materials were provided during in-person trainings, mailings, and collaborative meetings, with feedback solicited for further quality improvement.

The MCOs periodically monitored the progress of the interventions, recalculating the *Colorectal Cancer Screening* rates. Both MCOs demonstrated an increase in the rates of approximately 20 percentage

points from the baseline period (i.e., CY 2016) to the final remeasurement period (i.e., CY 2018). Based on DHHS review, NHHF and Well Sense met all elements included in the QIP.

Based on review of the MCOs’ *Colorectal Cancer Screening* QIP and DHHS oversight of the MCOs’ QIPs, the assurances of the Section 1915(b) Waiver renewal application are met and HSAG does not have any program improvement recommendations related to improving the quality of care for Section 1915(b) Waiver members.

### HEDIS Performance Measures

DHHS collected quality-related data from the MCOs based on clinical process and outcome performance measures related to prevention, acute and chronic care, and behavioral health through NCQA’s HEDIS. HEDIS 2019 (CY 2018) measure rates were compared to NCQA’s Quality Compass national Medicaid HMO averages as an indicator of performance per the New Hampshire MCM Quality Strategy. Prior to SFY 2019, the EQR Technical Reports compared the measure rates to NCQA’s Audit Means and Percentiles. Of note, DHHS has revised the comparison of performance measure rates to the Quality Compass national Medicaid 75th percentile moving forward. The quality of care-related performance measure results in Table 5-1 display the rates and comparison to national averages for the entire managed care population, as Section 1915(b) Waiver population-specific data were not yet available for all of these measures. DHHS, in conjunction with HSAG, determined which required HEDIS performance measures were deemed quality-related as part of EQRO activities. Rates that performed better than the national average are in bold.

**Table 5-1—HEDIS 2019 (CY 2018) Performance Measure Results**

Measure	NHHF	Well Sense
<b><i>Prevention</i></b>		
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>		
<i>Six or More Visits</i>	<b>73.24%</b>	<b>67.78%</b>
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>		
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	<b>78.10%</b>	<b>80.66%</b>
<b><i>Adolescent Well-Care Visits</i></b>		
<i>Adolescent Well-Care Visits</i>	<b>67.15%</b>	<b>61.27%</b>
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>		
<i>BMI Percentile Documentation—Total</i>	<b>78.59%</b>	67.68%
<i>Counseling for Nutrition—Total</i>	<b>75.67%</b>	66.16%
<i>Counseling for Physical Activity—Total</i>	<b>71.78%</b>	<b>64.63%</b>
<b><i>Childhood Immunization Status</i></b>		
<i>Combination 2</i>	<b>79.56%</b>	<b>75.18%</b>
<i>Combination 10</i>	<b>47.20%</b>	<b>41.61%</b>
<b><i>Immunizations for Adolescents</i></b>		
<i>Combination 1 (Meningococcal, Tdap)</i>	77.62%	<b>78.35%</b>
<b><i>Cervical Cancer Screening</i></b>		
<i>Cervical Cancer Screening</i>	<b>64.48%</b>	<b>60.94%</b>

Measure	NHFF	Well Sense
<b><i>Non-Recommended Cervical Cancer Screening in Adolescent Females*</i></b>		
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	<b>0.12%</b>	<b>0.20%</b>
<b><i>Chlamydia Screening in Women</i></b>		
<i>Total</i>	45.55%	47.38%
<b><i>Acute and Chronic Care</i></b>		
<b><i>Appropriate Testing for Children With Pharyngitis</i></b>		
<i>Appropriate Testing for Children With Pharyngitis</i>	<b>85.17%</b>	<b>84.05%</b>
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>		
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	<b>93.44%</b>	<b>94.59%</b>
<b><i>Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation</i></b>		
<i>Systemic Corticosteroid</i>	<b>83.50%</b>	<b>87.06%</b>
<i>Bronchodilator</i>	<b>86.50%</b>	<b>95.02%</b>
<b><i>Annual Monitoring for Patients on Persistent Medications</i></b>		
<i>Total</i>	<b>89.42%</b>	87.02%
<b><i>Comprehensive Diabetes Care</i></b>		
<i>Hemoglobin A1c (HbA1c) Testing</i>	<b>91.73%</b>	<b>89.54%</b>
<i>HbA1c Poor Control (&gt;9.0%)*</i>	<b>25.79%</b>	<b>40.39%</b>
<i>HbA1c Control (&lt;8.0%)</i>	<b>59.37%</b>	<b>49.39%</b>
<b><i>Controlling High Blood Pressure</i></b>		
<i>Controlling High Blood Pressure</i>	<b>70.07%</b>	<b>63.26%</b>
<b><i>Use of Imaging Studies for Low Back Pain</i></b>		
<i>Use of Imaging Studies for Low Back Pain</i>	70.00%	67.85%
<b><i>Asthma Medication Ratio</i></b>		
<i>Total</i>	<b>70.35%</b>	<b>63.77%</b>
<b><i>Medication Management for People With Asthma</i></b>		
<i>Medication Compliance 75%—Total</i>	<b>41.88%</b>	<b>43.88%</b>
<b><i>Behavioral Health</i></b>		
<b><i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i></b>		
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	<b>82.19%</b>	<b>79.65%</b>
<b><i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i></b>		
<i>Total</i>	29.65%	32.53%
<b><i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i></b>		
<i>Total</i>	<b>78.00%</b>	<b>64.62%</b>
<b><i>Antidepressant Medication Management</i></b>		
<i>Effective Acute Phase Treatment</i>	52.81%	<b>56.26%</b>
<i>Effective Continuation Phase Treatment</i>	<b>39.20%</b>	<b>43.31%</b>

Rates that performed above the national average are represented in **bold**.

\* Indicates a lower rate is better for this measure.

The MCOs demonstrated strength for the quality-related performance measures related to preventive care, with 10 of 12 (83.3 percent) and nine of 12 (75.0 percent) measure rates for NHHF and Well Sense, respectively, ranking above the national average. Additionally, the HEDIS 2018 performance measure results included in the 2018 New Hampshire EQR Technical Report for the Prevention domain show that both MCOs’ rates remained stable compared to HEDIS 2019, except Well Sense demonstrated a decline in performance of more than 5 percentage points for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* rates, with two indicators falling below the national average. Of note, NHHF improved by more than 5 percentage points for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* but still fell below the national average. Conversely, both MCOs fell below the 25th percentile for the *Chlamydia Screening in Women* measure in 2018 and 2019, indicating a continued opportunity to increase the screening of chlamydia in young women.

With 21 of 24 (87.5 percent) measure rates within the Acute and Chronic Care domain above the national average, the MCOs demonstrated strength with the quality of care provided to members with respiratory conditions (e.g., respiratory infections, COPD, asthma), diabetes, and hypertension. Of note, both MCOs demonstrated a decline in performance from HEDIS 2018 and fell below the national average for the *Use of Imaging Studies for Low Back Pain*.

Finally, the MCOs demonstrated there are areas for improvement within the behavioral health domain, as NHHF and Well Sense fell below the national average for the *Metabolic Monitoring for Children and Adolescents* measure. Of note, NHHF’s rate for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure increased by more than 15 percentage points from HEDIS 2018, indicating strength.

The figures below display the available quality of care-related performance measures for CY 2017 and CY 2018 that are specific to the Section 1915(b) Waiver population.

**Figure 5-1—Antidepressant Medication Management Measure Results**

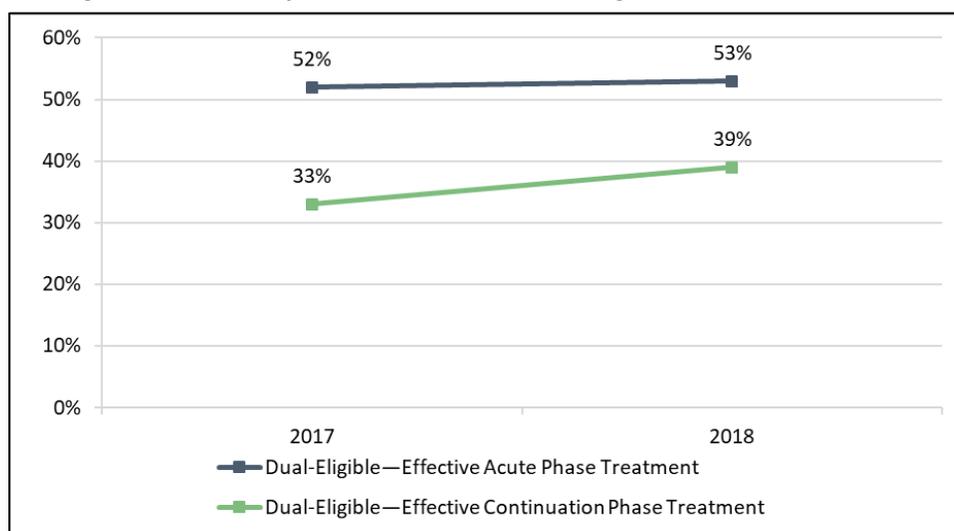
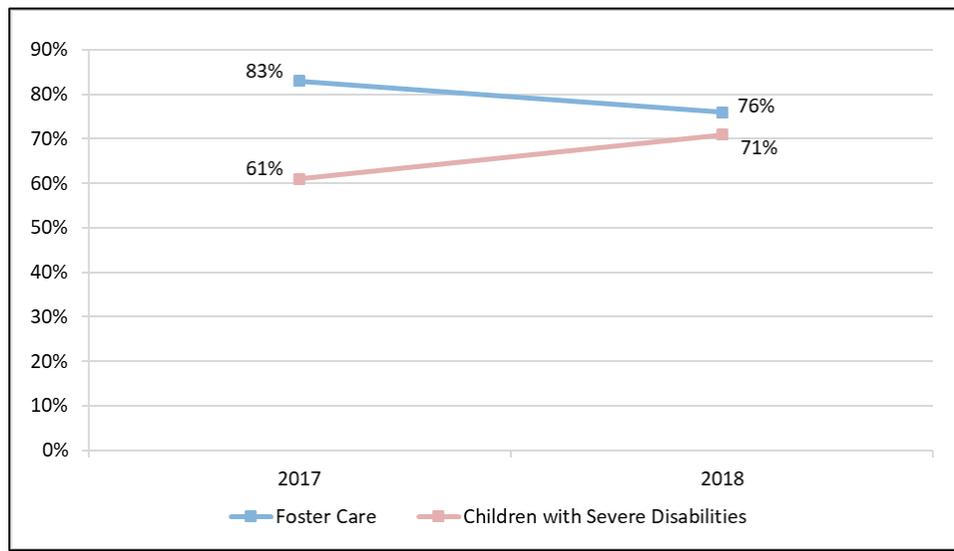


Figure 5-1 shows an increase in performance for the *Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* indicators and both rates were above the 50th percentile for CY 2018 for the dual-eligible members, indicating strength.

**Figure 5-2—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Measure Results**



Despite a decline in performance for the foster care population, both *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* rates for 2018 exceeded the 75th percentile, indicating strength for the appropriate treatment of foster care children and children with severe disabilities.

While DHHS demonstrated adequate measurement of quality of care measures and the MCOs demonstrated general strengths in the quality of care measures, going forward, HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population (e.g., *Metabolic Monitoring for Children and Adolescents on Antipsychotics*) to monitor and improve the quality of care specific to this population.

## Provider Quality

### NCQA MCO Accreditation

Per the Section 1915(b) Waiver renewal application and the MCO contract, the MCOs were required to obtain and maintain accreditation from NCQA. Accreditation levels (i.e., Excellent, followed by Commendable, Accredited, Provisional, and Interim) are based on compliance with NCQA’s standards and MCO performance on HEDIS and CAHPS measures. The MCOs were evaluated on the following standards: quality management and improvement, population health management, network management, utilization management, credentialing and recredentialing, members’ rights and responsibilities, member connections, and Medicaid benefits and services. MCOs additionally received star ratings (i.e., one star

for lower performance to four stars for higher performance) based on review of performance for the following categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living With Illness.

NHHF and Well Sense have been awarded the Commendable accreditation level, with the current accreditation status set to expire in 2021.<sup>5-1</sup> As NCQA states, “Achieving an accreditation status of Commendable from NCQA is a sign that a health plan is serious about quality. It is awarded to plans whose service and clinical quality meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement.”<sup>5-2</sup> Both MCOs received four stars for the Access and Service and Qualified Providers accreditation categories, indicating strength with providing access to needed care and customer service and ensuring that providers are licensed and that members are satisfied with care received. Additionally, NHHF and Well Sense received three stars for the Living With Illness category, demonstrating further strength with performing activities to help people live with their illnesses. Conversely, Well Sense received one star for the Staying Healthy category, indicating that DHHS and the MCO may want to consider investigating the cause for the lower performance category and implement improvement strategies to ensure members maintain their health and avoid getting sick.

Based on this review, HSAG found the MCOs met the NCQA accreditation requirement as outlined in the assurances in the Section 1915(b) Waiver renewal application. Therefore, HSAG has no recommendations for program improvement in this area.

### Provider Terminations

As part of the MCO contract, MCOs were required to notify DHHS and members of provider terminations. MCOs were required to have a transition plan in place for affected members within three calendar days following the effective date of the termination to ensure members had access to care.

HSAG reviewed a six-month sample of provider terminations for both NHHF and Well Sense in 2019. The majority of voluntary provider terminations were related to providers leaving Medicaid-participating practices or their provider hospital organization leaving the program.

Based on this review and the MCO contract requirements assuring a transition plan and timely member-notifications of provider terminations, appropriate assurances are in place to ensure quality of care, and HSAG has no recommendations for action.

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<sup>5-1</sup> National Committee for Quality Assurance Report Cards. *Health Plans*. Available at: <https://reportcards.ncqa.org/#/health-plans/list?state=New%20Hampshire&insurance=Medicaid>. Accessed on: Oct 4, 2019.

<sup>5-2</sup> National Committee for Quality Assurance Advertising and Marketing Guidelines. *Health Plan Accreditation*. Available at: [https://www.ncqa.org/wp-content/uploads/2018/08/20180804\\_HPA\\_Advertising\\_and\\_Marketing\\_Guidelines.pdf](https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf). Accessed on: Oct 4, 2019.

## Member Perception of Quality of Care and Services

### CAHPS Surveys

MCOs were required to conduct an annual survey, as outlined in the Section 1915(b) Waiver renewal application and the MCO contract, to report member perception quality of care and services through NCQA’s CAHPS. Of note, the CAHPS results were not limited to the Section 1915(b) Waiver population; however, the CCC results are more indicative of MCO performance as they relate to child Section 1915(b) Waiver members because these members may have a chronic condition (i.e., eligible for SSI). CAHPS measure rates were compared to NCQA’s Quality Compass CAHPS adult and general child Medicaid national averages as an indicator of performance, as outlined in the New Hampshire MCM Quality Strategy. DHHS aggregated and reviewed CAHPS data to monitor performance over time and identified any outliers in performance by MCO or statewide. If any outliers in performance were identified, DHHS followed-up with the MCO to address the issue.

Table 5-2 and Table 5-3 display the available CAHPS results for the adult and CCC populations for four global rating measures that capture the member’s numerical view from one to 10 of the different facets of care received (i.e., *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*). Additionally, Table 5-3 displays the quality of care and services-related 2018 CAHPS composite measure results for the CCC population that examine member experiences with how well the child’s personal doctor understands, communicates, and coordinates with the family and others in the child’s life (i.e., daycare/school, specialists) about the child’s overall care and development and how it affects the day-to-day activities of the family (i.e., *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children With Chronic Conditions*). Of note, bold rates indicate performance was above the national average.

**Table 5-2—Adult Medicaid CAHPS Results—CY 2016–2018**

Measure	2016		2017		2018	
	NHHF	Well Sense	NHHF	Well Sense	NHHF	Well Sense
<b>Global Ratings</b>						
<i>Rating of Health Plan</i>	<b>75.9%</b>	73.7%	<b>74.8%</b>	<b>80.3%</b>	<b>76.8%</b>	72.9%
<i>Rating of All Health Care</i>	<b>75.3%</b>	70.6%	<b>75.5%</b>	<b>74.3%</b>	<b>76.2%</b>	68.6%
<i>Rating of Personal Doctor</i>	<b>83.9%</b>	<b>81.3%</b>	<b>83.8%</b>	<b>81.9%</b>	<b>83.8%</b>	74.8%
<i>Rating of Specialist Seen Most Often</i>	<b>82.8%</b>	<b>82.1%</b>	<b>85.1%</b>	<b>87.9%</b>	80.6%	79.7%
<b>Composite Measures</b>						
<i>How Well Doctors Communicate</i>	<b>90.9%</b>	<b>92.8%</b>	<b>93.8%</b>	<b>91.4%</b>	<b>92.7%</b>	<b>92.6%</b>
<i>Customer Service</i>	<b>90.6%</b>	<b>91.2%<sup>+</sup></b>	87.4%	<b>89.2%</b>	<b>89.7%</b>	<b>91.5%<sup>+</sup></b>
<i>Shared Decision Making</i>	<b>81.5%</b>	<b>81.4%</b>	<b>86.9%</b>	<b>83.4%</b>	<b>80.5%</b>	<b>84.7%</b>

Rates that performed above the national average are represented in **bold**.

<sup>+</sup> Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

**Table 5-3—Child Medicaid With CCC Measurement Set CAHPS Results—CY 2018**

Measure	2018	
	NHHF	Well Sense
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	<b>84.9%</b>	81.8%
<i>Rating of All Health Care</i>	<b>86.3%</b>	<b>86.5%</b>
<i>Rating of Personal Doctor</i>	<b>89.0%</b>	86.4%
<i>Rating of Specialist Seen Most Often</i>	<b>86.5%</b>	<b>86.6%</b>
<b>Composite Measures</b>		
<i>How Well Doctors Communicate</i>	<b>96.9%</b>	<b>94.3%</b>
<i>Customer Service</i>	87.4%	83.4% <sup>+</sup>
<i>Shared Decision Making</i>	<b>89.4%</b>	<b>86.6%</b>
<i>FCC: Personal Doctor Who Knows Child</i>	<b>91.4%</b>	<b>92.3%</b>
<i>Coordination of Care for Children With Chronic Conditions</i>	76.6%	77.5%

Rates that performed above the national average are represented in **bold**.

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

For NHHF, the MCO’s performance for the adult population was positive and remained relatively stable from 2016 to 2018, with only the 2018 *Rating of Specialist Seen Most Often* rate falling below the national average. Conversely, Well Sense demonstrated a decline in the adult global ratings measures, with all four (i.e., *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) falling below the national average for 2018 and indicating opportunities to improve the quality of care for members. Of note, Well Sense was above the national average for all adult composite measures related to quality of care and services.

The 2018 CCC results indicated strength in multiple areas for NHHF and Well Sense, with seven of nine (77.8 percent) and five of nine (55.6 percent) rates above the national average, respectively. Of note, both MCOs fell below the national average and demonstrated improvement opportunities for *Customer Service* and *Coordination of Care for Children With Chronic Conditions*.

HSAG recommends DHHS and the MCOs consider investigating the adult and CCC rates that fell below the national average and implement improvement strategies as monitored by DHHS through the annual QAPI submissions, to ensure the quality of care and services provided to Section 1915(b) Waiver members are adequate.

### Behavioral Health Satisfaction Survey

The MCOs were required to administer the Behavioral Health Satisfaction Survey to gain perception of the quality of care provided to those members who seek treatment for mental health and SUD conditions, as indicated in the Section 1915(b) Waiver renewal application. Of note, the results for this survey were not limited to the Section 1915(b) Waiver population; however, the survey questions

provide MCM program members’ perspectives on behavioral health services received in the last 12 months. DHHS aggregated and reviewed the behavioral health survey data to monitor performance over time and identify any outliers in performance by MCO or statewide. If any outliers in performance were identified, DHHS followed-up with the MCO to address the issue. Table 5-4 and Table 5-5 display the results of the 2018 Behavioral Health Satisfaction Survey for NHHF and Well Sense for the questions related to quality of care. Six response choices were available to members (i.e., Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree, Not Applicable), and HSAG aggregated the Strongly Agree and Agree responses to show the percentage of positive responses of members.

**Table 5-4—Adult Behavioral Health Satisfaction Survey Results—2018**

Measure	2018	
	NHHF	Well Sense
<b>Quality and Appropriateness</b>		
<i>Staff here believed that I could grow, change, and recover.</i>	70.59%	80.30%
<i>I felt free to complain.</i>	76.70%	84.85%
<i>I was given information about how to file a complaint.</i>	44.44% <sup>+</sup>	57.25%
<i>I was given information about my rights.</i>	78.00%	84.85%
<i>Staff encouraged me to take responsibility for how I live my life.</i>	63.00%	76.52%
<i>Staff told me what side effects to watch out for.</i>	65.00%	72.73%
<i>Staff respected my wishes about who is and who is not to be given information about my treatment.</i>	79.00%	87.22%
<i>Staff were sensitive to my cultural/ethnic background (race, religion, language, etc.).</i>	57.58% <sup>+</sup>	79.55%
<i>Staff helped me obtain the information I needed so that I could take charge of managing my illness.</i>	68.32%	80.30%
<i>I was encouraged to use consumer-run programs (support groups, crisis respite, crisis phone line, etc.)</i>	50.52% <sup>+</sup>	65.41%
<b>General Satisfaction</b>		
<i>I like the services that I have received.</i>	84.00%	87.69%
<i>If I had other choices, I would still get services from this agency.</i>	75.49%	82.31%
<i>I would recommend this agency to a friend or family member.</i>	81.55%	80.77%
<i>I am happy with my counselor or psychiatrist.</i>	69.00%	92.25%

<sup>+</sup> Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

**Table 5-5—Child Behavioral Health Satisfaction Survey Results—2018**

Measure	2018	
	NHHF <sup>+</sup>	Well Sense
<b>Quality of Services Received</b>		
<i>Staff treated me with respect.</i>	92.05%	94.07%
<i>Staff respected my family's religious/spiritual beliefs</i>	43.02%	69.63%
<i>Staff were sensitive to my cultural/ethnic background.</i>	42.35%	68.15%
<b>General Satisfaction</b>		
<i>Overall, I am satisfied with the services my child received.</i>	76.14%	85.93%
<i>The people helping my child stuck with us no matter what.</i>	62.50%	84.33%
<i>The services my child and/or my family received were right for us.</i>	68.18%	84.33%
<i>I am happy with my child's counselor or psychiatrist.</i>	68.24%	78.36%

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

Although there were no national benchmarks for comparison to the behavioral health survey, HSAG recommends DHHS and the MCOs review the results of the surveys to identify any potential areas of concern related to the quality of behavioral healthcare and services. Of note, for both the adult and child results, Well Sense’s rates were 5 percentage points or higher than NHHF’s for 18 of 21 (85.7 percent) measures related to quality of care and services, with 10 of these measures at least 10 percentage points or higher. As a result, HSAG further recommends DHHS and NHHF investigate the difference in the rates between the MCOs and consider implementing improvement strategies to ensure the NHHF members’ perception of their quality of care is comparable to those individuals enrolled with Well Sense.

**Quality-Related Member Grievances**

DHHS required the MCOs to routinely monitor member grievances relative to quality of care and services. Table 5-6 displays the statewide quality-related member grievances processed for the quarter prior to the Section 1915(b) Waiver renewal (i.e., January 1, 2018–March 31, 2018) and additionally through Q1 of 2019 (i.e., April 1, 2018–March 31, 2019) for both the Section 1915(b) Waiver and non-1915(b) populations.

**Table 5-6—Quality-Related Member Grievances**

Category	Q1 2018		Q2 2018		Q3 2018		Q4 2018		Q1 2019	
	1915(b)	Non-1915(b)								
Quality of Care	1	4	2	0	0	4	0	0	1	0

The volume of quality-related grievances submitted over the five quarters reviewed for both the Section 1915(b) Waiver and the non-1915(b) populations was minimal, indicating the oversight and monitoring of the grievances program was sufficient. The SFY 2019 Compliance Reviews showed both MCOs demonstrated 100 percent compliance with the requirements reviewed within the grievances standard, further demonstrating strength and that each MCO has appropriate grievance monitoring, resolution, and notification processes in place, meeting assurances of the Section 1915(b) Waiver renewal application; therefore, there are no recommendations specific to quality-related grievances. Of note, review of the grievances filed showed the majority were related to provider complaints; however, the results of the peer review are confidential so HSAG was unable to see the resolution.

## **Program Integrity**

### **Fraud, Abuse, and Waste**

DHHS assured within the Section 1915(b) Waiver renewal application compliance with the following regulations related to program integrity: Section 1932(d)(1) of the Act and 42 CFR 438.610 “Prohibited Affiliations with Individuals Barred by Federal Agencies,” Section 1902(p)(2) and 42 CFR 431.55, and Section 1932(d)(1) of the Act and 42 CFR §438.608 “Program Integrity Requirements.” Additionally, the CMS Regional Office has reviewed and approved the MCO contracts related to the provisions in 42 CFR §438.604 “Data that must be Certified” and 42 §CFR 438.606 “Source, Content, Timing of Certification.” As part of the monitoring of the requirements, DHHS required on-site reviews and independent assessments at the MCO level.

The MCO contracts required a Program Integrity Plan that addressed the prevention, identification, and resolution of fraud, abuse, and waste activities. DHHS reviewed and approved the MCOs’ Program Integrity Plans. As required, the Program Integrity Plans included fraud, waste, and abuse prevention and review policies and procedures (e.g., provider and employee training, internal monitoring and enforcement standards, payment suspension for providers, communication and reporting for employees and members). The Program Integrity Plans were not specific to the Section 1915(b) Waiver population, but rather include the activities of the MCO overall.

DHHS required each MCO to submit an annual fraud, waste, and abuse report that summarized the MCO’s fraud and abuse activities for the previous year and identified any proposed changes for the coming year. HSAG reviewed the annual fraud, waste, and abuse reports for NHHF and Well Sense. For the review period (i.e., July 1, 2017–June 30, 2018), NHHF opened 64 provider cases and Well Sense opened 43 provider cases. Possible actions depending on the severity related to cases include no action; education; CAPs; referral to federal/state government, provider enrollment and credentialing, and compliance; provider termination; and adjustment of payments (e.g., enforcement of pre-payment review, suspension, recovery).

For NHHF, the most common cases were related to overutilization of services (e.g., laboratory, durable medical equipment), supplies, or controlled substances; up-coding; and billing for services not rendered. NHHF indicated challenges in the review process, such as difficulty retrieving medical records from current providers and providers that have left the network, which led to delays in processing cases. For

Well Sense, the most common cases were related to up-coding of behavioral health services, overbilling for services, and billing for services not rendered or out-of-network. Well Sense also experienced delays in processing its fraud, waste, and abuse cases due to difficulty retrieving medical records. NHHF referred 11 provider cases and Well Sense referred nine provider cases to the Medicaid Fraud Control Unit (MFCU). Overpayments were identified in the amount of \$537,957.53 for NHHF and \$254,637.30 for Well Sense, with \$14,446.32 and \$60,500.73 recovered, respectively.

Of note, DHHS' Program Integrity Unit (PIU) identified that Well Sense needed to address its processes for mailing verification of services letters to members. Well Sense enhanced its processes and has seen an increase in responses.

Following review of the MCOs' program integrity procedures and reports, HSAG determined the assurances of the Section 1915(b) Waiver renewal application are met and does not have any recommendations related to program integrity for Section 1915(b) Waiver members.

## Conclusions

HSAG reviewed references and data sources related to the quality of care and services for Section 1915(b) Waiver members as outlined in the assurances in the Section 1915(b) Waiver renewal application. DHHS has rigorous standards in place and demonstrated appropriate monitoring and oversight of this population and the overall MCM program. Additionally, the MCOs implemented the standards as outlined by DHHS and the renewal application. Minor feedback and recommendations were noted in the Quality of Care Assessment section; however, HSAG does not have any concerns that would impede DHHS from continuing implementation of mandatory managed care for the Section 1915(b) Waiver population.

## Recommendations

As all areas reviewed related to quality of care met the assurances in the Section 1915(b) Waiver renewal application, these recommendations are noted as options to be considered for potential program improvement:

- **HEDIS Performance Measures:** HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve the quality of care.
- **CAHPS Surveys:** HSAG recommends DHHS and the MCOs consider investigating the adult and CCC rates that fell below the national average and implement improvement strategies as monitored by DHHS through the annual QAPI submissions, to ensure the quality of care and services provided to Section 1915(b) Waiver members are adequate.
- **Behavioral Health Satisfaction Survey:** HSAG recommends DHHS and the MCOs review the results of the surveys to identify any potential areas of concern related to the quality of behavioral healthcare and services. HSAG further recommends DHHS and NHHF investigate the difference in the rates among the MCOs and consider implementing improvement strategies to ensure the NHHF members' perception of their quality of care is comparable to those individuals enrolled in Well Sense.

### Results

DHHS contracted with Milliman to assess the cost-effectiveness assurances outlined in the Section 1915(b) Waiver renewal application. As outlined in the Section 1915(b) Waiver renewal application, DHHS assured that the actual waiver costs will be less than or equal to DHHS' projections and that DHHS will regularly monitor the cost-effectiveness of the waiver. This section includes an assessment of the cost-effectiveness of the Section 1915(b) Waiver by MEG using actual data from July 2016 through June 2017 and projections of April 2018 through March 2020 (i.e., the time period of the Section 1915(b) Waiver renewal).

### *Cost-Effectiveness Calculations*

#### **Service and Administrative Expenditures**

Milliman, in conjunction with DHHS, developed the list of state plan services provided to Section 1915(b) Waiver members, distinguishing between those covered by capitated reimbursement and FFS. The state plan services did not change from the initial Section 1915(b) Waiver period to the renewal period.

Milliman used the administrative expenditures DHHS reported on the CMS 64.10 Waiver forms for retrospective years one (i.e., July 2015–June 2016) and two (i.e., July 2016–June 2017), referred to as R1 and R2. The administrative costs include both capitation payments and FFS claims. Milliman reported that 30.0 percent and 29.2 percent of overall medical expenditures can be attributed to the Section 1915(b) Waiver population for R1 and R2, respectively.

Table 6-1 displays the actual administrative costs per member per month (PMPM) for R2, the most recent data available, and the projected costs for prospective years one (i.e., April 2018–March 2019) and two (i.e., April 2019–March 2020).

**Table 6-1—Administrative Expenditures by Medicaid Eligibility Group**

MEG	Actual July 2016 to June 2017			Projected April 2018 to March 2019			Projected April 2019 to March 2020		
	PMPM	Administrative Cost PMPM	% Total Costs	PMPM	Administrative Cost PMPM	% Total Costs	PMPM	Administrative Cost PMPM	% Total Costs
Foster Care / Adoption	\$1,413.22	\$82.50	5.84%	\$1,510.16	\$87.45	5.79%	\$1,588.31	\$91.84	5.78%
Severely Disabled Children	\$1,384.66	\$79.81	5.76%	\$1,466.46	\$83.96	5.73%	\$1,543.69	\$88.18	5.71%
Dual-Eligibles	\$1,990.63	\$116.37	5.85%	\$2,183.45	\$127.11	5.82%	\$2,285.18	\$132.85	5.81%
Federally Recognized Tribe Members	\$382.55	\$22.36	5.85%	\$406.05	\$22.77	5.61%	\$427.51	\$23.92	5.60%
<b>Total</b>	<b>\$1,783.02</b>	<b>\$104.03</b>	<b>5.83%</b>	<b>\$1,934.85</b>	<b>\$112.33</b>	<b>5.81%</b>	<b>\$2,024.92</b>	<b>\$117.39</b>	<b>5.80%</b>

Table 6-1 shows that the percentage of total costs for the administrative expenditures is projected to be similar to R2 and are evenly distributed among the MEGs. As a result, HSAG does not have any recommendations for action.

### Retrospective Waiver Expenditures

Milliman reviewed the actual expenditures for R1 and R2 to calculate the cost-effectiveness calculations for the initial period of the Section 1915(b) Waiver. All state plan services included in the MCM program related to the Section 1915(b) Waiver population were included in the calculations; however, services covered by additional Section 1915(c) Waivers (i.e., Choices for Independence, Developmentally Disabled, ABD, and In-Home Supports Services) were excluded. Milliman included the following components in the cost-effectiveness calculations: FFS claims, capitation payments, health insurance providers fee, prescription drug rebates, Medicaid Quality Improvement Program (MQIP) payments, Proportionate Share (ProShare) Incentive Adjustment payments, and new service funding (i.e., HB 400). Table 6-2 displays the results of the cost-effectiveness calculations PMPM for R1 and R2.

**Table 6-2—Cost-Effectiveness Summary by Medicaid Eligibility Group—Section 1915(b) Waiver Initial Period**

MEG	Actual July 2015 to June 2016			Actual July 2016 to June 2017		
	MM	Cost (Millions)	PMPM	MM	Cost (Millions)	PMPM
Foster Care / Adoption	27,549	\$34.26	\$1,243.42	28,271	\$39.95	\$1,413.22
Severely Disabled Children	53,350	\$75.98	\$1,424.20	48,979	\$67.82	\$1,384.66
Dual-Eligibles	210,651	\$407.17	\$1,932.89	204,364	\$406.81	\$1,990.63
Federally Recognized Tribe Members	9,808	\$3.54	\$360.48	8,899	\$3.40	\$382.55
<b>Total</b>	<b>301,358</b>	<b>\$520.94</b>	<b>\$1,728.63</b>	<b>290,512</b>	<b>\$517.99</b>	<b>\$1,783.02</b>

Table 6-2 shows the Section 1915(b) Waiver costs were similar across R1 and R2. Of note, the retrospective period calculations are lower than the original cost-effectiveness targets; therefore, the Section 1915(b) Waiver demonstrated cost-effectiveness during the initial waiver period. As a result, HSAG does not have any recommendations for action.

### Renewal Cost Comparisons

To develop the P1 and P2 projections, Milliman used the results of the R1 and R2 actual expenditures and accounted for changes in trend and other adjustments accepted to CMS.

Table 6-3 displays the results of the projected cost-effectiveness calculations PMPM for the renewal period of the Section 1915(b) Waiver.

**Table 6-3—Cost-Effectiveness Summary by Medicaid Eligibility Group—Section 1915(b) Waiver Renewal Period**

MEG	Actual July 2016 to June 2017			Projected April 2018 to March 2019					Projected April 2019 to March 2020				
	MM	Cost (Millions)	PMPM	MM	Cost (Millions)	PMPM	PMPM Effect of Service Adjustment	Adjusted Change in Cost (Millions)	MM	Cost (Millions)	PMPM	PMPM Effect of Service Adjustment	Adjusted Change in Cost (Millions)
Foster Care / Adoption	28,271	\$39.95	\$1,413.22	30,577	\$46.18	\$1,510.16	\$91.99	\$3.41	31,434	\$49.93	\$1,588.31	\$73.76	\$4.77
Severely Disabled Children	48,979	\$67.82	\$1,384.66	45,384	\$66.55	\$1,466.46	\$77.65	\$(4.79)	43,737	\$67.52	\$1,543.69	\$73.01	\$(6.89)
Dual-Eligibles	204,364	\$406.81	\$1,990.63	197,387	\$430.98	\$2,183.45	\$182.07	\$(11.76)	194,712	\$444.95	\$2,285.18	\$96.00	\$(16.00)
Federally Recognized Tribe Members	8,899	\$3.40	\$382.55	9,699	\$3.94	\$406.05	\$23.08	\$0.31	9,956	\$4.26	\$427.51	\$20.32	\$0.42
<b>Total</b>	<b>290,512</b>	<b>\$517.99</b>	<b>\$1,783.02</b>	<b>283,046</b>	<b>\$547.65</b>	<b>\$1,934.85</b>	<b>\$150.83</b>	<b>\$(13.03)</b>	<b>279,838</b>	<b>\$566.65</b>	<b>\$2,024.92</b>	<b>\$87.64</b>	<b>\$(18.07)</b>

Table 6-3 shows the projected expenditures during the renewal period were similar to the initial Section 1915(b) Waiver period, with adjustments for trends and changes to the capitation payment rates. As a result, HSAG does not have any recommendations for action.

### Adjustments, Targets, and Projections

As part of its cost-effectiveness calculations for the renewal period of the Section 1915(b) Waiver, Milliman accounted for actual changes to the capitation payment rates for the MCM program, along with observed national utilization and unit cost trends found in the 2016 Actuarial Report on the Financial Outlook for Medicaid. These inflation adjustments and program adjustments were used in accordance with CMS’ definition of the cost-effectiveness process. Table 6-4 displays the adjustments Milliman used when calculating the cost-effectiveness projections.

**Table 6-4—Adjustments by Medicaid Eligibility Group**

MEG	Adjustments from R2 to P1			Adjustments from P1 to P2		
	Inflation	Program	Total	Inflation	Program	Total
Foster Care / Adoption	6.0%	0.9%	7.0%	5.0%	0.2%	5.2%
Severely Disabled Children	5.1%	0.7%	5.8%	5.0%	0.3%	5.3%
Dual-Eligibles	9.2%	0.4%	9.6%	4.5%	0.1%	4.6%
Federally Recognized Tribe Members	1.8%	4.5%	6.4%	5.0%	0.3%	5.3%

Table 6-5 displays the member month projections by MEG calculated by Milliman, which were based on historical enrollment trends during R2.

**Table 6-5—Member Month Projections**

MEG	Actual July 2016 to June 2017	Projected April 2018 to March 2019		Projected April 2019 to March 2020	
	MM	Projected Change in MM	MM	Projected Change in MM	MM
Foster Care / Adoption	28,271	8.16%	30,577	2.80%	31,434
Severely Disabled Children	48,979	-7.34%	45,384	-3.63%	43,737
Dual-Eligibles	204,364	-3.41%	197,387	-1.36%	194,712
Federally Recognized Tribe Members	8,899	8.99%	9,699	2.65%	9,956
<b>Total</b>	<b>290,512</b>	<b>-2.57%</b>	<b>283,046</b>	<b>-1.13%</b>	<b>279,838</b>

## Conclusions

HSAG reviewed references and data sources related to the cost-effectiveness of the Section 1915(b) Waiver as outlined in the assurances in the Section 1915(b) Waiver renewal application. Based on the calculations by Milliman, HSAG does not have any concerns that would impede DHHS from continuing implementation of mandatory managed care for the Section 1915(b) Waiver population.

## Recommendations

HSAG does not have any cost-effectiveness recommendations for DHHS' consideration related to program improvement of the Section 1915(b) Waiver.

## 7. Overall Conclusions and Recommendations

### Conclusions

While HSAG provided minor feedback and recommendations for potential program improvement based upon the independent assessment of access to and quality of care, no areas of correction were identified as they relate to the assurances in the Section 1915(b) Waiver renewal application. As a result, HSAG recommends continuation of DHHS' Section 1915(b) Waiver program.

### Recommendations

As all areas reviewed related to access to care, quality of care, and cost-effectiveness met the assurances outlined in the Section 1915(b) Waiver renewal application, the recommendations below are noted as options for DHHS' consideration for potential program improvement. Of note, HSAG does not have any cost-effectiveness program improvement recommendations.

#### *Access to Care*

- **Compliance Reviews:** HSAG recommends DHHS and the MCOs investigate the areas identified as opportunities for improvement during the SFY 2019 Compliance Reviews for specific impact to the Section 1915(b) Waiver members, identifying CAP effectiveness, and consider implementing improvement strategies to ensure these members are not adversely affected moving forward.
- **Marketing and Communication:** HSAG recommends DHHS notify the MCOs that their respective websites do not appear to comply with DHHS' Marketing and Communications Guidelines related to notifying users when they leave the MCO's website and are redirected to another webpage of this finding and provide a time frame by which the MCOs must meet this requirement.
- **Member Materials:** HSAG recommends DHHS ensure the MCOs update their provider directories and websites to indicate if a provider has completed the required cultural competence training.
- **Member Interviews:** HSAG suggests DHHS do further investigation into the recommendations provided by Horn Research to determine if they are widespread among the Section 1915(b) Waiver population and consider implementing additional requirements in the MCO contract, if determined necessary, based on the additional investigation findings.
- **Utilization Performance Measures:** HSAG recommends DHHS continue to monitor utilization of outpatient and emergency services to ensure that utilization rates return to normal levels after the influx of the NHHPP PAP Section 1115 Demonstration Project members into the MCM program in Q1 2019.
- **HEDIS Performance Measures:** Going forward, HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve access to care.

- **Access-Related Member Appeals and Grievances:** HSAG recommends DHHS and the MCOs investigate the root cause of transportation appeals and grievances to ensure there are no transportation barriers related to accessing services.

### *Quality of Care*

- **HEDIS Performance Measures:** HSAG recommends DHHS expand the collection of data specific to the Section 1915(b) Waiver population to monitor and improve the quality of care.
- **CAHPS Surveys:** HSAG recommends DHHS and the MCOs consider investigating the adult and CCC rates that fell below the national average and implement improvement strategies as monitored by DHHS through the annual QAPI submissions, to ensure the quality of care and services provided to Section 1915(b) Waiver members are adequate.
- **Behavioral Health Satisfaction Survey:** HSAG recommends DHHS and the MCOs review the results of the surveys to identify any potential areas of concern related to the quality of behavioral healthcare and services. HSAG further recommends DHHS and NHHF investigate the difference in the rates among the MCOs and consider implementing improvement strategies to ensure the NHHF members' perception of their quality of care is comparable to those individuals enrolled in Well Sense.