New Hampshire Medicaid Care Management Quality Performance Report

Key Indicators – April 2015

A Report Prepared by the Medicaid Quality Program
Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services

April 8, 2015

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

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Overview

Introduction

The New Hampshire Medicaid Care Management (MCM) Quality Program Performance Report presents key indicators used to monitor MCM. This monthly report presents the most up to date generated and validated data for the MCM program. Where available, each indicator is presented with comparators. Comparators are usually updated annually. Where available, indicators are also presented with confidence intervals. Calculating indicators from populations can vary. Confidence intervals present the range of values for a specific key indicator at the 95% confidence level.

The key indicators are organized into topic areas called domains. The key indicators are drawn from measures that are both available now, or will be in the future; placeholders allow users of the report to better understand when indicators become available and to provide a consistent set of information.

The report presents program-wide averages. Additional information is available for all key indicators. Additionally, the Medicaid Quality Program continues to develop focused reports and a web-based reporting system allowing user designed reports.

Quality Domains

- Access and Use of Care
- Customer Experience of Care
- Provider Service Experience
- Utilization Management
- Grievances and Appeals
- Preventative Care
- Chronic Medical Care
- Behavioral Health Care
- Substance Use Disorder Care
- General

DOMAIN: Access and Use of Care

Introduction

Access and Use of Care includes key indicators in the following areas:

- Provider Network
- Non-Emergent Medical Transportation
- Ambulatory Care including Emergency Care
- Inpatient Care

Provider Network

Figure 1-1: Member Request for Assistance Accessing Providers

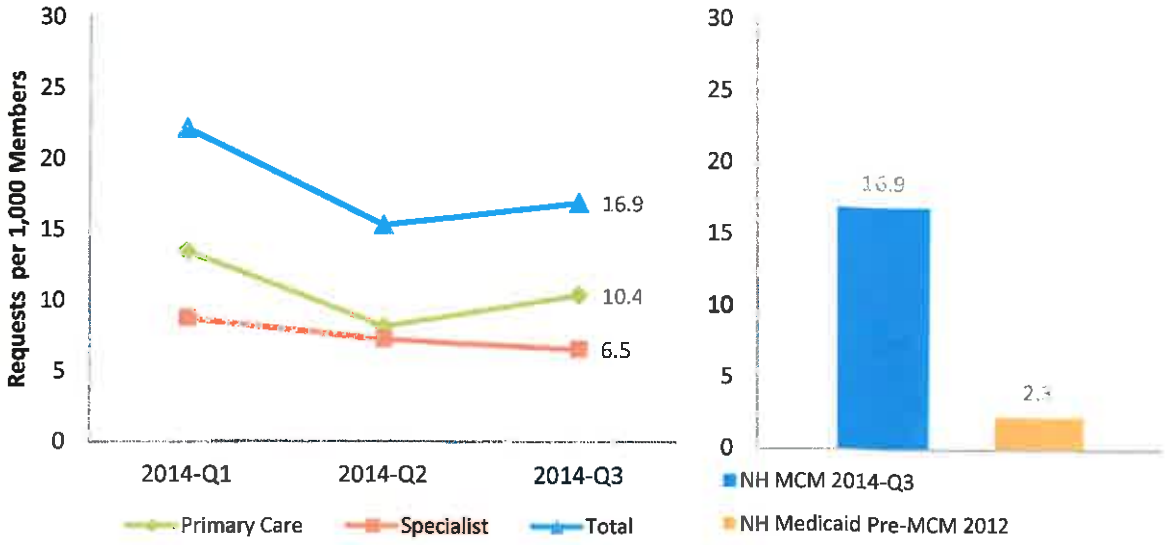


Chart unchanged from last months report.

Description: Access to care is an important first step in meeting health care needs. A high volume of calls requesting assistance accessing providers could indicate problems with a provider network. This measure describes members requesting help finding and getting appointments for doctors, divided by the number of members. Multiple requests by a single member are all individually counted in the rate. The rate is shown per 1,000 members. For example, a rate of 11 specialists would indicate that out of every 1,000 members there were 11 individual requests for assistance in accessing a specialist.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Comparator Description: The data source is the "NH Medicaid Access to Care Information Report, February 2013." The comparison data is a combine value for all physician types and includes additional populations that are not included in the *Medicaid Care Management* program, such as members who are not mandatory or who opted out of the program.

Figure 1-2: Provider Network Adequacy

	12/1/13 – 6/30/14	7/1/14 – 12/31/14
	Standard Met	Standard Met
Primary Care Providers –		
Time: 2 providers within 40 minutes	X	X
Distance: 2 providers within 15 miles		
Hospitals –		
Time: 1 hospital within 60 minutes	X	X
Distance: 1 hospital within 45 miles		
Pharmacies–		
Time: 1 pharmacy within 45 minutes	X	X
Distance: 1 pharmacy within 15 miles		
Mental Health Providers –		
Time: 1 provider within 45 minutes	X	X
Distance: 1 provider within 25 miles		

Table indicates that standard is met when 90% or more of members in each county meet time or distance standards.
Table unchanged from last months report.

Description: Provider network adequacy is important to ensure that members have access to health care providers. This table shows whether the MCOs are meeting MCM contract time and distance standards for different provider types. Failure to meet time and distance standards could indicate inadequate access providers.

Frequency: Reported biannually, available approximately 1 month after end of the quarter.

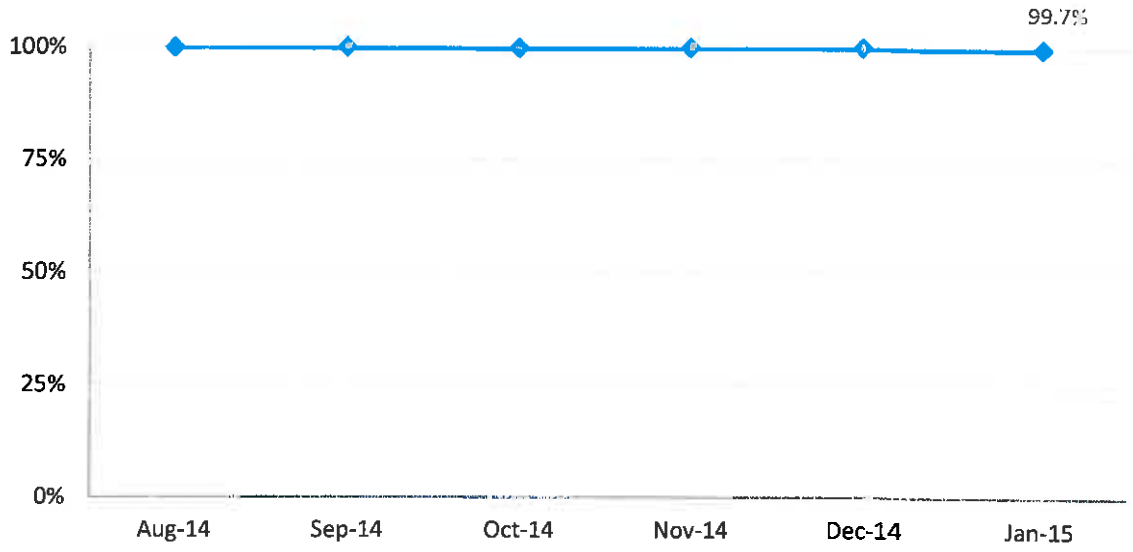
Figure 1-3: Member to Provider Ratio: Substance Abuse Counselors - NHHPP Members

(Available Winter 2015)

Description: Access to care is an important first step in meeting health care needs. A low or falling ratio of members to providers could indicate an inadequate provider network and would increase member difficulty accessing care. This measure describes the average number of members, divided by the number of substance use disorder providers.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

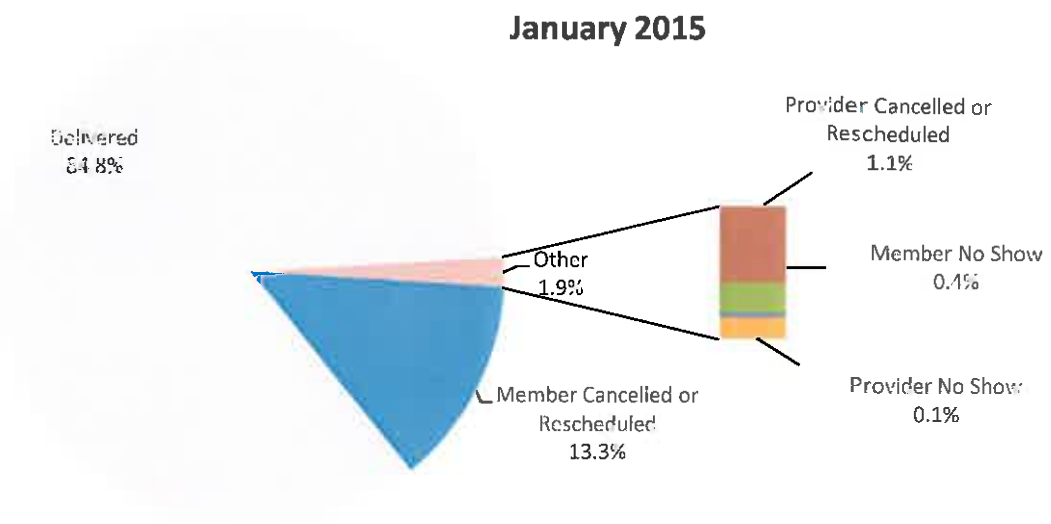
Figure 1-4: Non-Emergent Transportation Requests Approved



Description: A lack of transportation can be a barrier to accessing health services. A low or falling rate of requests for transportation that have been made, but not approved could indicate that transportation needs are not being met. This measure describes the number of non-emergent requests for transportation approved, divided by the total number of non-emergent transportation requests, as a percentage. The types of transportation included in this measure are contracted transportation providers, volunteer drivers, member drivers, public transportation, and other.

Frequency: Reported monthly, available approximately 2 months after end of the quarter.

Figure 1-5: Scheduled Non-Emergent Transportation Results by Outcome

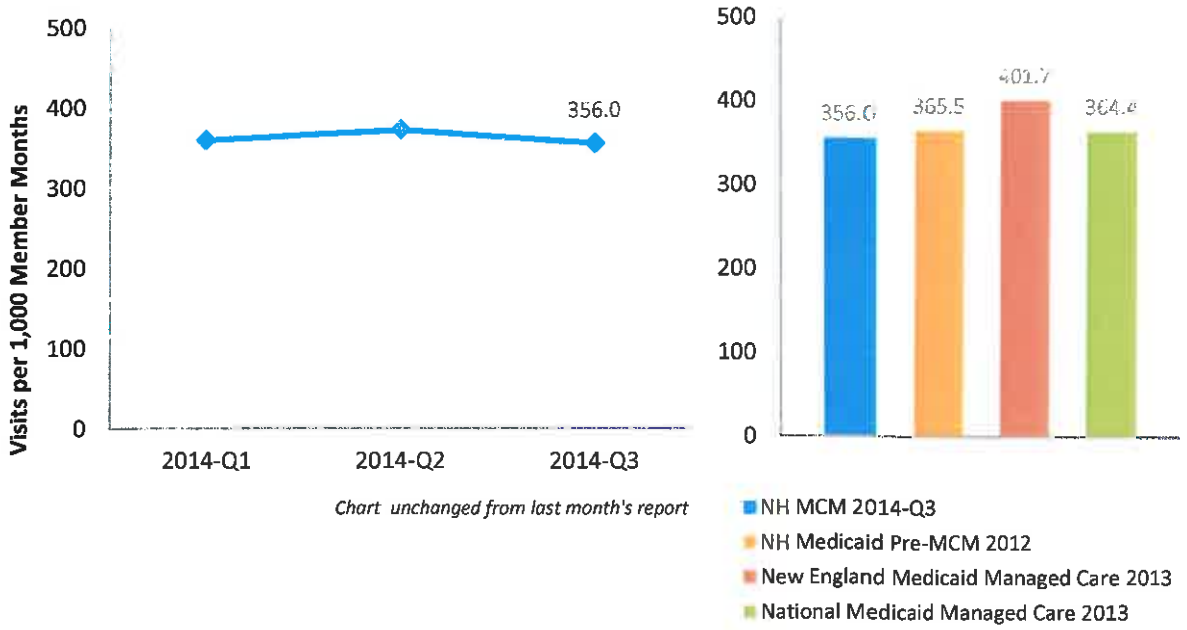


	Member Cancelled or Rescheduled	Provider Cancelled or Rescheduled	Member No Show	Provider No Show	Delivered
Jan-15	2,376	13	78	13	15,210

Description: The successful delivery of scheduled transportation is an important component of access to health services. Transportation scheduled but not delivered could indicate that transportation needs are not being met. This measure describes the number of approved and scheduled non-emergent trips for each indicated outcome, divided by the total number of approved trips, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the quarter.

Figure 1-6: Physician and ARNP Clinic Visits

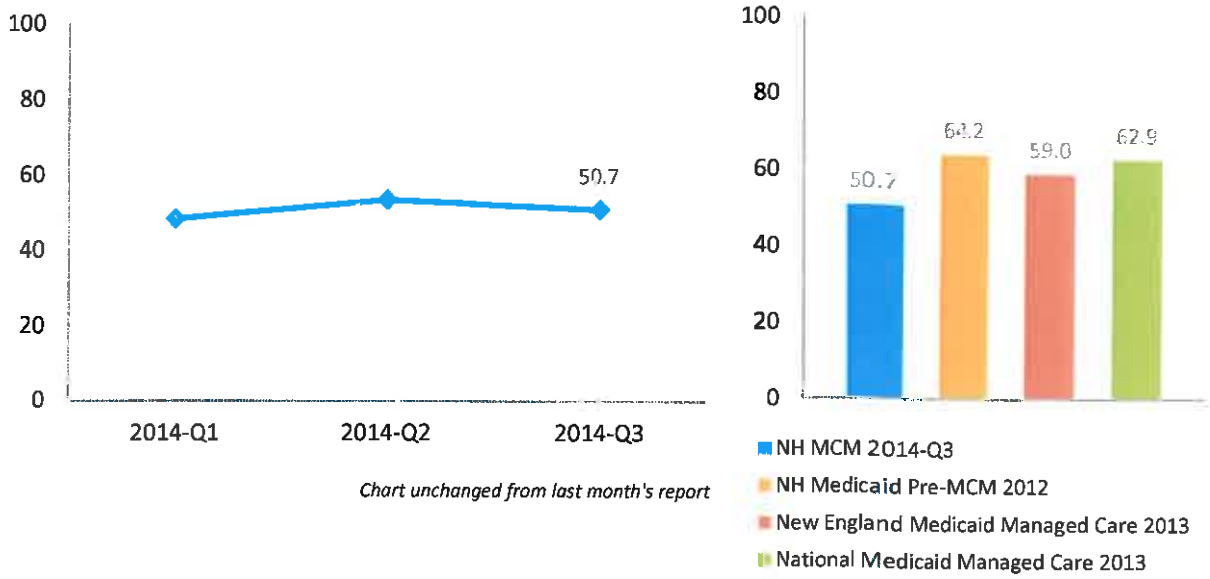


Description: Measuring provider visits is a standard industry approach to better understand the use of ambulatory (outpatient) health services utilization. This measure describes the number of provider office visits, divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Comparator Description: The data source is the "NH Medicaid Access to Care Information Report, February 2013." The comparison data included additional populations that are not included in the *Medicaid Care Management* program, such as members who are not mandatory or who opted out of the program.

Figure 1-7: Emergency Department Visits

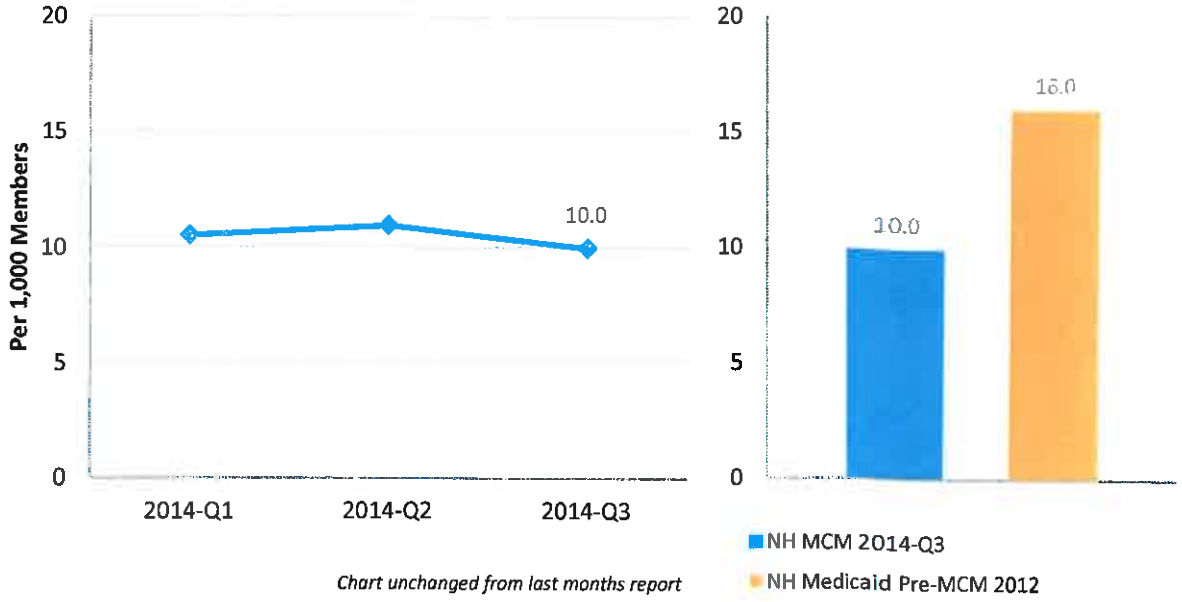


Description: Measuring emergency department visits is a standard industry approach to better understand the use of emergency departments. This measure describes the number of emergency department visits, divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Comparator Description: The NH FFS data source is the "NH Medicaid Access to Care Information Report, February 2013." The comparison data included additional populations that are not included in the *Medicaid Care Management* program, such as members who are not mandatory or who opted out of the program. The New England and national Medicaid data source is the *NCQA 2014 Quality Compass*.

Figure 1-8: Emergency Department Visits Potentially Treatable by Primary Care



Description: The Emergency Department is not the best setting for primary care health services. A high or increasing number of visits could indicate that members are having difficulty accessing primary care services. This measure describes emergency department visits for reasons that might have been managed in a doctor's office (for example, colds, rashes, etc.), divided by the number of member months. The result is a quarterly rate of visits per 1,000 member months. Member months are a count of how many months each member was in the managed care program. A member who was in for the full quarter would add 3 member months to the total; a member who was in the program for 1 month would add only 1 month to the total. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Comparator Description: The NH FFS data source is the "NH Medicaid Access to Care Information Report, February 2013." The comparison data included additional populations that are not included in the *Medicaid Care Management* program, such as members who are not mandatory or who opted out of the program.

Figure 1-9: Inpatient Hospital Utilization Summary

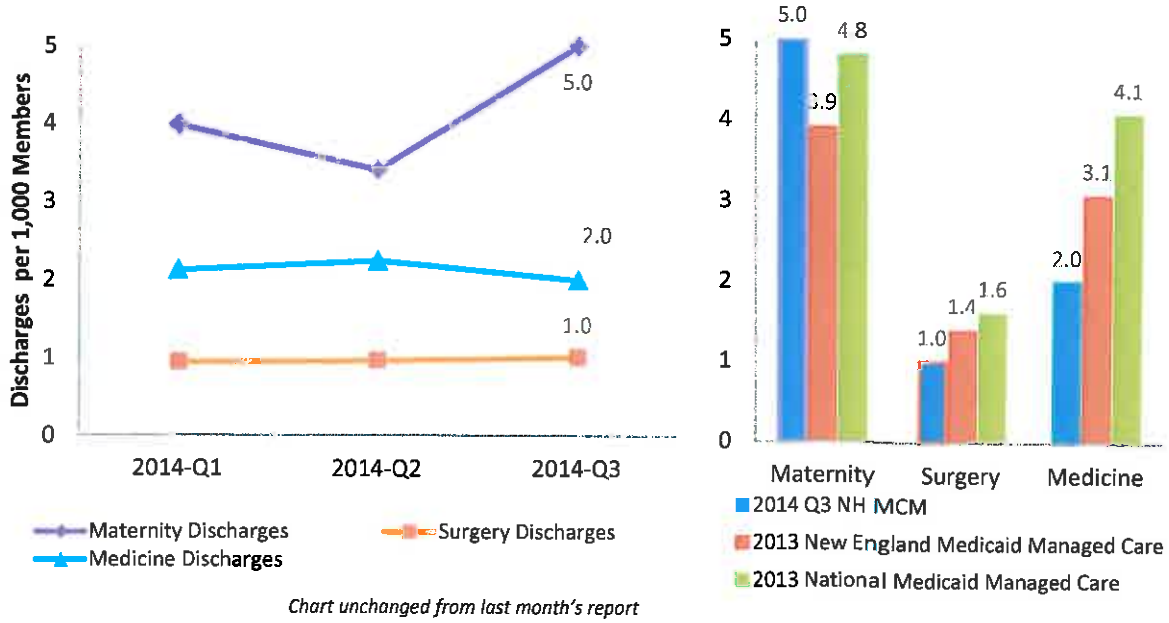


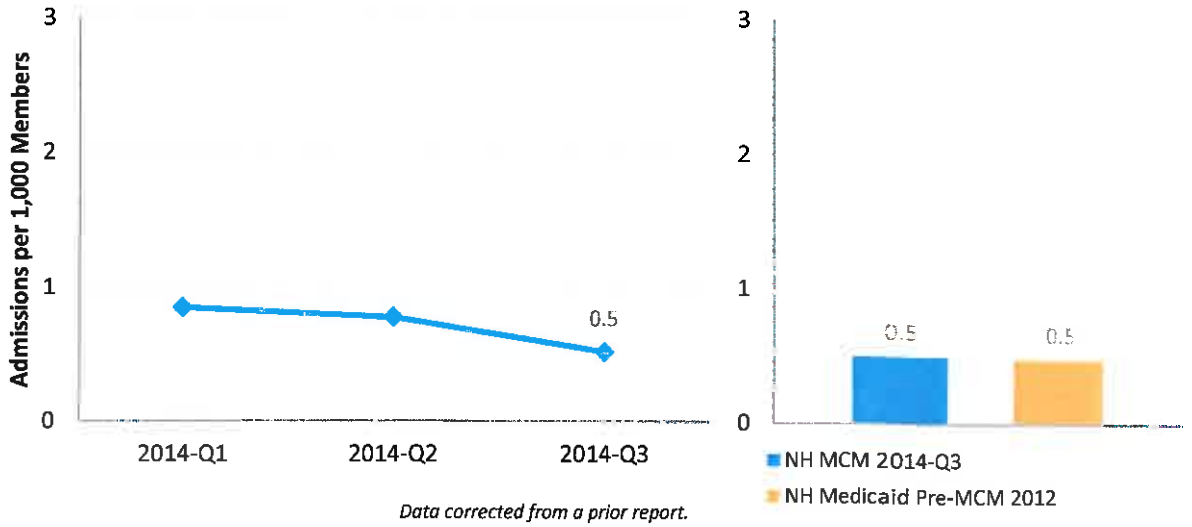
Chart unchanged from last month's report

Description: Measuring hospital admissions is a standard industry approach to better understand the use of acute (hospital) health services. This measure describes the number of admissions to a hospital, divided by the number of member months. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Comparator Description: The New England and national Medicaid data source is the *NCQA 2014 Quality Compass*.

Figure 1-10: Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members



Data corrected from a prior report.

Description: Ambulatory care sensitive admissions are conditions that can be impacted by the availability, use, and quality of ambulatory (office) care. A high or increasing number of admissions could indicate that members are having difficulty accessing primary care services. This measure describes the number of inpatient hospital admissions for ambulatory care sensitive conditions, divided by the number of member months. The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. The denominator is divided by 1,000 to calculate a rate that can be more easily compared.

Frequency: Reported quarterly, available approximately 5 months after end of the quarter.

Comparator Description: The NH FFS data source is the "NH Medicaid Access to Care Information Report, February 2013." The comparison data included additional populations that are not included in the *Medicaid Care Management* program, such as members who are not mandatory or who opted out of the program.

New Notable Results

- In January nearly 100% of requested transportation rides were approved. (Figure 1-4)
- The majority of approved and scheduled transportation rides are delivered. The largest proportion of approved and scheduled trips that were not delivered was the result of members cancelling or rescheduling the trip. (Figure 1-5)
- The following data validation issue should be noted:
    - Figure 1-10: Inpatient Hospital Utilization for Ambulatory Care Sensitive Conductions: data was corrected from a previous report.

DOMAIN: Customer Experience of Care

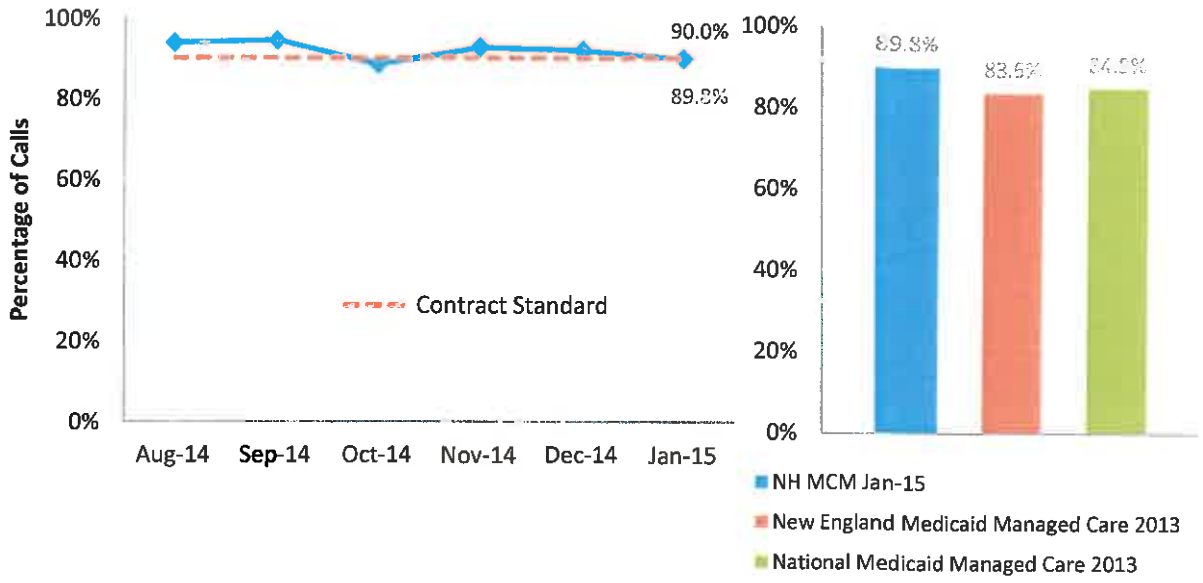
Introduction

Customer Experience of Care includes key indicators in the following areas:

- Member Communications
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Member Call Center

Figure 2-1: Calls Answered in 30 Seconds

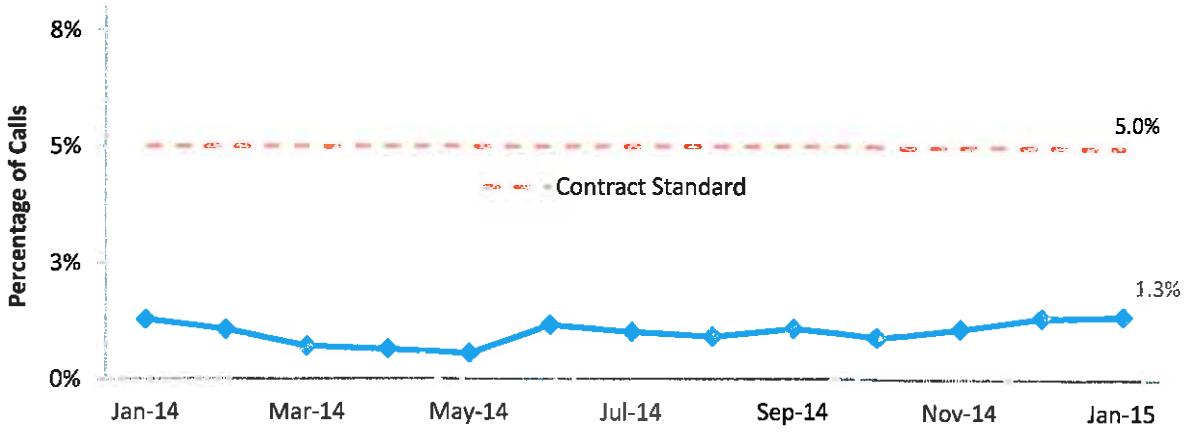


Description: Answering incoming calls quickly is an important component of a good customer experience of care. A falling number of calls answered within 30 seconds could indicate problems within a call center. The MCM contract standard for this measure is 90%. This measure describes the number of calls from a member to their MCO that were answered within 30 seconds, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Comparator Description: The New England and national Medicaid data source is the *NCQA 2014 Quality Compass*.

Figure 2-2: Member Communications: Calls Abandoned



Description: Minimizing the number of calls that are abandoned is an important component of customer experience of care. A rising percentage of calls abandoned could indicate problems within a call center. The MCM contract standard for this measure is less than 5% of calls are abandoned. This measure describes the number of calls from a member to their MCO that were abandoned, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Customer Satisfaction Survey

Annual CAHPS Report

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standard national tool that measures member satisfaction with their health care. DHHS performed a CAHPS survey to measure early satisfaction with the MCM program and to create a baseline for future surveys. The DHHS survey was administered by a certified vendor following standard CAHPS protocols in the winter of 2015 using a statistically valid sample of members enrolled in MCM. The populations were divided into adults and children. For children, the survey was conducted with the member's parent.

Frequency: Annually in Summer. The 2014 CAHPS survey, conducted by DHHS as a baseline for the MCM program, is available and can be downloaded from: http://www.dhhs.nh.gov/ombp/quality/index.htm

New Notable Results

- Member calls are being handled near contract standards. (Figure 2-1 and 2-2.)

DOMAIN: Provider Service Experience

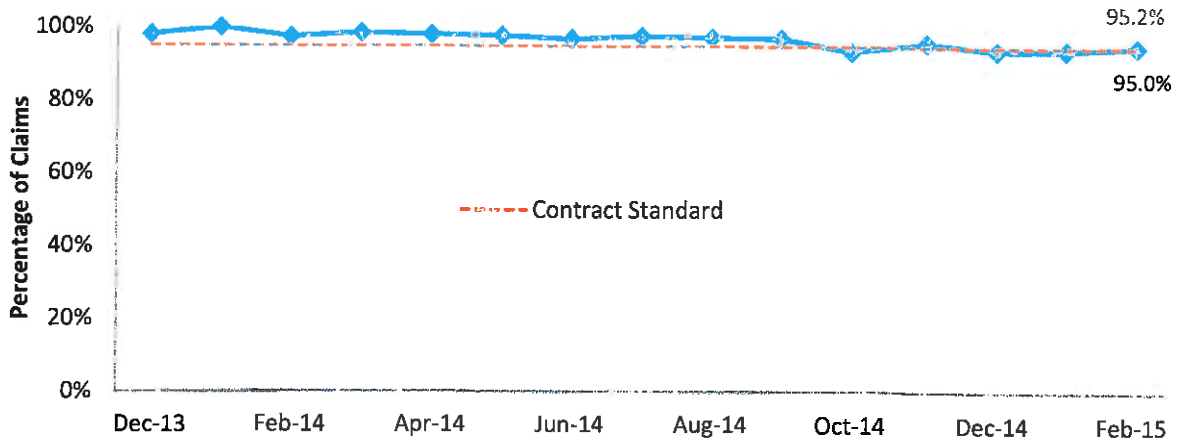
Introduction

Provider Service Experience includes key indicators in the following areas:

- Claims Processing
- Provider Call Center
- Provider Satisfaction Survey

Claims Processing

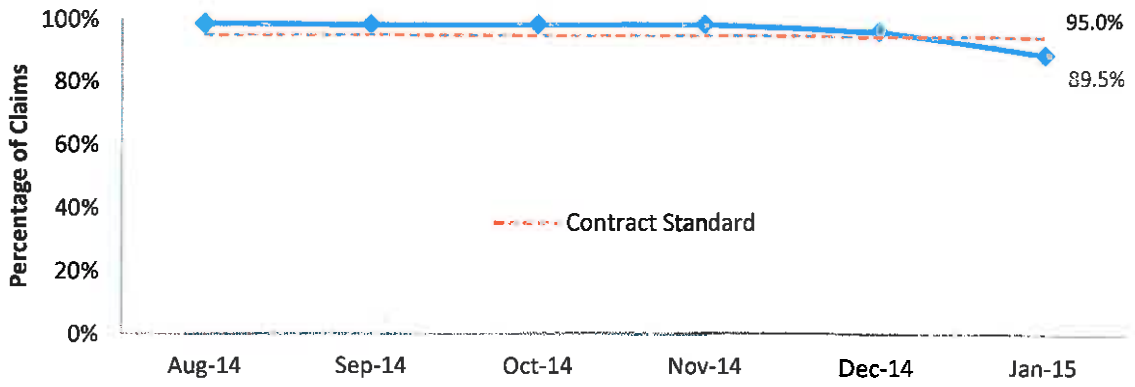
Figure 3-1: Professional and Facility Claims Processed in 30 Days



Description: Paying claims within 30 days is an important component of a good provider service experience. Claims must be "clean" of any inaccuracies in order to pay. A falling number of claims processed within 30 days could impact how quickly providers receive payment. The MCM contract standard for this measure is 95%. This measure describes the number of claims paid or denied in the month, divided by the number of claims received in the month, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

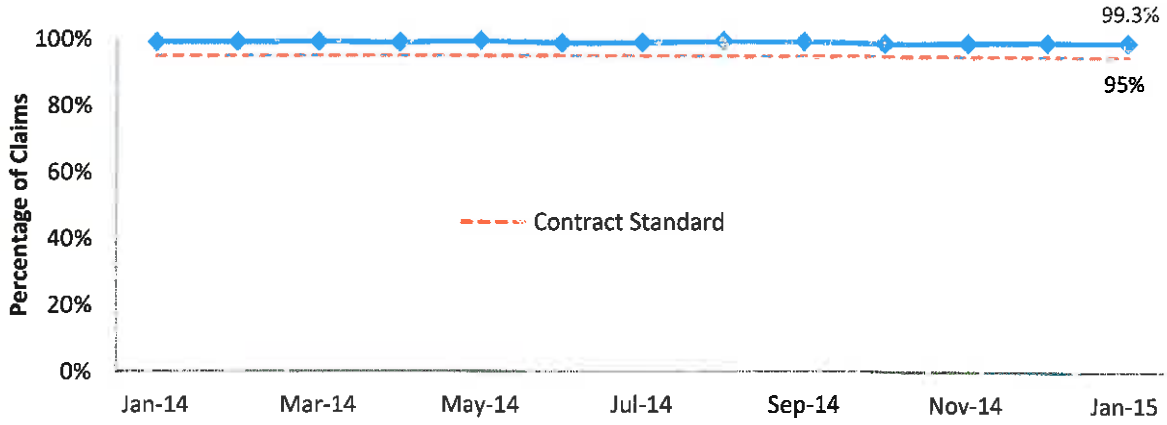
Figure 3-2: Pharmacy Claims Processed in Less than One Second



Description: Processing pharmacy claims in less than one second is an important part of a good pharmacist experience of service. The measure is a federal requirement for all Medicaid programs. The MCM contract standard for this measure is 95%. This measure describes the number of pharmacy claims accurately processed within one second as a paid or denied claim, divided by the total number of pharmacy claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

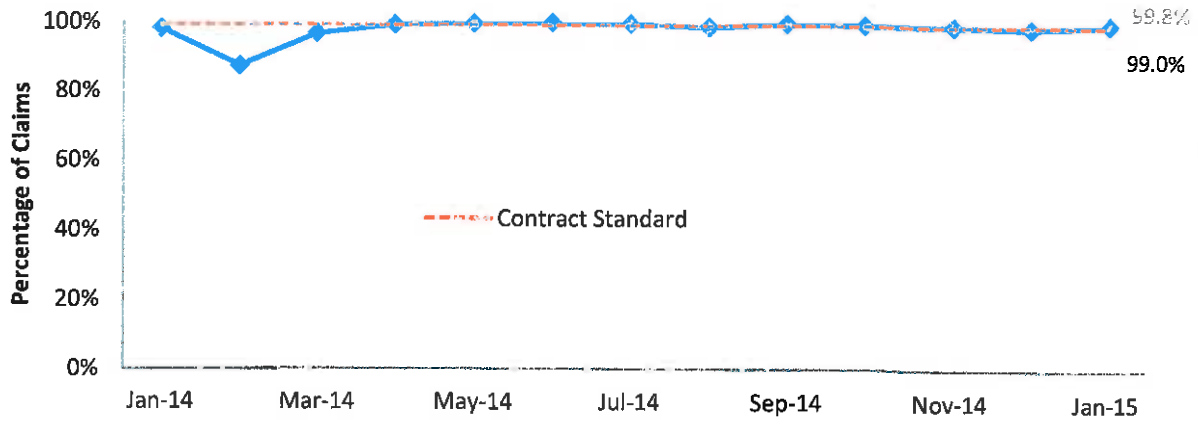
Figure 3-3: Claims Processing Accuracy



Description: Processing claims accurately is an important component of a good provider service experience. A falling number of claims processed accurately may indicate health plan system problems that need to be addressed. The MCM contract standard for this measure is 95%. This measure describes the number of claims correctly processed, divided by the total number of claims, from a sample of claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 3-4: Claims Financial Accuracy

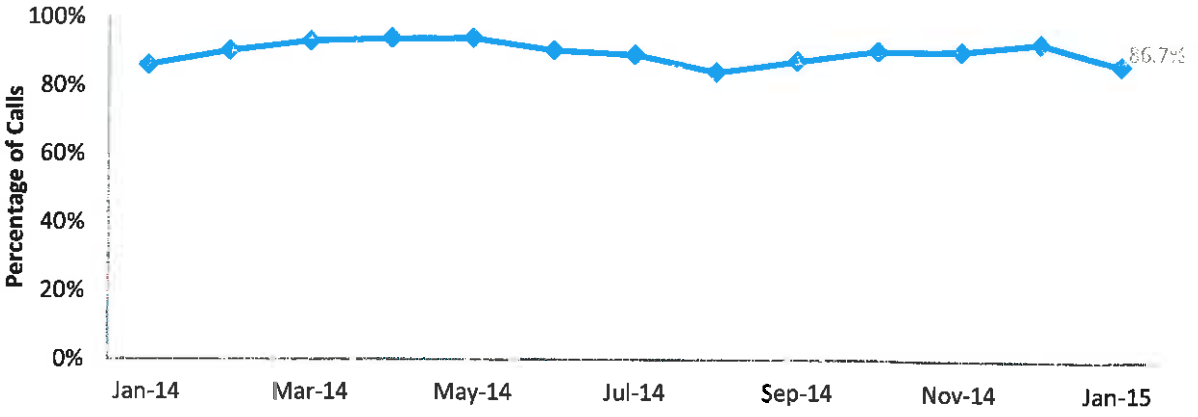


Description: Paying claims accurately is an important component of a good provider service experience. A falling number of claims paid accurately may indicate health plan system problems that need to be addressed. The MCM contract standard for this measure is 99%. This measure describes the number of claims correctly paid or denied, divided by the total number of claims, from a sample of claims, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Provider Call Center

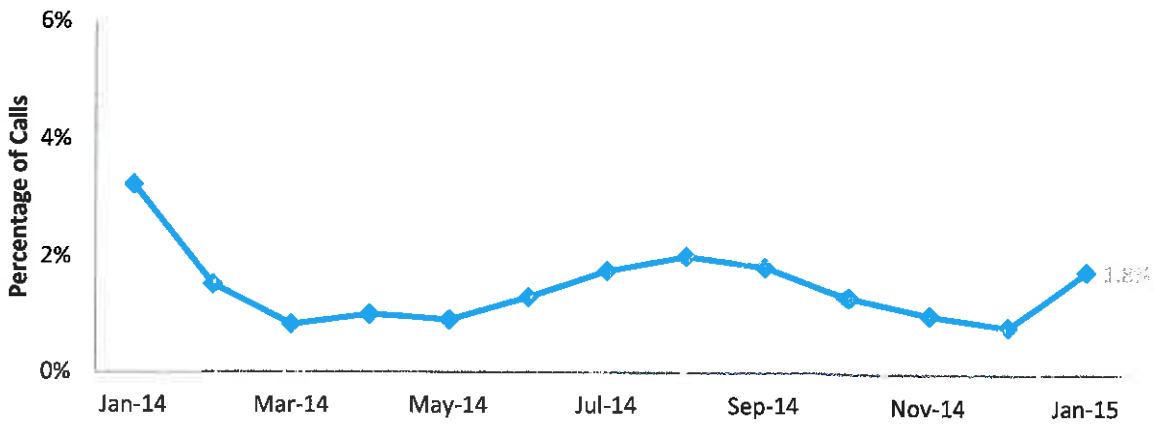
Figure 3-5: Calls Answered in 30 Seconds



Description: Answering incoming calls quickly is an important component of a good provider service experience. A falling number of calls answered within 30 seconds could indicate problems within a call center. This measure describes the number of calls from a provider to an MCO that were answered within 30 seconds, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 3-6: Provider Communications: Calls Abandoned



Description: Minimizing the number of calls that are abandoned is an important component of a good provider service experience. A rising percentage of calls abandoned could indicate problems within a call center. This measure describes the number of calls from a provider to their MCO that were abandoned, divided by the number total number of calls, as a percentage.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Provider Satisfaction Survey

Annual Provider Satisfaction Report

(Available Fall 2015)

Each MCO will conduct and produce an analytic narrative report that interprets the results from an annual provider satisfaction survey. This survey, administered by a third party, is based on a statistically valid sample of each major provider type: primary care providers, specialists, hospitals, pharmacies, durable medical equipment (DME) providers, and home health providers.

New Notable Results

- Provider clean claims are being processed within MCM contract standards for timeliness. (Figure 3-1)
- Pharmacy claims are being processed below contract standards for timeliness. This is attributable to one MCO who actively engaged in processes understanding and improvement. (Figure 3-2)
- Provider calls had a higher rate of abandonment and a longer average speed to answer in January. Both MCOs experienced call center staff shortages due to winter snowstorms. (Figure 3-5 and 3-6)

DOMAIN: Utilization Management

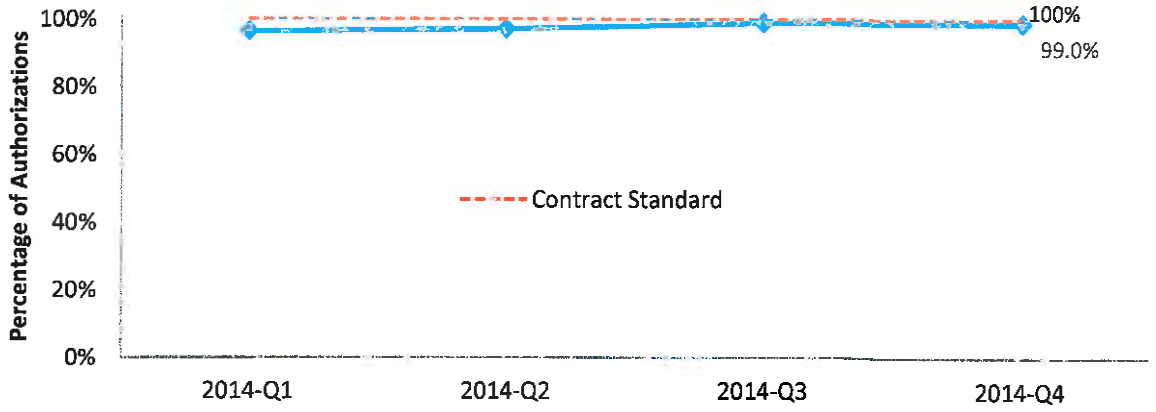
Introduction

Utilization Management includes key indicators in the following areas:

- Service Authorization Processing
- Service Authorization Determination
- Pharmacy Utilization Management

Service Authorization Processing

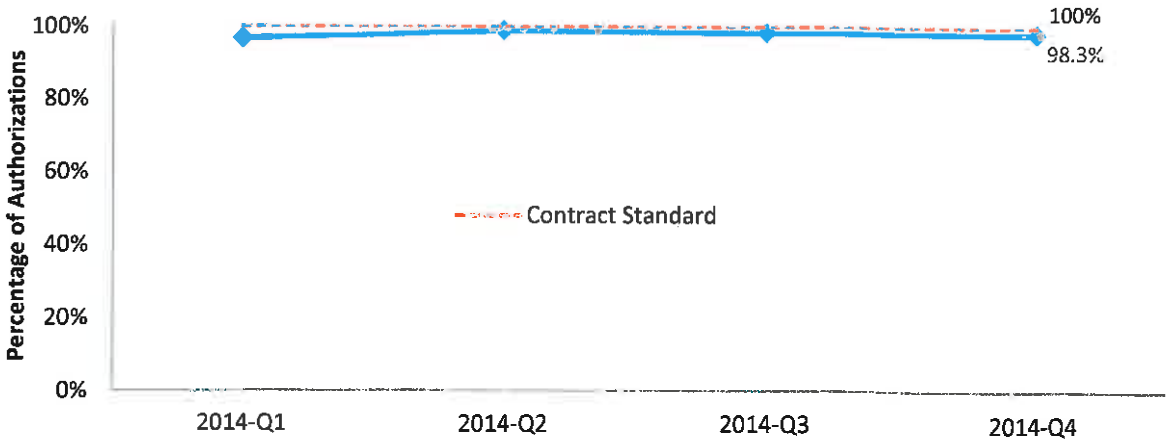
Figure 4-1: Urgent Medical Service Authorization Processing Rate



Description: When medical services requiring prior authorization are needed quickly, an urgent service authorization decision must be made within 72 hours. Longer times for authorization may contribute to member difficulties getting needed or timely care. (Note: Emergency care does not require prior authorization.) The MCM contract standard for this measure is 100%. This measure describes the number of urgent authorizations, both approved and denied, divided by the total number of urgent authorization requests received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

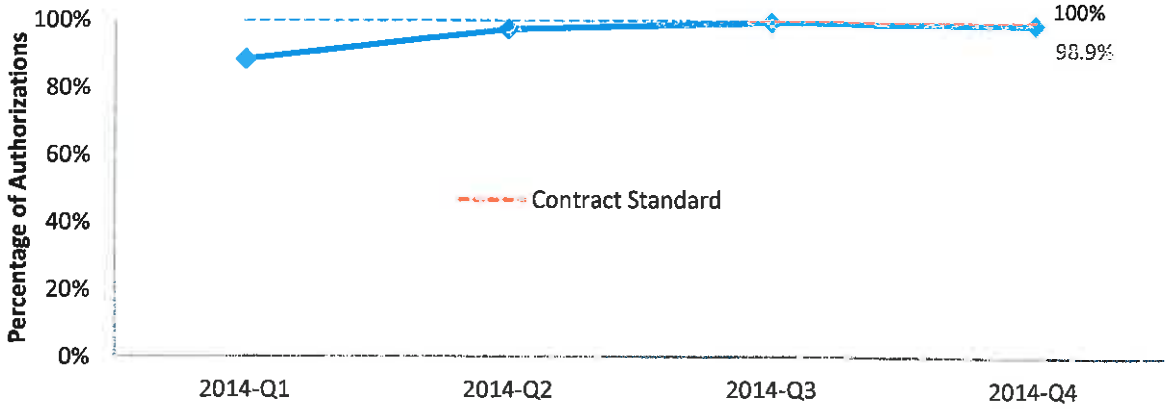
Figure 4-2: Routine Medical Service Authorization Processing Rate



Description: When routine medical services requiring prior authorization are needed, a service authorization decision must be made within 14 days. Longer times for authorization may contribute to member difficulties getting needed or timely care. The MCM contract standard for this measure is 100%. This measure describes the number of routine authorizations, both approved and denied, divided by the total number of routine authorization requests received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 4-3: Pharmacy Service Authorization Processing Rate



Description: When pharmacy services requiring prior authorization are need, a service authorization decision must be made within 24 hours. Longer times for authorization may contribute to member difficulties getting needed or timely care. This measure describes the number of pharmacy authorizations, both approved and denied, divided by the total number of pharmacy authorization requests received, as a percentage. The contract standard is 100%.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service

	2014 Q1			2014 Q2			2014 Q3			2014 Q4		
Average Membership	111,241			118,362			123,116			136,990		
	Requests	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***
All Services	23,938	3,193	13%	31,200	2,898	9%	32,645	5,307	16%	27,613	4,521	16%
Service Category	***Requests***	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***	***Requests***	***Denial***	***% Denial***
In-Network Inpatient Admissions Non-Surgical	1,945	37	2%	2,806	36	1%	3,117	28	1%	2,729	28	1%
In-Network Inpatient Admissions Surgical	214	2	1%	187	11	6%	194	3	2%	140	5	4%
Out-of-Network Inpatient Admissions	344	14	4%	213	3	1%	361	33	9%	216	8	4%
Outpatient Surgeries	1,202	77	6%	817	63	8%	473	77	16%	393	57	15%
Community Mental Health Center	84	10	12%	191	10	5%	116	7	6%	127	0	0%
Physician/ Medical Services	2,492	143	6%	2,643	230	9%	3,317	364	11%	2,644	356	13%
Psychology	278	13	5%	303	16	5%	361	7	2%	426	13	3%
PT/OT/ST	2,120	143	7%	2,472	170	7%	3,422	189	6%	2,985	141	5%
Wheelchair Van	497	16	3%	710	17	2%	1,652	11	1%	1,473	7	0%
Pharmacy	8,609	2,314	27%	9,091	1,744	19%	10,543	3,852	37%	7,030	2,817	40%
Private Duty Nursing	307	0	0%	279	1	0%	386	0	0%	413	1	0%
Medical Supplies	1,381	55	4%	1,063	27	3%	1,592	19	1%	1,620	97	6%
DME Pediatric and Adults	1,514	171	11%	1,318	38	3%	1,588	80	5%	1,631	56	3%
Imaging Studies	1,794	94	5%	1,887	99	5%	3,792	372	10%	4,390	774	18%
Other	909	99	11%	1,472	302	21%	1,393	255	18%	1,018	154	15%

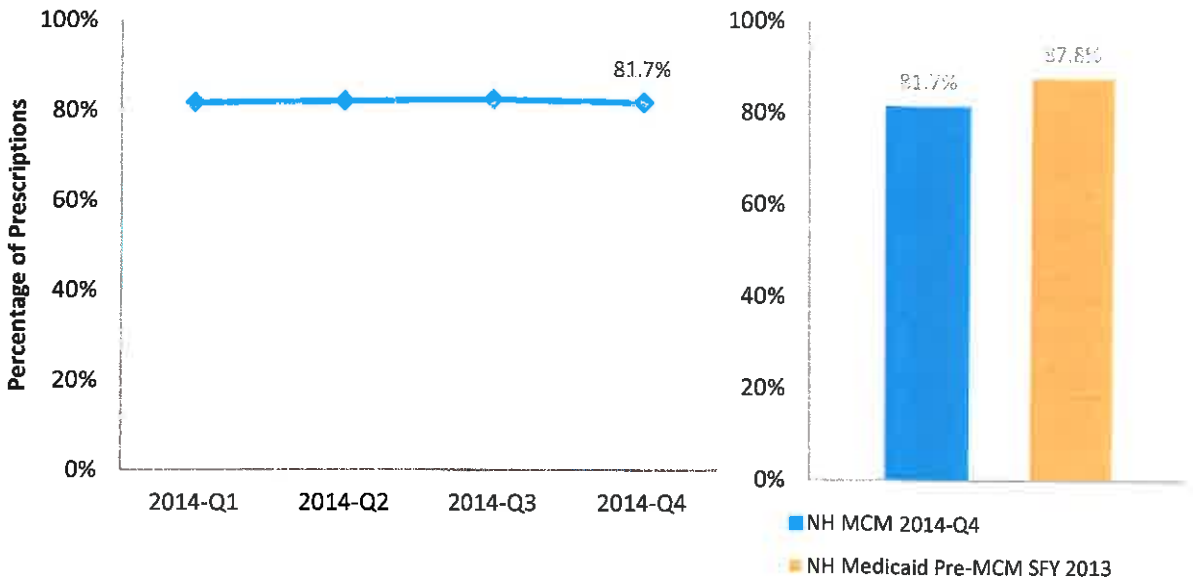
Omits services with < 100 requests in the most recent quarter (Psychology, License Nurse Attendant, Vision, Podiatry, Audiology, Transplant)
Pharmacy data corrected from prior report.

Description: Measuring the types and outcomes for health care service authorizations is a standard industry approach to better understand health care services utilization. The measure counts the total number of service authorizations received, approved and denied, by selected categories of service. It also includes the percent of service authorizations received, approved, and denied by all categories of service. Pending authorizations are not included so the approval and denial rate will not total 100% in this table.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Pharmacy Utilization Management

Figure 4-5: Pharmacy Utilization Management: Generic Drug Substitution



Description: Number of prescriptions filled for generic drugs during the measure data period, divided by the total number of generics and multi-source brand (drugs for which a generic is available) prescriptions filled during the measure data period, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Comparator Description: The New England and national Medicaid data source is the *New Hampshire Medicaid Pharmacy Program State Fiscal Year 2013 Annual Report*. The comparison data included additional populations that are not included in the Medicaid Care Management program, such as members who are not mandatory or who opted out of the program.

New Notable Results

- Service Authorizations are being processed close to contract standards. (Figure 4-1, through 4-3)
- The majority of the service authorization benefit decision rates has are consistent. This rate may represent more appropriate utilization. (Figure 4-4)
- Pharmacy service authorization rates remain high. (Figure 4-4) Of note, pharmacy appeals are falling. (Figure 5-2). The Department is working to better understand this measure.
- The generic drug substitution rate is lower than the Medicaid pre-MCM rate. (Figure 4-5)
- The following data validation issue should be noted:
    - Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service: pharmacy data has been corrected from a previous report.

DOMAIN: Grievances and Appeals

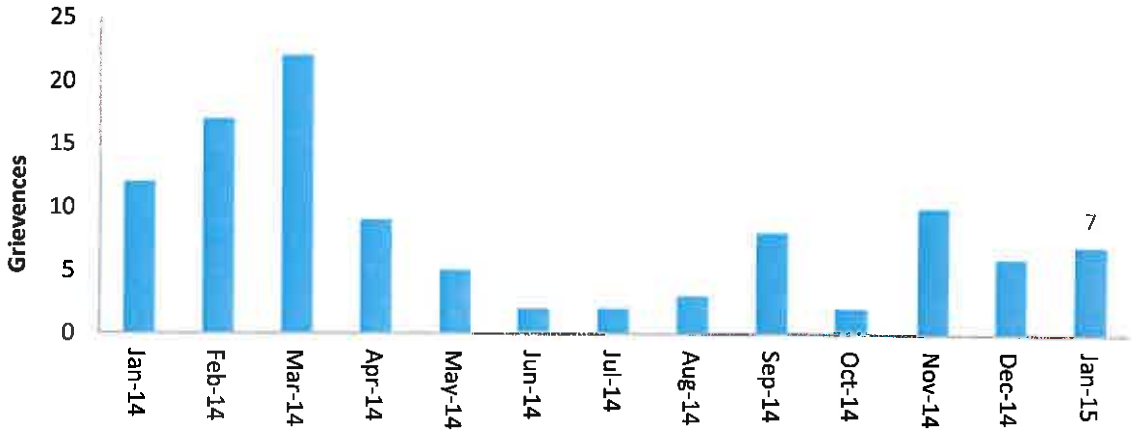
Introduction

Grievances and Appeals include key indicators in the following areas:

- Counts of Grievances and Appeals
- Processing Timeframes

Counts

Figure 5-1: Grievances



Description: Grievances are counted when a member contacts the health plan with a concern or complaint. An increasing number of grievances, or a single serious grievance, could indicate that additional health plan attention is needed. This measure counts the total number of grievances received each month.

Frequency: Reported monthly, available approximately 2 months after end of the month.

Figure 5-2: Number of Appeals

	2014 Q1	2014 Q2	2014 Q3	2014 Q4
All Services	275	463	360	310
Services				
Inpatient Admissions	15	7	11	26
Outpatient Hospital	4	6	2	16
Physician Services	26	15	40	20
PT/OT/ST Therapies	26	21	22	22
Pharmacy	171	375	243	184
Other	19	29	30	30

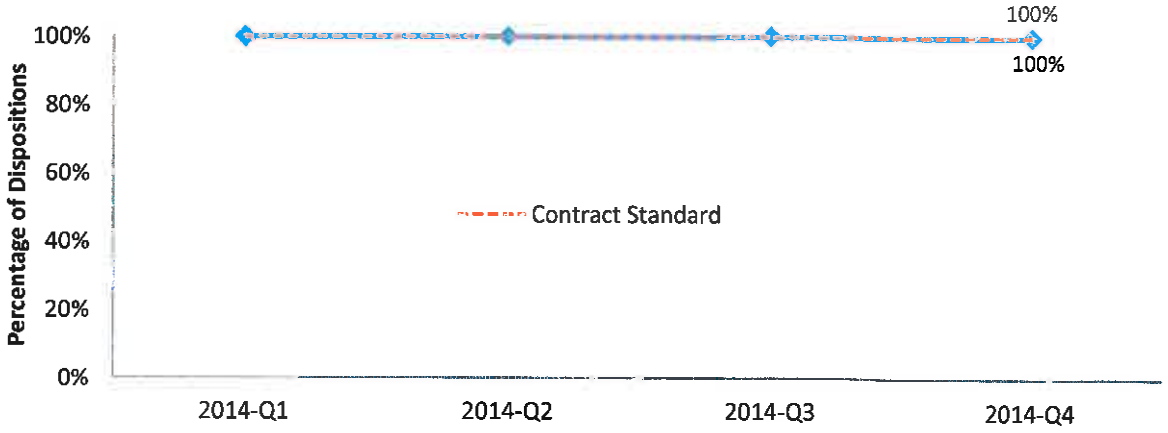
Table omits services with <10 appeals in the most recent quarter (Community Mental Health Center, Psychology, NEMT, Wheelchair Van, Home Health, Private Duty Nursing, Personal Care Attendant, Medical Supplies, Vision, Podiatry, Methadone, Non-nurse Midwives, and Audiology.)

Description: Measuring the number of service authorization appeals by type of health care service is a standard industry approach to better understand health care services utilization. A rising number of appeals could indicate difficulties with utilization management or access to health care services. This measure counts the total number of appeals received, by selected categories of service, and the total of all appeals received.

Frequency: Reported quarterly, available approximately 2 months after end of the quarter.

Processing Timeframes

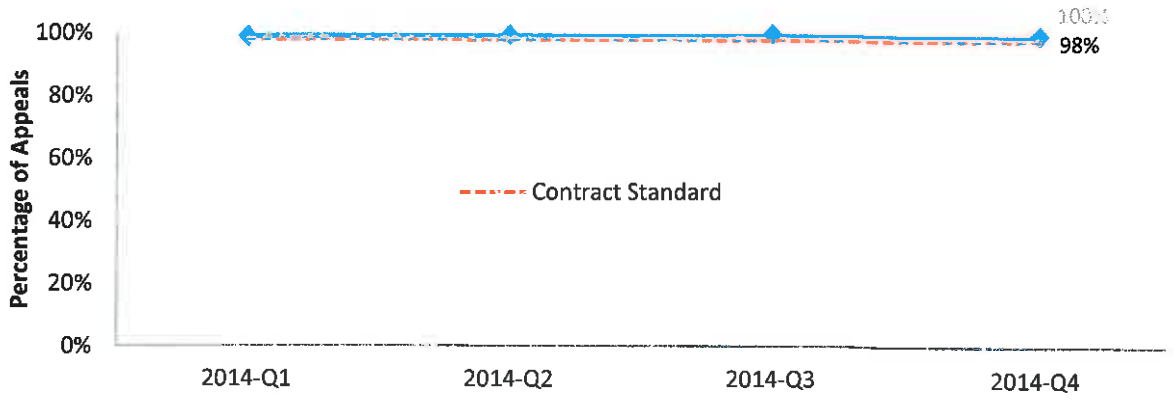
Figure 5-3: Grievance Dispositions Made in 45 Calendar Days



Description: Resolving grievances within 45 days ensures that substantive problems are recognized and addressed by the health plan. A falling rate of grievances resolved within 45 days could contribute to difficulties for other members. The MCM contract standard for this measure is 100%. This measure counts the number of grievances resolved within 45 days, divided by the total number of grievances received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

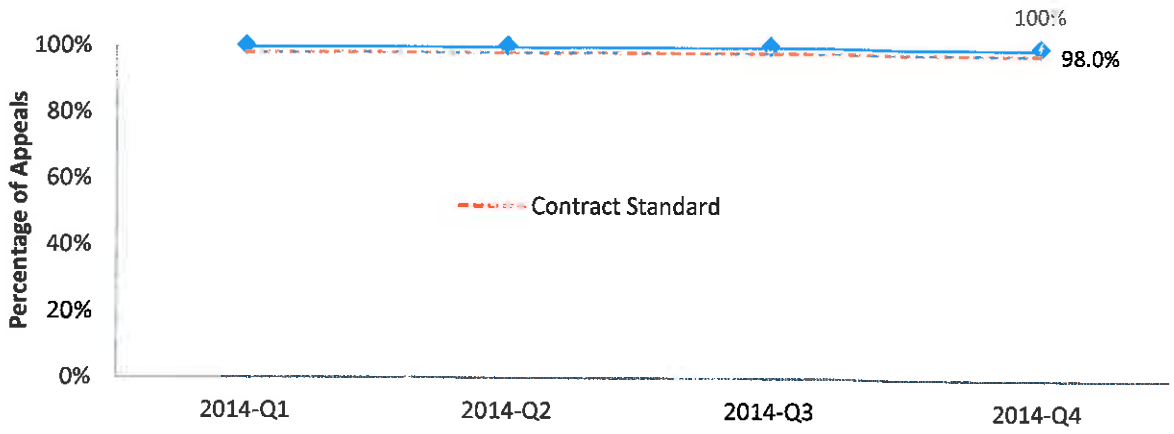
Figure 5-4: Standard Appeals Resolved in 30 Calendar Days



Description: Standard appeals require a decision within 30 calendar days. Resolving appeals within 30 days ensures that needed health care services are not inordinately delayed. A falling rate of appeals resolved within 30 days could contribute to delays in needed health care for members. The contract standard for this measure is 98%. This measure counts the number of routine appeals resolved within 30 days, divided by the total number of appeals received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

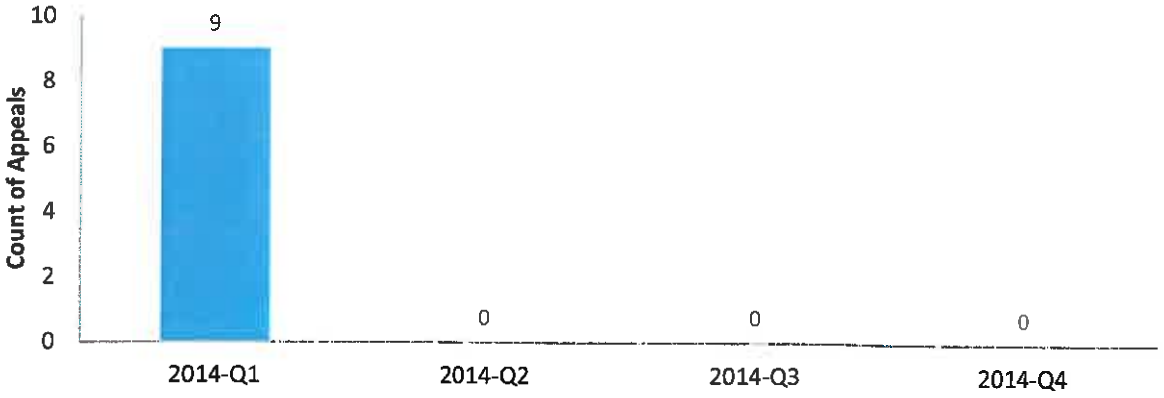
Figure 5-5: Expedited Appeals Resolved in 3 Calendar Days



Description: Expedited appeals require a decision within 3 calendar days. Resolving expedited appeals within 3 days ensures that needed health care services are not inordinately delayed. A falling rate of expedited appeals resolved within 3 days could contribute delays in needed health care for members. The contract standard for this measure is 100%. This measure counts the number of expedited appeals resolved, divided by the total number of expedited appeals received, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Figure 5-6: Appeals Elevated to State Fair Hearing



Description: A member may file a request for a State Fair Hearing, if a member does not agree with the MCO's resolution of the appeal. Appeals elevated to State Fair Hearings are an indicator of member satisfaction with the MCO's decision. This measure counts the number of appeals that have elevated to a State Fair Hearing.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

New Notable Results

- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards. (Figures 5-3 through 5-5)
- Appeals being filed with the MCOs have decreased. (Figure 5-2)

DOMAIN: Preventive Care

Introduction

Preventive Care includes key indicators in the following areas:

- Prevention Assessment
- Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Care Measures

Prevention Assessment

Figure 6-1: Health Risk Assessment Completed for Members with Chronic Conditions

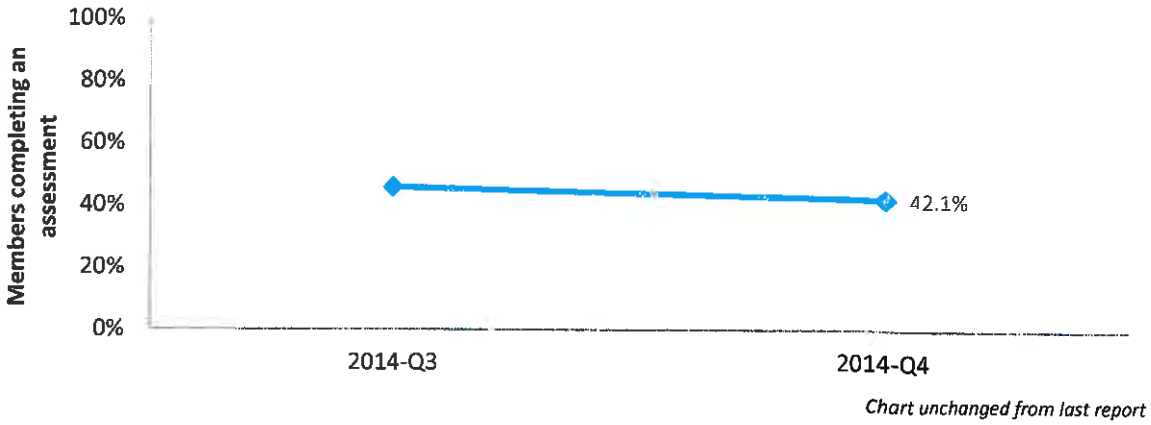


Chart unchanged from last report

Description: Health risk assessments help a health plan understand what medical services a member with chronic conditions may need. Health risk assessments are helpful in identifying and addressing gaps in preventive services. A low or falling number of health risk assessments completed could contribute to missed opportunities to provide preventive care for members with chronic conditions. This measure counts the percentage of health risk assessments completed in the last 12 months for members with chronic conditions.

Frequency: Reported quarterly, available approximately 2 months after end of the quarter.

Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Care Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standard national tool to measure performance on important dimensions of care and service, including preventive care and services. Altogether, HEDIS consists of 81 measures across five domains of care. The re-

sults, available annually in the summer, allow an ability to monitor and conduct performance improvement activities related to health outcomes. The five domains of care are:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan board certification and membership overview

New Notable Results

None.

DOMAIN: Chronic Medical Care

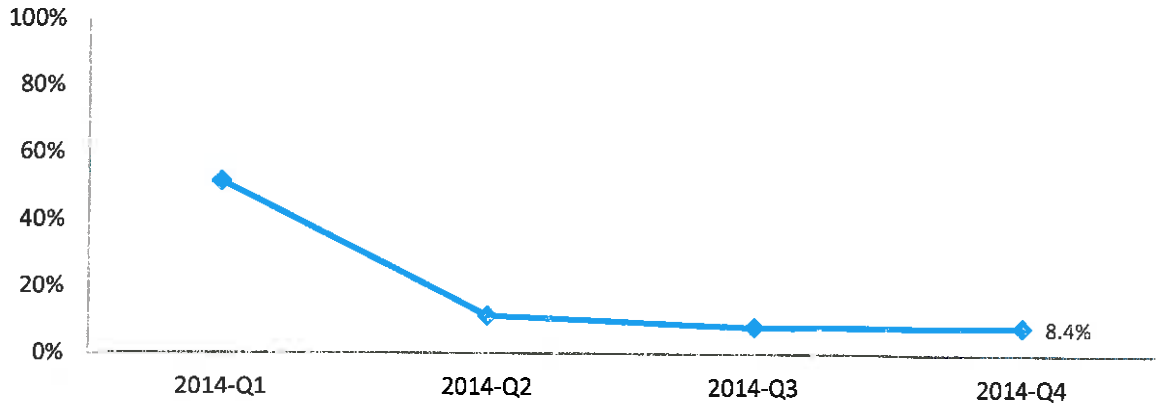
Introduction

Chronic Medical Care includes key indicators in the following areas:

- Pharmacy Services
- Healthcare Effectiveness Data and Information Set (HEDIS) Chronic Care Measures

Pharmacy

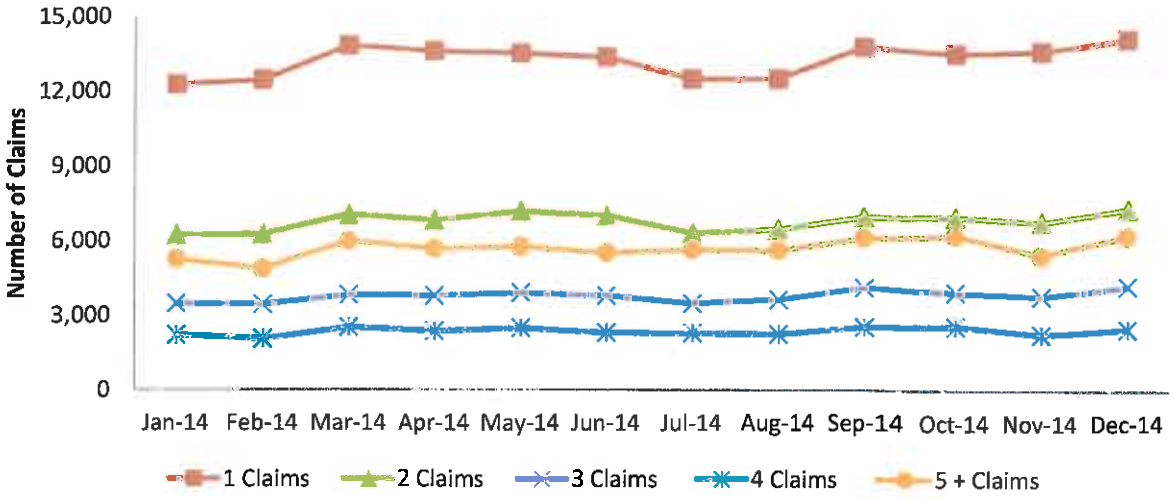
Figure 7-1: Maintenance Medication Gaps



Description: Missing medication doses can contribute to poor health. A rising number of missed doses may indicate greater risk for adverse health outcomes. This measure describes the number of maintenance medications with gaps greater than 20 days between refills, divided by the number of members on maintenance medications, as a percentage. Maintenance medications are drugs that a member takes for longer than 120 days.

Frequency: Reported quarterly, available approximately 6 months after end of the quarter.

Figure 7-2: Polypharmacy Monitoring for All Medications



Description: Medications can interact with each other and can contribute to poor health. Polypharmacy means that a member is taking multiple medications. Members on multiple medications can be at greater risk for adverse health outcomes. A rising or high number of members using multiple medications may indicate drug use review is needed. This measure describes the number of members taking multiple medications, divided by the number of members, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standard national tool to measure performance on important dimensions of care and service, including preventive care and services. Altogether, HEDIS consists of 81 measures across five domains of care. The results, available annually in the summer, allow an ability to monitor and conduct performance improvement activities related to health outcomes. The five domains of care are:

- Effectiveness of care
- Access and availability of care
- Experience of care
- Utilization and relative resource use
- Health plan board certification and membership overview

New Notable Results

- Maintenance medication gaps are falling indicating a smaller number of prescriptions with long gaps between refills. (Figure 6-2)

DOMAIN: Behavioral Health Care

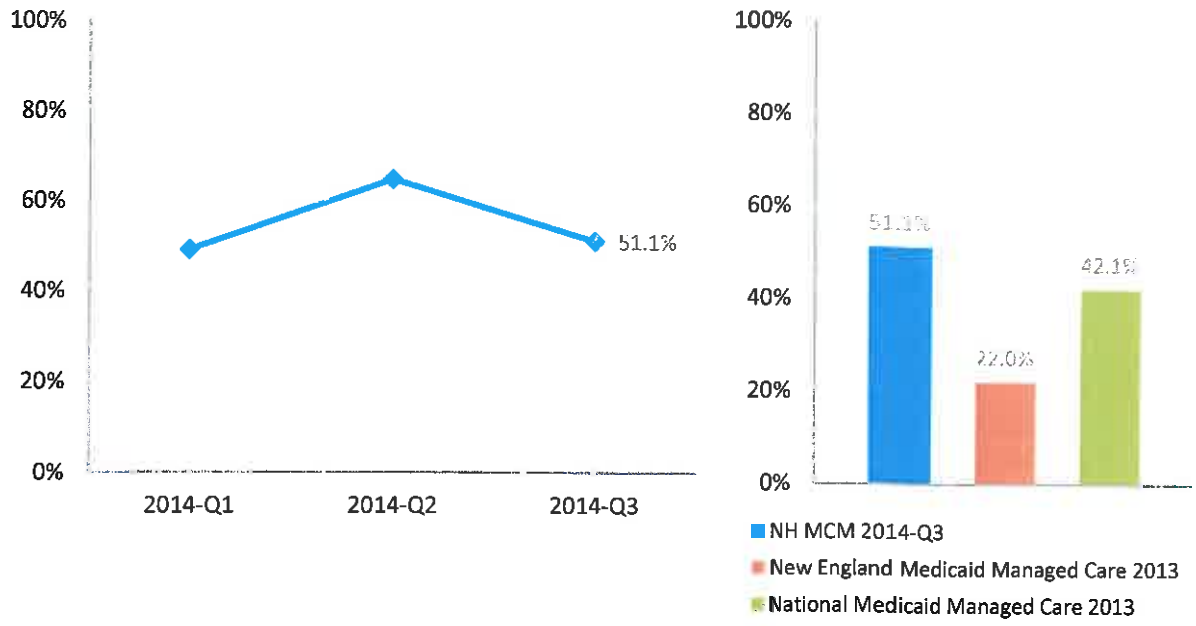
Introduction

Behavioral Health Care includes key indicators in the following areas:

- New Hampshire Hospital Discharges
- Behavioral Health Survey

New Hampshire Hospital Discharges

Figure 8-1: New Hampshire Hospital Members with Follow-up Appointment 7 Calendar Days Post Discharge

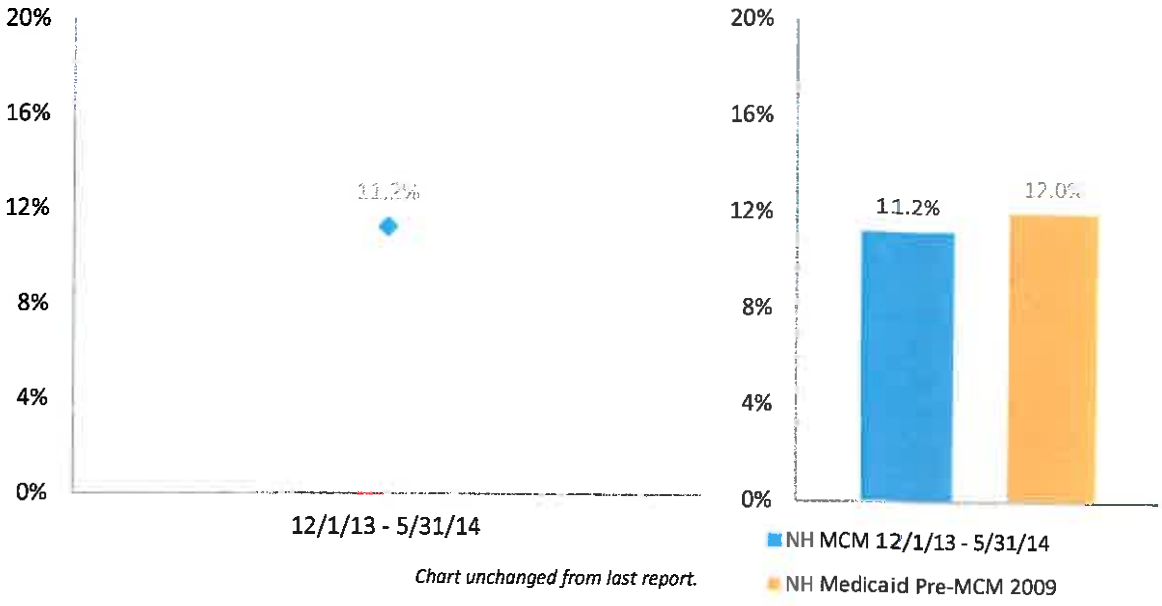


Description: A follow appointment within 7 days of discharge from a New Hampshire Hospital can help ensure that a member continues to improve and stays well after discharge. A low or falling number of follow up appointments within 7 days could indicate that better discharge planning is needed. This measure describes the number of adult members who were discharged from New Hampshire Hospital and followed-up with a provider within 7 days of discharge, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

Frequency: Reported quarterly, available approximately 3 months after end of the quarter.

Comparator Description: The New England and national Medicaid data source is the *NCQA 2014 Quality Compass.* The MCM data includes populations served by New Hampshire Hospital that are not included in the comparison data.

Figure 8-2: Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members



Description: Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to an outpatient care setting. A high or increasing number of readmissions could indicate that better discharge planning is needed. This measure describes the number of adult members who were readmitted to New Hampshire Hospital within 30 days, divided by the total number of members discharged from New Hampshire Hospital, as a percentage.

Frequency: Reported annually, available approximately 3 months after end of the state fiscal year.

Comparator Description: The NH FFS data source was compiled for the national Medicaid Medical Directors Network. The comparison data measures all mental health readmissions as well as additional populations that are not included in the Medicaid Care Management program, such as members who are not mandatory or who opted out of the program.

Behavioral Health Survey

Annual Behavioral Health Annual Survey

(Available Summer 2015)

Description: This narrative report will describe results from a consumer satisfaction survey from members with behavioral health conditions. Substance Abuse and Mental Health Services Administration (SAMHSA) tools and methodology will be used.

Frequency: Collected annually and available approximately in August.

New Notable Results

- The rate of follow-up appointments after a discharge from NH Hospital has decreased, which is attributable to one MCO. While the overall rate remains higher than New England and national Medicaid managed care rates, the Department is working to better understand this measure. (Figure 8-1)

DOMAIN: Substance Use Disorder Care

Introduction

Substance use disorder (SUD) services will be initiated in phases with the start of the New Hampshire Health Protection Program (NHHPP). When implemented, Substance Use Disorder Care will include key indicators in the following areas:

- Rate of Substance Use Disorder Service Users and Utilization in NHHPP Population
- Use of the ED for SUD conditions in NHHPP and Existing Medicaid Population

Substance Use Disorder Services Users and Utilization

- Overall Rate of Any SUD Service
- Outpatient Counseling
- Medically Monitored Withdrawal
- Opioid Treatment Center
- Use of Buprenorphine
- Partial Hospitalization
- Intensive Outpatient Treatment
- Inpatient Withdrawal
- Rehabilitation
- Mobile Crisis Intervention
- Office Based Crisis Intervention

(Measures available beginning June 2015)

Use of the ED for SUD in the NHHPP and Existing Medicaid Population

(Available June 2015)

New Notable Results

Data is not yet available.

DOMAIN: General

Introduction

The General domain includes key indicators in the following area:

- External Quality Review Organization (EQRO) Technical Report

External Quality Review Organization Technical Report

Annual Report: EQRO Technical Report

Description: An External Quality Review Organization is an independent entity ensuring compliance with federal and state regulations and quality outcomes. HSAG, Inc. is the EQRO for the New Hampshire MCM program. The EQRO Technical report is an annual detailed report describing MCO data aggregation and analysis and the way in which MCO conclusions were drawn regarding the timeliness, quality, and access to care furnished by the managed care organization.

Frequency: Annual in November. The 2014 EQRO Technical Report is available and can be downloaded from: http://www.dhhs.state.nh.us/ombp/quality/documents/eqro-tech-rpt.pdf

New Notable Results

Appendix A

Acronym List

APRN	Advanced Practice Registered Nurse
CAHPS	Consumer Assessment of Healthcare Providers and Systems; a national consumer satisfaction survey
DME	Durable Medical Equipment
EQR	External Quality Review
EQRO	External Quality Review Organization; the State of New Hampshire's current EQRO is HSAG, Inc.
FFS	Fee For Service
HEDIS	Healthcare Effectiveness Data and Information Set; a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance
MCM	Medicaid Care Management
MCO	Managed Care Organization
NEMT	Non-Emergency Medical Transportation
PT/OT/ST	Physical Therapy/Occupational Therapy/Speech Therapy
Q1	Quarter 1: January 1 – March 31
Q2	Quarter 2: April 1 – June 30
Q3	Quarter 3: July 1 – September 30
Q4	Quarter 4: October 1 – December 31
SAMHSA	Substance Abuse and Mental Health Services Administration
SFY	State Fiscal Year
SUD	Substance Use Disorder

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