



# New Hampshire Medicaid Care Management Quality Performance Report

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*Key Indicators – November 2014*

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

October 31, 2014

*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*

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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.

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 is developing focused reports and a web-based reporting system allowing user directed reports.

### *Quality Domains*

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- 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

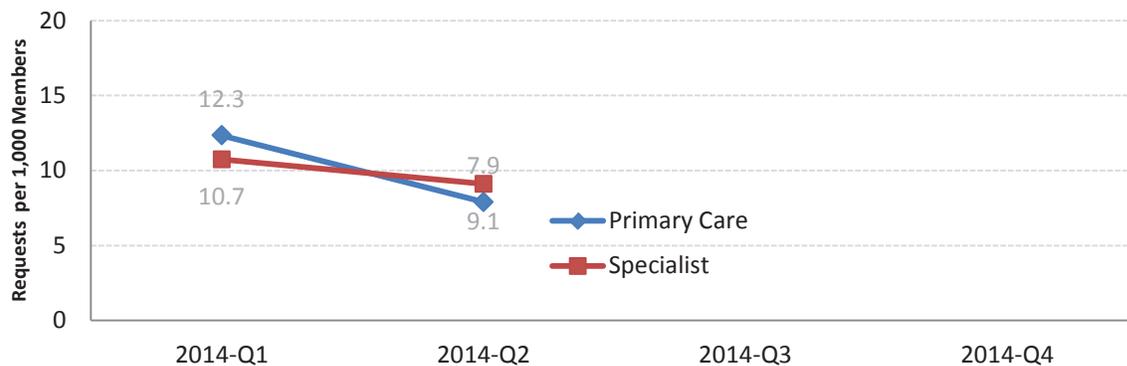
### Introduction

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

- Provider Network
- Ambulatory Care
- Non-Emergent Medical Transportation
- Inpatient Care
- Pharmacy

### Provider Network

**Figure 1-1: Member Request for Assistance Accessing Providers**



**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 1000 members there were 11 individual requests for assistance in accessing a specialist.

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

### **Figure 1-2: Member to Provider Ratio**

(Previously reported data is being reviewed.)

Description: Access to care is an important first step in meeting health care needs. A high or rising ratio of members to providers could indicate an inadequate provider network and could increase member difficulty accessing care. This measure describes the average number of members, divided by the number of primary care doctors, pediatricians, and maternity providers.

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

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

(Measure Available January 2015)

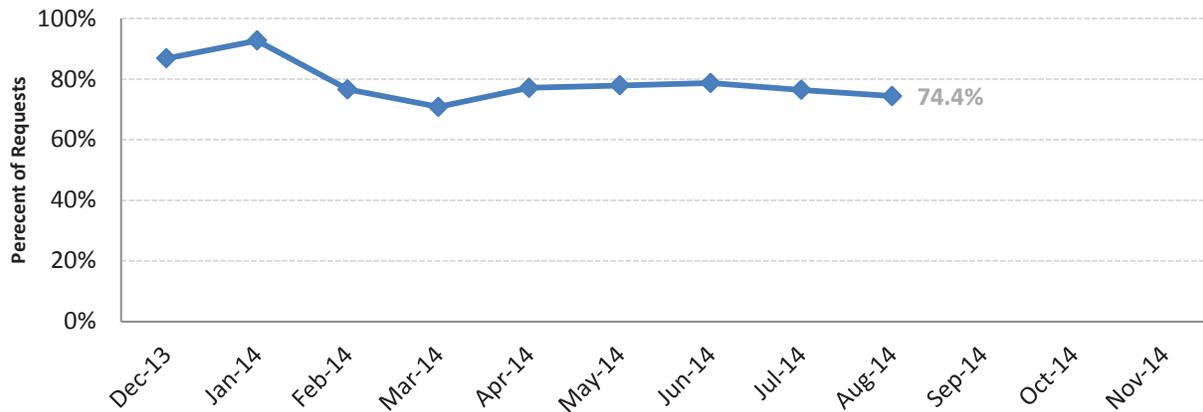
Description: Access to care is an important first step in meeting health care needs. A high or raising ratio of members to providers could indicate an inadequate provider network and could increase member difficulty accessing care. This measure describes the average number of members, divided by the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

Frequency: Reported quarterly, available approximately 3 months after end of the quarter. First available January 2015.

## Non-Emergent Medical Transportation

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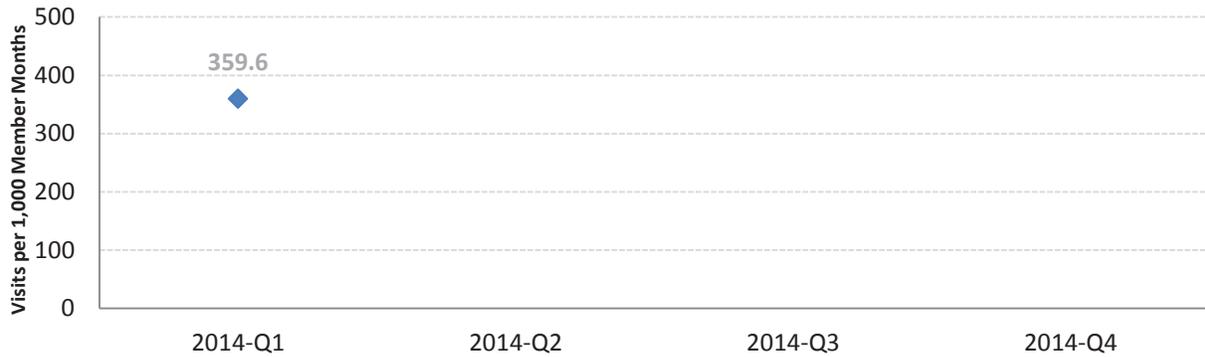
**Figure 1-4: Transportation Requests Approved and Delivered**



**Description:** A lack of transportation can be a barrier to accessing health services. A low or falling rate of requests for approved transportation that have been made, but not approved or not delivered could indicate that transportation needs are not being met. This measure describes the number of non-emergent requests for transportation approved and delivered, 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.

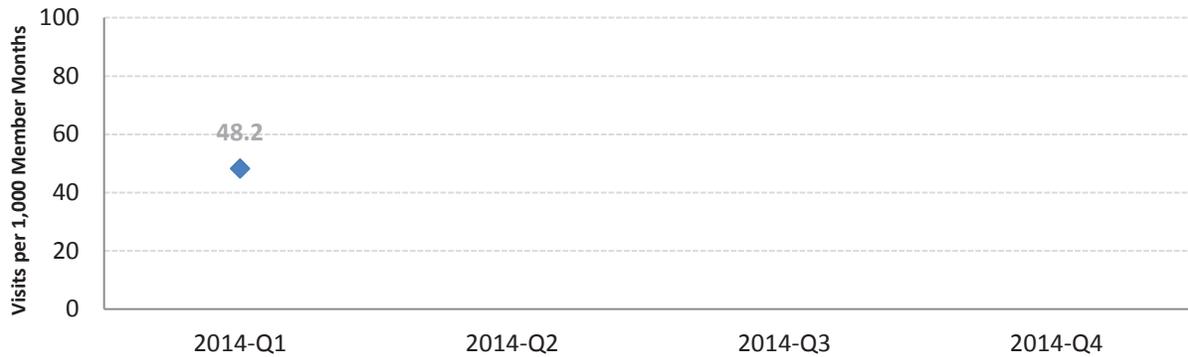
**Figure 1-5: Physician and ARNP Clinic Visits**



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 the rate that can be compared.

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

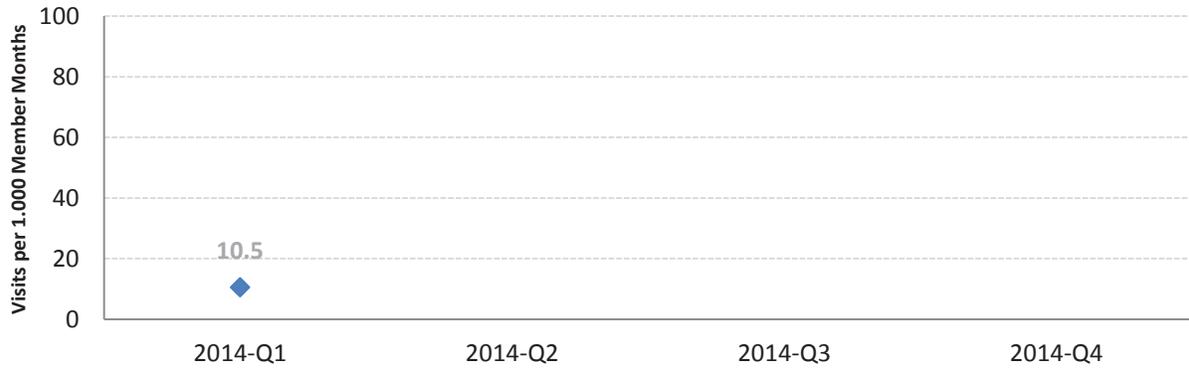
**Figure 1-6: Emergency Department Visits**



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 the rate that can be compared.

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

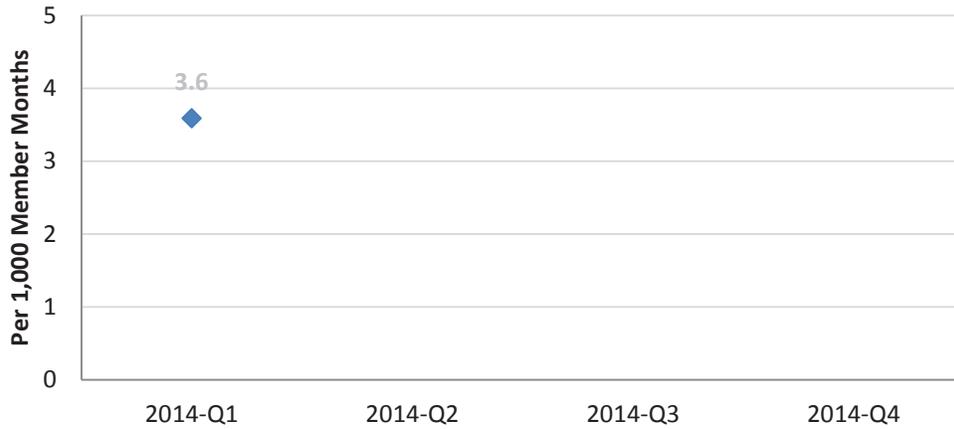
**Figure 1-7: Emergency Department Visits Potentially Treatable by Primary Care**



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, as a per member per month. 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 the rate that can be compared.

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

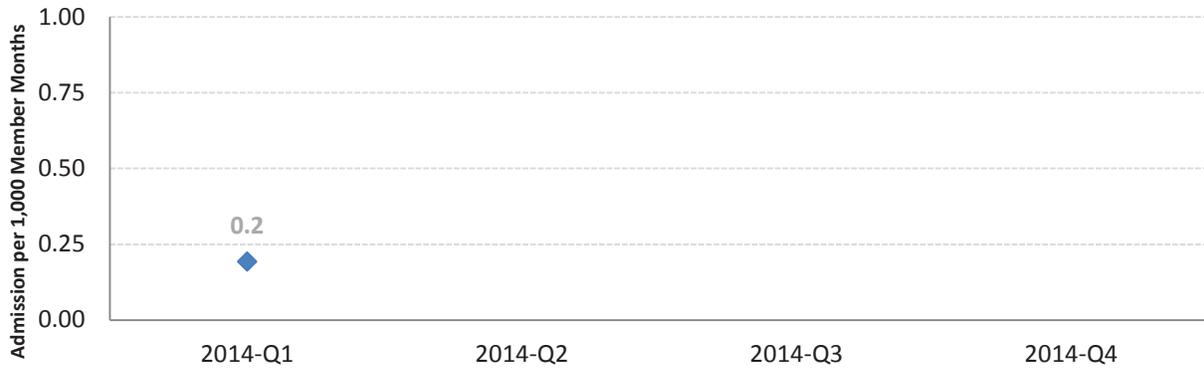
**Figure 1-8: Inpatient Hospital Utilization Summary**



Description: Measuring hospital admissions is a standard industry approach to better understand the use of acute (hospital) health services, excluding maternity. 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 the rate that can be compared.

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

**Figure 1-9: Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members**



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 the rate that can be compared.

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

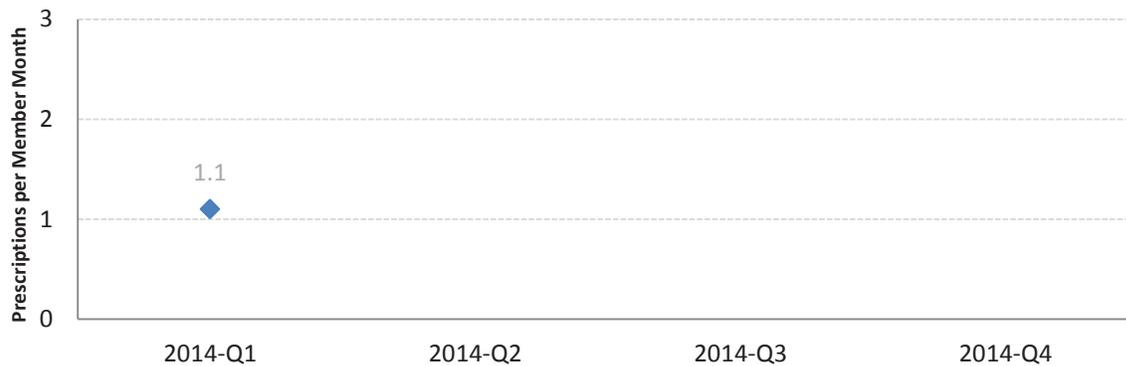
**Figure 1-10: All Cause Readmissions within 30 Days**

(Available Summer 2015)

Description: Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to the next care setting, either to another medical facility or home. 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 a hospital for any reason within 30 days of discharge, divided by the total number of members discharged from a hospital, as a percentage.

Frequency: Reported annually.

**Figure 1-11: Prescriptions Filled**



Description: Measuring the number of prescriptions filled is a standard industry approach to better understand the use of pharmacy services. This measure describes the number of prescriptions filled divided by the total member months, as per member per month. 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.

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

### *New Notable Results*

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- Requests for both Primary Care and Specialists are trending downward suggesting members have an increasing understanding of how to access care in their MCO's network. (Figure 1-1)
- 25.6% of August transportation requests were not approved or not delivered. (Figure 1-4) The most common reason transportation was not delivered, was that the ride was delivered in the following month, and not represented in the month it was requested. The Department is reviewing this measure with changes anticipated in early 2015. Rides that are not delivered will be categorized in part to include:
  - Ride cancelled by member
  - Ride cancelled by the provider;
  - The member failed to show up for transportation, or
  - The provider of transportation failed to show up.
- 99.1% of transportation request in Quarter 2 of 2014 have been approved.

- Data Notes:
  - Member to Provider Ratio – previously reported data is undergoing correction. (Figure 1-2)

## DOMAIN: Customer Experience of Care

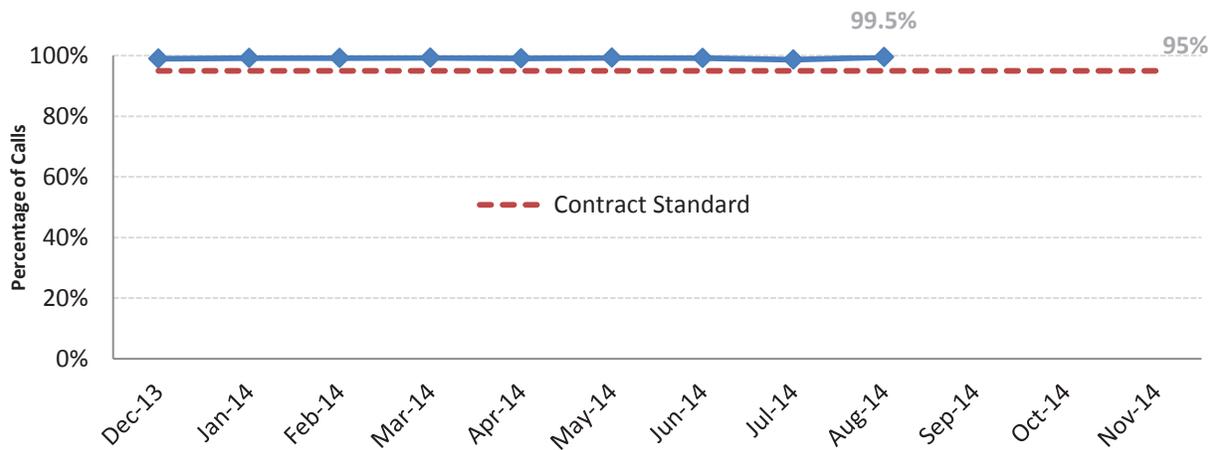
### Introduction

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

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

### Member Call Center

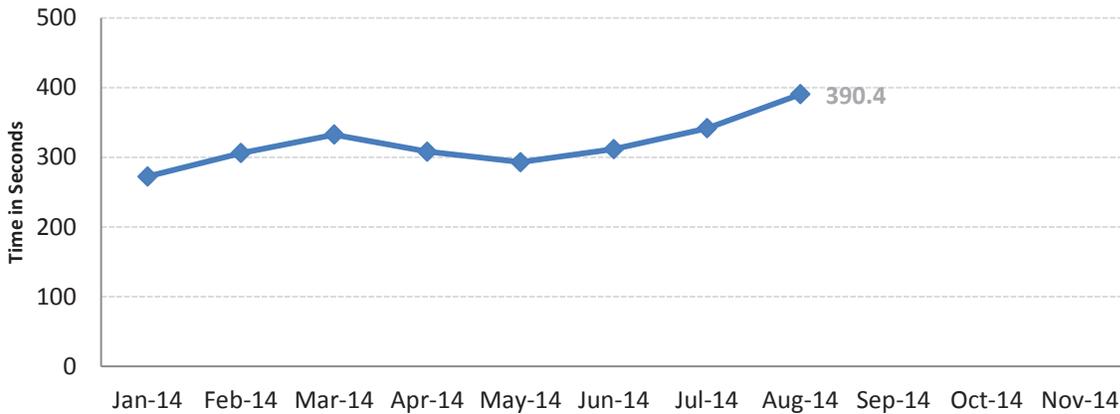
**Figure 2-1: Calls Answered in 30 Seconds**



**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.

**Figure 2-2: Average Call Time**



Description: Overall call time is an important component of a good customer experience of care. A rising average call time could indicate problems within a call center. This measure describes the average number of seconds for a member’s call with the MCO.

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

### *Customer Satisfaction Survey*

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#### **Annual CAHPS Report**

**(Available Winter 2014, then annually in summer starting in 2015)**

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standard national tool that measures member satisfaction with their health care. DHHS is performing a CAHPS survey to measure year one satisfaction with the MCM program with results available in the winter of 2014. The MCOs will administer the survey beginning January 2015 and each January thereafter, with results available the following summer.

The CAHPS survey provides statistically valid measurement of members’ satisfaction and experience with care including these key areas:

- Member’s overall rating of their own health,
- Satisfaction with health plan, personal doctor, specialist seen most often, and the health plan,
- Satisfaction with health plan customer service,
- Satisfaction with ability to access needed care, and
- Satisfaction with how well doctors communicate and shared decision making.

### *New Notable Results*

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- Member calls are being answered quickly and within MCM contract standards. (Figure 2-1)
- Member average calls times are increasing. The Department will monitor this trend. (Figure 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

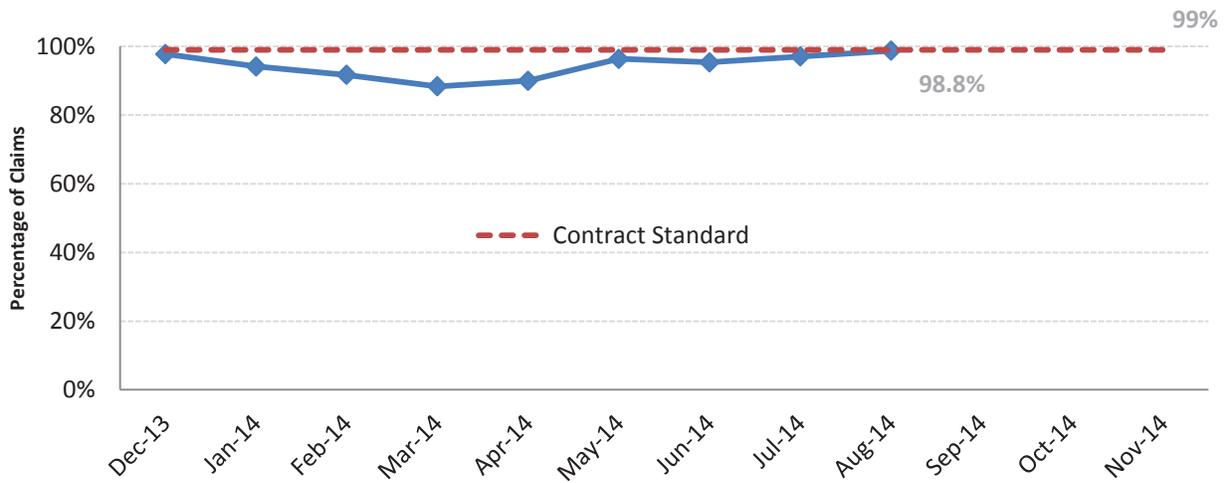
**Figure 3-1: Professional and Facility Claims Processed in 30 Days**



**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 and member experience of service. This measure is a federal requirement for all Medicaid programs. The MCM contract standard for this measure is 99%. 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.

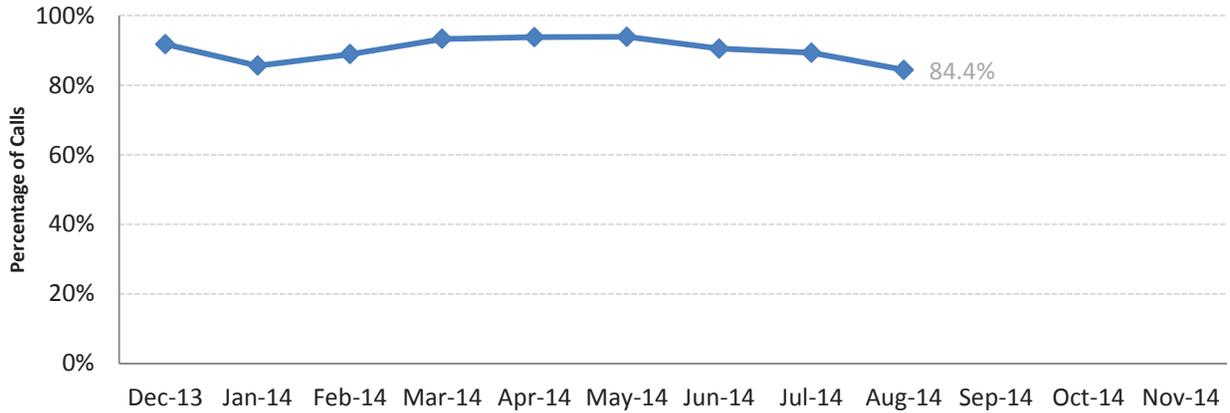
**Figure 3-3: Claims Processing Accuracy**



**Description:** Paying claims accurately is an important component of a good provider service experience. A falling number of claims paid accurately may indicate health plan payment system problems that need to be addressed. The MCM contract standard for this measure is 95%. 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.

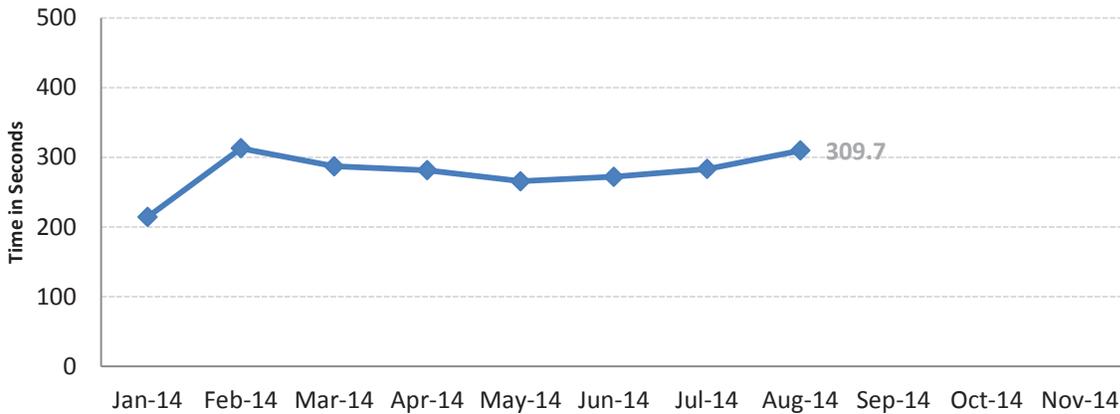
**Figure 3-4: Calls Answered in 30 Seconds**



**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 3-5: Average Call Time**



Description: Overall call time is an important component of a good provider service experience. A rising average call time could indicate problems within a call center. This measure describes the average number of seconds for a provider’s call with the MCO.

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

### *Provider Satisfaction Survey*

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#### **Annual Provider Satisfaction Report**

(Available Winter 2014)

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*

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- Clean provider claims are being paid, accurately and within MCM contract standards for timeliness. (Figure 3-1 and 3-3)

- The trend in answering provider calls within 30 seconds is downward indicating that a rising number of calls are being answered in more than 30 seconds. The Department will monitor this trend. (Figure 3-4)

## DOMAIN: Utilization Management

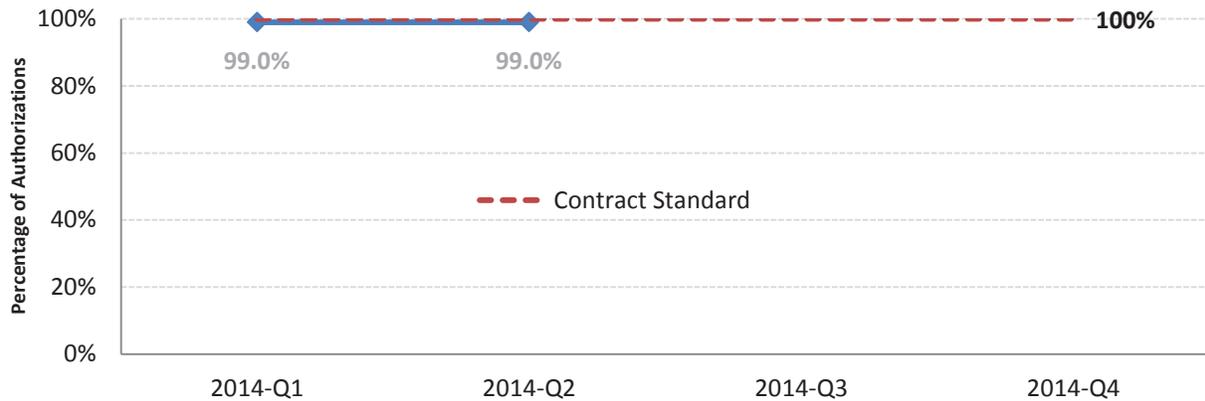
### Introduction

Utilization Management includes key indicators in the following areas:

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

### Service Authorization Processing

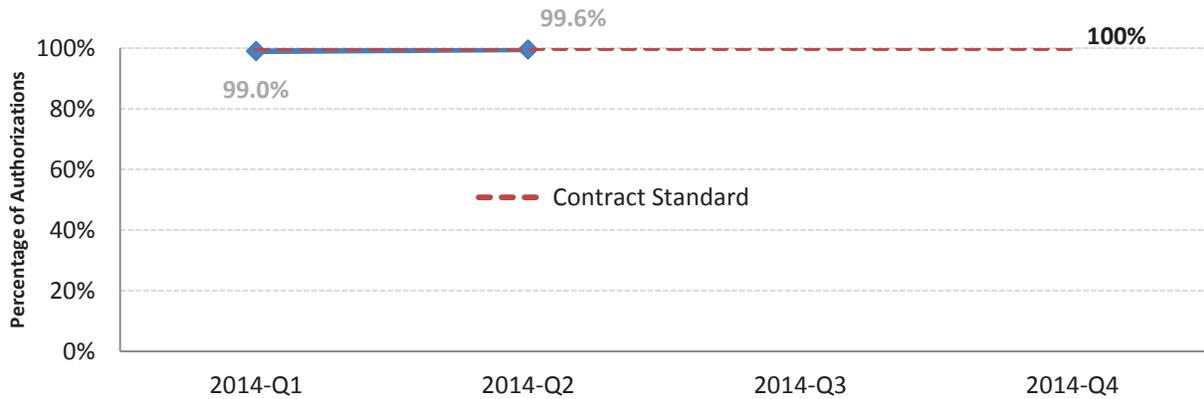
**Figure 4-1: Urgent Medical Service Authorization Processing Rate**



**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.

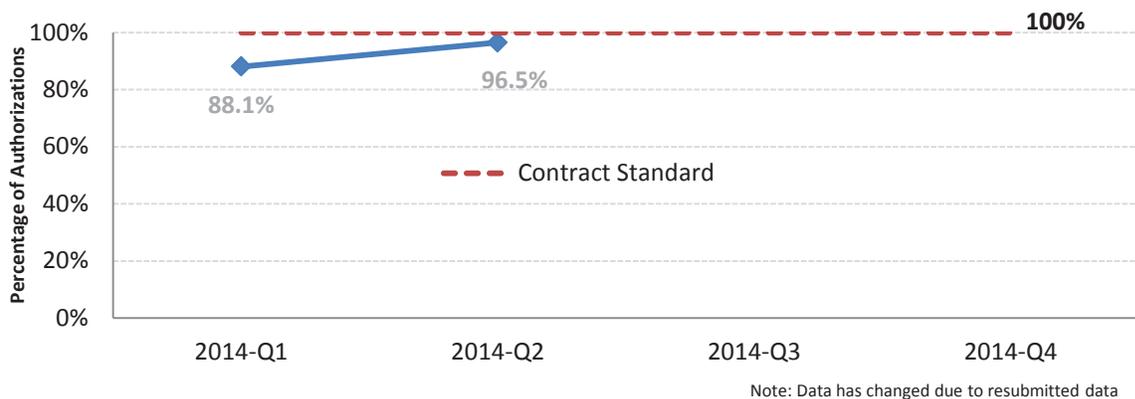
**Figure 4-2: Routine Medical Service Authorization Processing Rate**



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 needed, 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.

*Service Authorization Determinations*

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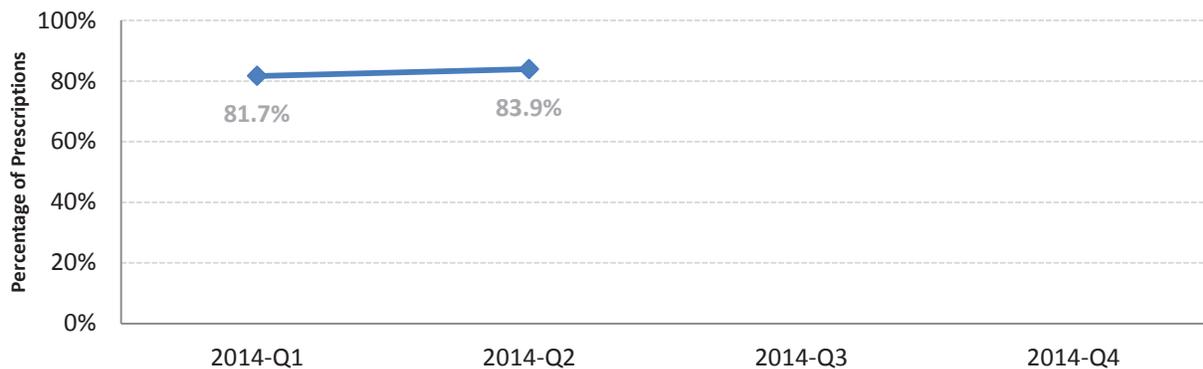
**Figure 4-4: Service Authorization Requests and Benefit Decisions by Type of Service**

| Average Membership         | 2014 Q1  |                 |               | 2014 Q2  |                 |               |
|----------------------------|----------|-----------------|---------------|----------|-----------------|---------------|
|                            | Requests | Approval Rate % | Denial Rate % | Requests | Approval Rate % | Denial Rate % |
| <b>All Services</b>        | 102,067  | 85.1            | 6.3           | 153,257  | 86.5            | 6.7           |
| <b>Selected Services</b>   |          |                 |               |          |                 |               |
| PT/OT/ST                   | 3,984    | 85.9            | 7.3           | 5,553    | 87.5            | 7.4           |
| NEMT                       | 21,887   | 98.6            | 1.3           | 37,448   | 99.1            | 0.4           |
| Pharmacy                   | 10,440   | 79.2            | 14.1          | 14,119   | 82.0            | 12.0          |
| Physician/Medical Services | 22,896   | 78.7            | 8.0           | 33,729   | 78.7            | 9.9           |
| Private Duty Nursing       | 420      | 81.4            | 2.6           | 640      | 85.9            | 4.4           |
| Personal Care Attendant    | 93       | 78.5            | 1.1           | 120      | 78.3            | 7.5           |

**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.

**Figure 4-5: Generic Drug Utilization Adjusted for Preferred Brands**



**Description:** Measuring generic drug use is a standard industry approach to better understand pharmacy services utilization. This measure describes the number of generic prescriptions filled, divided by the total number of prescriptions filled, as a percentage. This measure does not include generics on the non-preferred list.

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

### *New Notable Results*

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- Urgent and routine service authorizations are being processed very close to MCM contract standards for timeliness. (Figure 4-1 and 4-2)
- The pharmacy service authorization processing rate is trending upward toward the contract standard. The Department will continue to monitor this indicator. (Figure 4-3)
- An increase in the service authorizations, both approvals and denials, reflects the close of the initial 90 day transition into the MCM program. (Figure 4-4) The health plans have begun to review services according to DHHS approved utilization management policies. An increase in denials may represent more appropriate utilization management.
  - In Quarter 2, the health plans received 37,448 requests for NEMT. The percentage of denied requests for NEMT has decreased from Quarter 1 to Quarter 2. Initial denials for NEMT were in part due to a lack of adherence to prior authorization procedures. A reduction in denials may represent an increasing understanding in how to access services from the MCOs.

- While the number of therapies reviewed increased from Quarter 1 to Quarter 2, the percentage of denied requests for therapies has remained essentially the same from Quarter 1 to Quarter 2.
  - The percentage of denied requests for drugs has increased. The Department will continue to monitor this trend.
- Generic drug utilization is increasing and could contribute to program cost savings. (Figure 4-5)

## DOMAIN: Grievances and Appeals

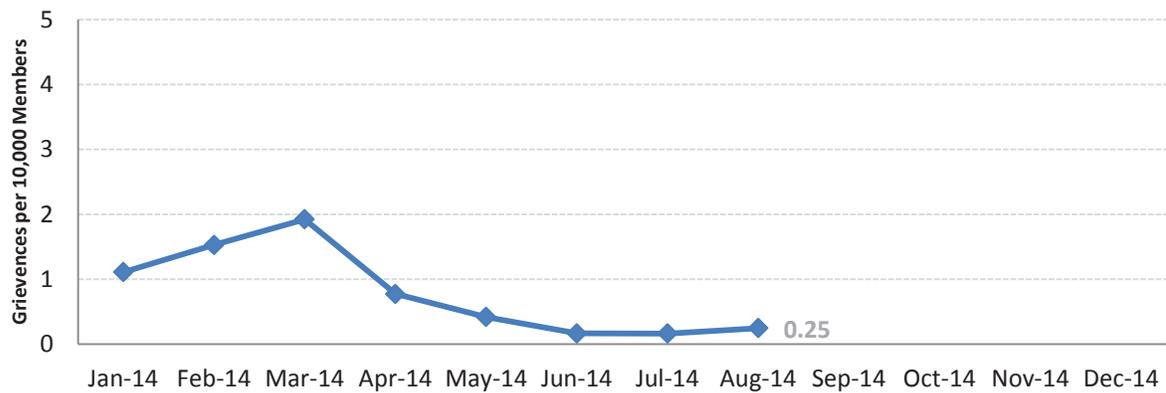
### Introduction

Grievances and Appeals include key indicators in the following areas:

- Counts
- 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. For ease of presentation, the rate is shown per 10,000 members. For example, a rate of 1 grievance would indicate that out of every 10,000 members there was 1 individual filing of a grievance.

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

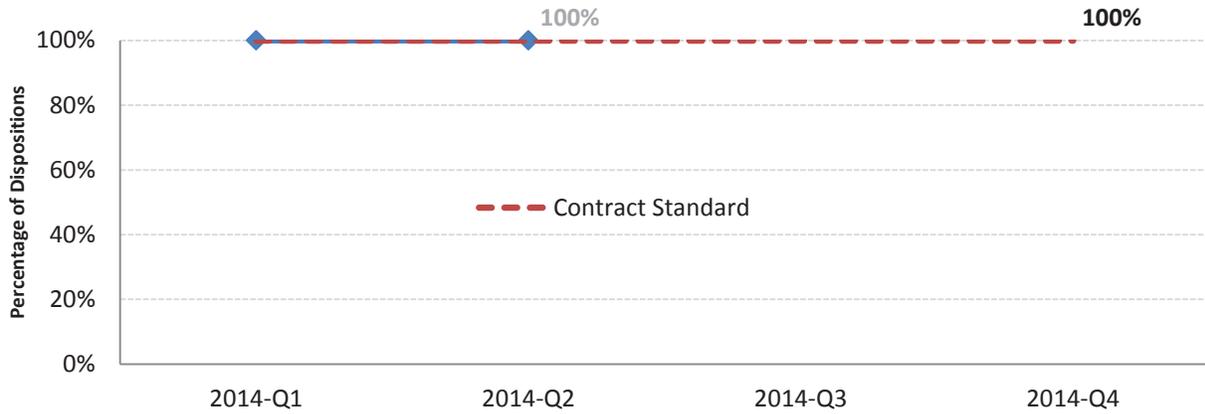
**Figure 5-2: Number of Appeals**

|                          | 2014 Q-1   | 2014 Q-2   |
|--------------------------|------------|------------|
| <b>All Services</b>      | <b>275</b> | <b>464</b> |
| <b>Selected Services</b> |            |            |
| Inpatient Admissions     | 15         | 7          |
| PT/OT/ST                 | 26         | 21         |
| NEMT                     | 0          | 5          |
| Pharmacy                 | 171        | 375        |
| Private Duty Nursing     | 1          | 0          |
| Personal Care Attendant  | 0          | 0          |

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.

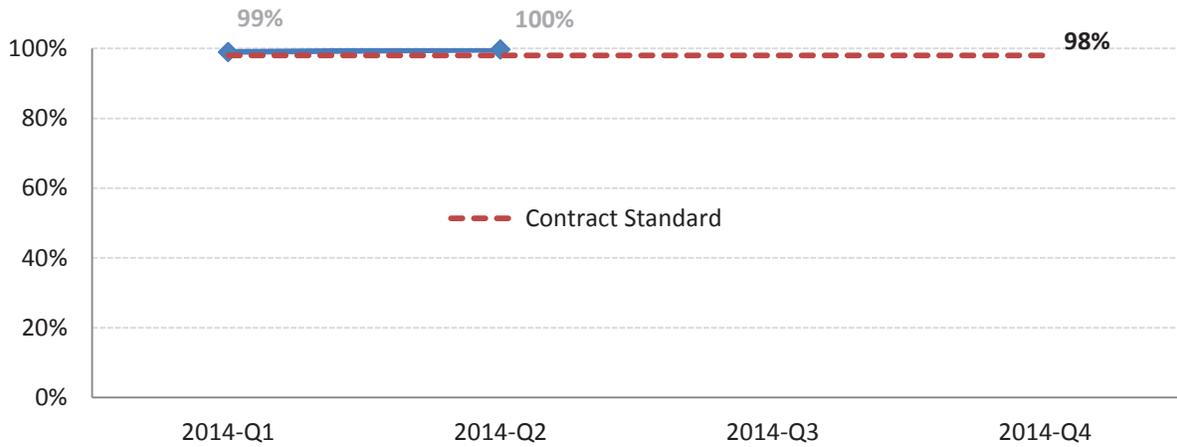
**Figure 5-3: Grievance Dispositions Made in 45 Calendar Days**



**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 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.

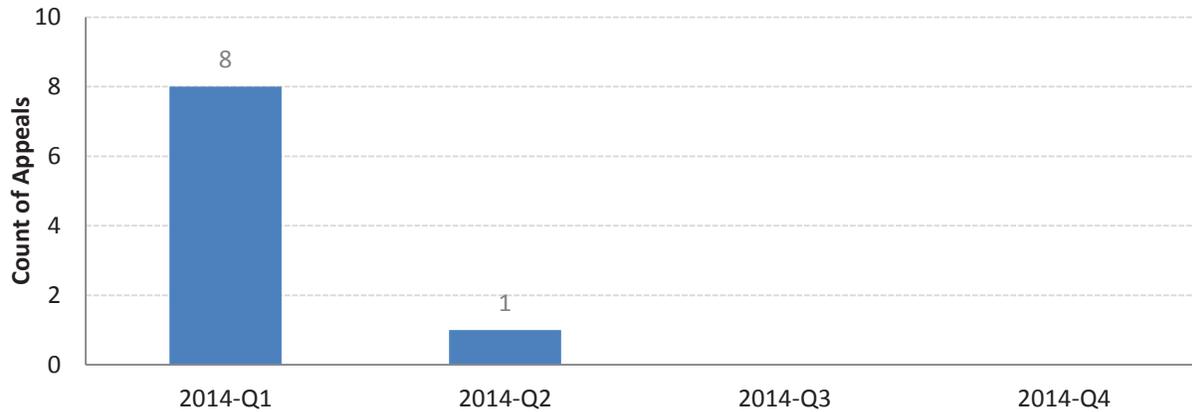
**Figure 5-5: Expedited Appeals Resolved in 3 Calendar Days**



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 lack of satisfaction with the MCOs appeal determination. 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.

- Grievances have decreased. (Figure 5-1)
- Inpatient admission and therapy service appeals have fallen; pharmacy and transportation appeals have increased. The increase in pharmacy appeals primarily relates to a change in one MCO’s pharmacy utilization management. A review of pharmacy service authorizations is underway. The Department will continue to closely monitor this indicator. (Figure 5-2)
- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards. (Figure 5-3 – 5.5)
- There have been nine State Fair Hearing requests for Q1 and Q2 of 2014. All fair hearings requests were either settled prior to the hearing or were withdrawn because of a reversed decision by the MCO. ( Figure 5-6)

## DOMAIN: Preventive Care

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### *Introduction*

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Preventive Care includes key indicators in the following areas:

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

### *Prevention Assessment*

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#### **Figure 6-1: Health Risk Assessment Completed**

(Available March 2015)

Description: Health risk assessments help a health plan to better understand what medical services a member 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. This measure counts the total number of health risk assessments completed.

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

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

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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*

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Data not yet available.

## DOMAIN: Chronic Medical Care

### Introduction

Chronic Medical Care includes key indicators in the following areas:

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

### Pharmacy

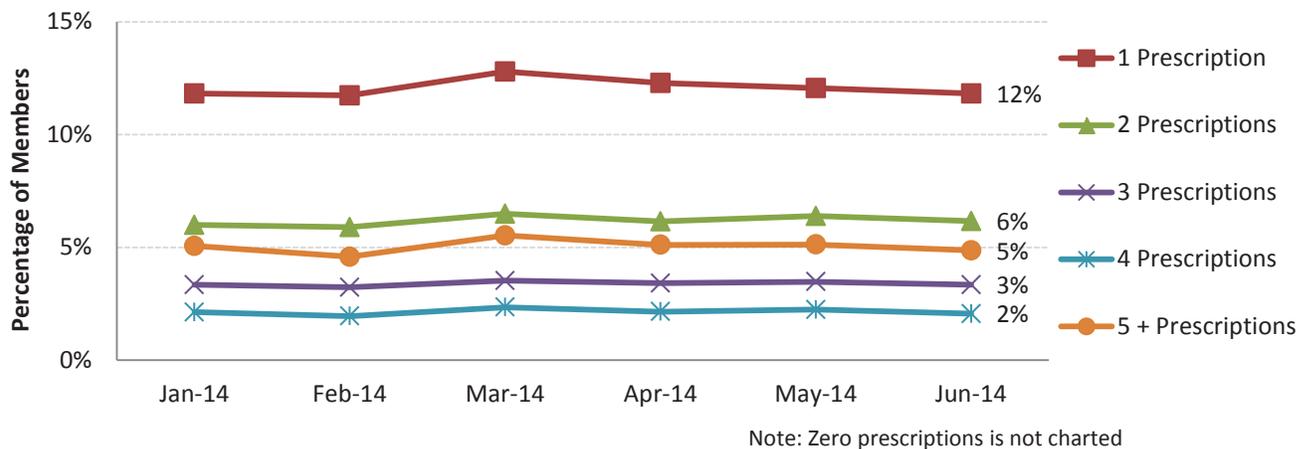
**Figure 6-2: Maintenance Medication Gaps**

(Reported data is being reviewed.)

**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 6-3: 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 filling multiple medication prescriptions, divided by the total number of members enrolled, as a percentage.

Frequency: Reported monthly on a quarterly basis, available approximately 3 months after end of the quarter.

### *Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Measures*

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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*

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- In June, 28% of members filled at least one medication prescription. An increased number of medications used correlates with complex health needs. The Department will review polypharmacy rates with the MCOs. (Figure 6-3)

### *Introduction*

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Behavioral Health Care includes key indicators in the following areas:

- New Hampshire Hospital Discharges
- Behavioral Health Survey

### *New Hampshire Hospital Discharges*

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#### **Figure 7-1: Members with Follow-up Appointment 7 Calendar Days Post Discharge**

(Previously reported data is being reviewed.)

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. One indication of a low or falling number of follow up appointments within 7 days could be 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 mental health practitioner 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.

#### **Figure 7-2: Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members**

(Data is currently being reviewed.)

Description: Hospital readmissions can be an indication of avoidable difficulties transitioning from a hospital to an outpatient care setting. One indication of a high or increasing number of readmissions could be 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 quarterly, available approximately 3 months after end of the quarter.

**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*

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- Data Notes:
  - Members with Follow-up Appointment 7 Calendar Days Post Discharge – The Department is working to assure accurate reporting of this measure. (Figure 7-1)
  - Readmission to New Hampshire Hospital at 30 days -Excluding New Hampshire Health Protection Program (NHHPP) Members - The Department is working to assure accurate reporting of this measure. (Figure 7-2)

## DOMAIN: Substance Use Disorder Care

### *Introduction*

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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:

- Overall Rate of Users of Any SUD Service in NHHPP Population
- SUD Service Utilization by Service
- Use of the ED for SUD conditions in NHHPP and Existing Medicaid Population

#### **Substance Use Disorder Services:**

Overall Rate of Users of Any SUD Service in NHHPP Population.

(Available February 2015)

#### **SUD Service Utilization by 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

(Available February 2015)

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

(Available February 2015)

### *New Notable Results*

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Data not yet available.

## DOMAIN: General

### *Introduction*

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The General domain includes key indicators in the following area:

- External Quality Review Organization (EQRO) Technical Report

### *External Quality Review Organization Technical Report*

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#### **Annual Report: EQRO Technical Report**

(Available November 2014)

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.

The full content of the Technical Report will be available as a stand-alone document.

Frequency: Annual in November.

## Appendix A

### *Acronym List*

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|        |   |
|--------|---|
| 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.   |
| 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  |
| SAMHSA | Substance Abuse and Mental Health Services Administration   |
| SUD    | Substance Use Disorder  |