



New Hampshire Medicaid Care Management Quality Performance Report

Key Indicators – August 2014

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

July 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*

Overview

Introduction

The Medicaid Care Management Quality Program Performance Report presents key indicators that allow monitoring the performance of New Hampshire's Medicaid Care Management (MCM) program. The report is released monthly in order to present the most up to date information that has been generated and validated. Measures will be updated monthly, quarterly and annually.

The indicators are organized into topic areas called domains. The 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. These domains and indicators are the information the Department uses to track performance of the program.

Due to the breadth of the MCM program, the report presents program-wide averages. For all measures additional information is available. Beyond this report, there are additional quality information products for the Medicaid Quality Program in development that will provide more detailed information either in the form of reports focusing on specific topic areas or through a coming web-based reporting system.

Quality Domains

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

DOMAIN: Access & Use of Care

Provider Network

Figure 1-1: Member Request for Assistance Accessing Providers

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 counted in the rate. For ease of presentation, 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.



Figure 1-1

Figure 1-2: Member to Provider Ratio

This measure describes the average number of members, divided by the number of primary care doctors, pediatricians, and maternity providers.

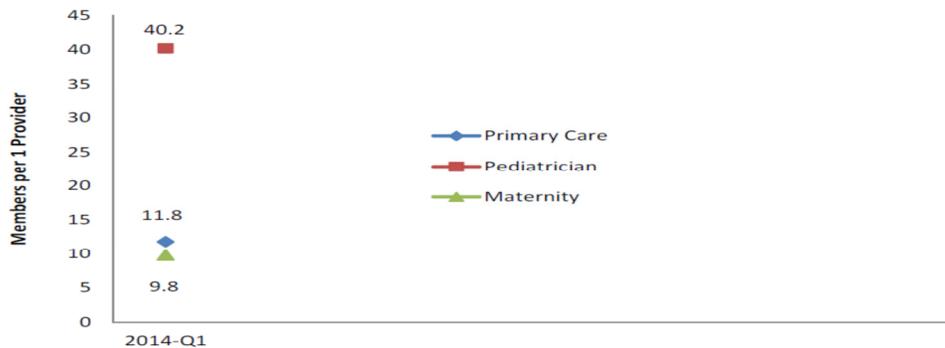


Figure # 1-2

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

This measure describes the average number of members, divided by the number of substance use disorder providers.

(Measure Available December 2014)

Non-Emergent Medical Transportation

Figure 1-4: Transportation Requests Approved & Delivered

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 provider, volunteer driver, member, public transportation, and other.

(Measure Available September 2014)

Ambulatory Care

Figure 1-5: Physician/APRN/Clinic visits

This measure describes the number of provider office visits, divided by the number of member months, as a per member per month rate for the quarter. 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.

(Available September 2014)

Figure 1-6: Emergency Department visits

This measure describes the total emergency department visits, 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.

(Available September 2014)

Figure 1-7: Emergency Department visits potentially treatable by Primary Care

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.

(Available September 2014)

Inpatient Care

Figure 1-8: Inpatient Hospital Utilization Summary

The measure describes the number of admissions to a hospital, divided by the number of member months. The denominator is divided by 100,000 to calculate the rate that can be compared.

(Available September 2014)

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

The measure describes the number of inpatient hospital admissions for ambulatory care sensitive conditions, divided by the number of member months. Ambulatory care sensitive admissions are for conditions that can be impacted (“sensitive”) by the availability, use, and quality of ambulatory (office) care. The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis. The denominator is divided by 100,000 to calculate the rate that can be compared.

(Available September 2014)

Figure 1-10: All Cause Readmissions by 30 days

The 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.

(Available Summer 2015)

Pharmacy

Figure 1-11: Prescriptions Filled Per Member Per Month

This measure describes the number of prescriptions filled divided by the total member months, as a 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. The denominator is divided by 1,000 to calculate the rate that can be compared.

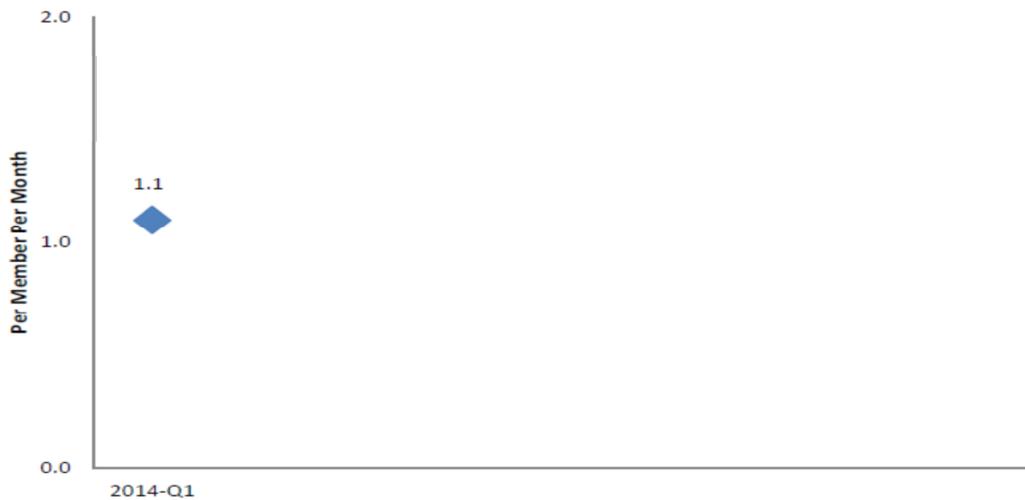


Figure 1-11

Notable Results

- A high number of member calls requesting assistance finding a doctor would be expected at the beginning of a new program like the MCM program.
- There are a high number of members per pediatrician. Other access to pediatricians should be monitored to ensure that members are able to meet their health services needs.

DOMAIN: Customer Experience of Care

Member Communication/Outreach

Figure 2-1: New Member Welcome calls

This measure describes the number of new member calls made during the reporting period.
(Available September 2014)

Member Call Center

Figure 2-2: Calls Answered in 30 Seconds

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. 90% is the MCM contract standard for this measure.

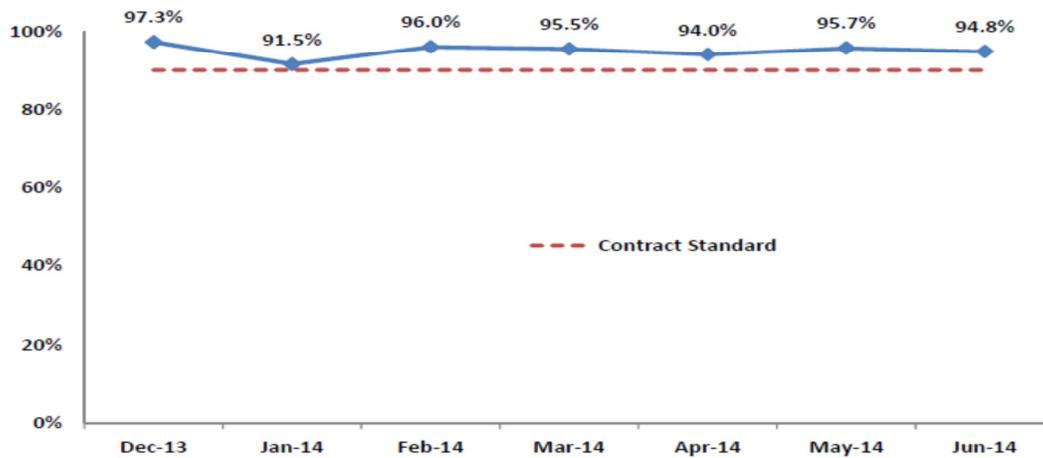


Figure # 2-2

Figure 2-3: Average Hold Time

This measure describes the average number of seconds on hold for calls from a member to their MCO.

(Available September 2014)

Customer Satisfaction Survey

Annual CAHPS Report: (Available Winter 2014, then annually in Summer starting in 2015)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a national standard 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 to be available in the winter of 2014. The MCOs are required to administer the survey beginning January 2015 and each January thereafter, with results available the following summer.

The CAHPS survey provides statistically valid measurement of member's satisfaction and experience with care including these key areas:

- Satisfaction with health plan and providers to include ratings of health care, personal doctor, specialist seen most often, and the health plan itself; and
- Satisfaction with ability to access needed care to include ratings of customer service, getting care quickly, getting needed care, how well doctors communicate, and shared decision making.

Notable Results

- Member calls are being answered quickly and within MCM contract standards.

DOMAIN: Provider Service Experience

Claims Processing

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

This measure describes the number of days when 95% or more of claims received the month before were paid or denied, divided by the number of days in the month, as a percentage. 95% is the MCM contract standard for this measure.

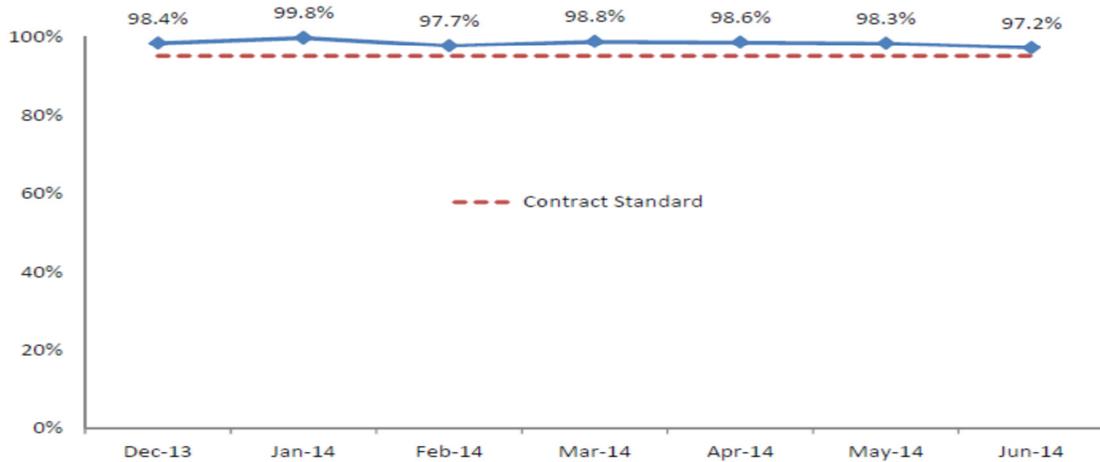


Figure # 3-1

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

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. 99% is the MCM contract standard for this measure.

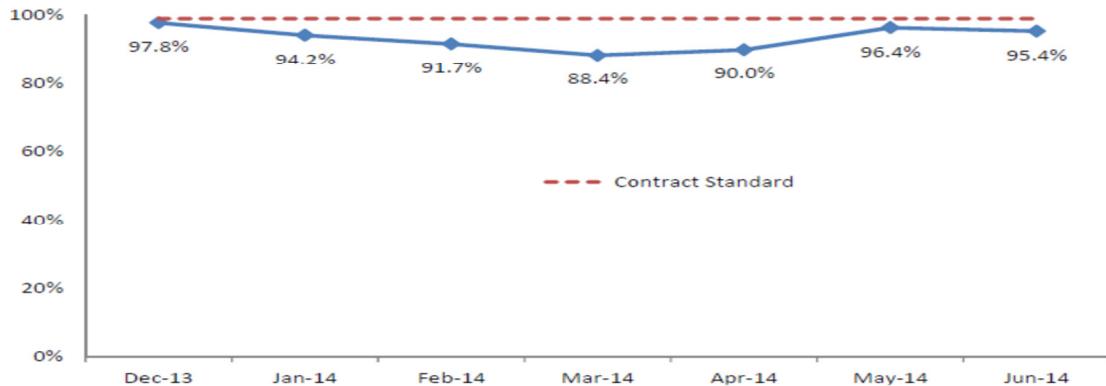


Figure # 3-2

Figure 3-3: Claims Processing Accuracy

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. 95% is the MCM contract standard for this measure.

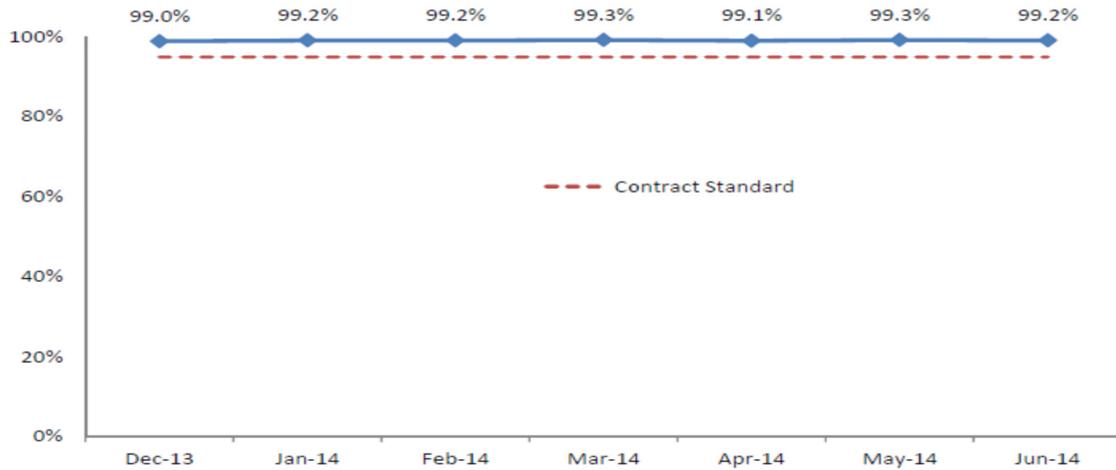


Figure # 3-3

Provider Call Center

Figure 3-4: Calls Answered in 30 Seconds

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.

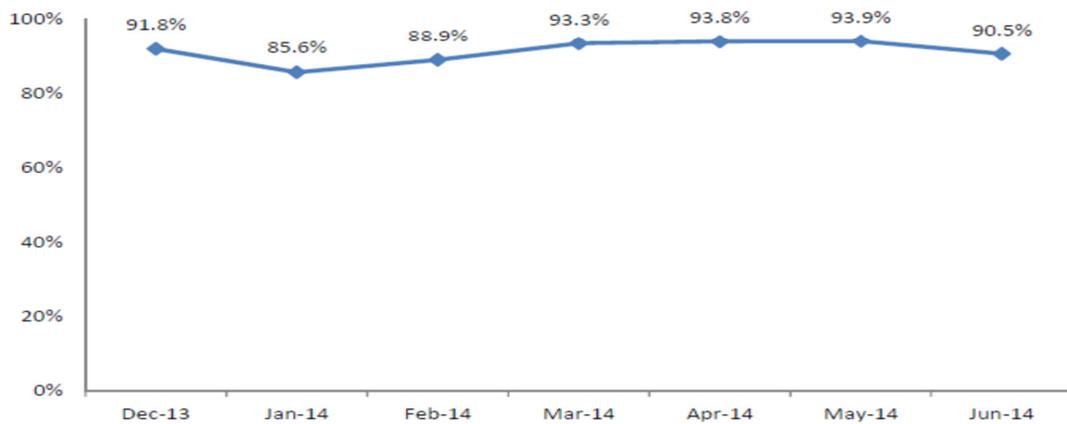


Figure # 3-4

Figure 3-5: Average Hold Time

This measure describes the average number of seconds on hold for calls from a provider to a MCO.

(Available September 2014)

Provider Satisfaction Survey

Annual Report: (Available Winter 2014)

On an annual basis, the MCOs 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.

Notable Results

- Provider claims are being paid quickly, accurately and within MCM contract standards.
- Pharmacy claims are not being paid as quickly as the contract standard requires. For the first three months of the MCM program, most pharmacy claims were process based on previous fee-for-service Medicaid program approvals. After the first three months, the MCOs approved all pharmacy claims. This system slowing is trending upward but will be closely monitored.
- Provider calls are being answered quickly and within industry standards.

Service Authorization Processing

Figure 4-1: Urgent Medical Service Authorization Processing Rate

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. Urgent authorizations require a decision within 72 hours. 100% is the MCM contract standard for this measure.



Figure 4-1

Figure 4-2: Routine Medical Service Authorization Processing Rate

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. Routine authorizations require a decision within 14 calendar days. 100% is the MCM contract standard for this measure.

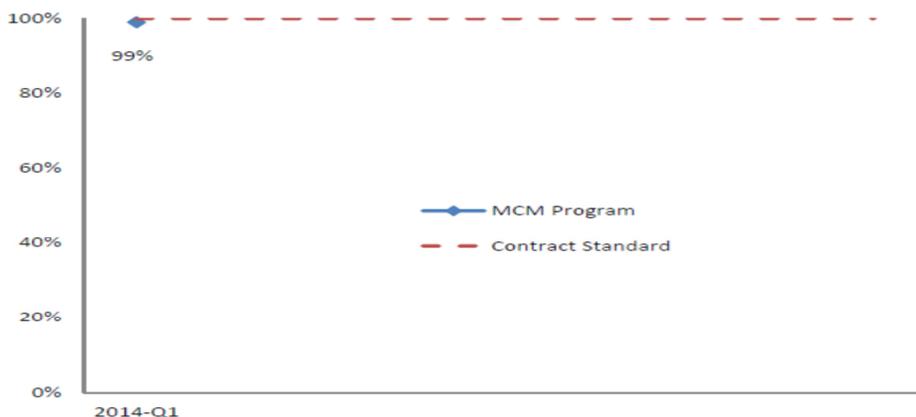


Figure 4-2

Figure 4-3: Pharmacy Service Authorization Processing Rate

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. Pharmacy authorizations require a decision within 24 hours. 100% is the MCM contract standard for this measure.

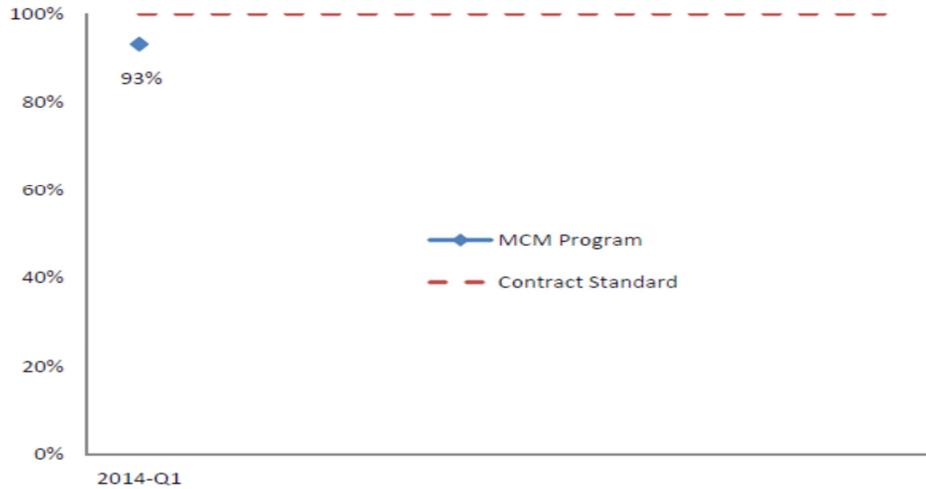


Figure 4-3

Service Authorization Determinations

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

The measures counts the total number of service authorizations received, approved and denied, by selected categories of service. It also includes the number of service authorizations received, approved, and denied by all categories of service.

	Requests	Approval Rate %	Denial Rate %
All Services – 2014 Q1	96,045	84.5	6.4
Selected Services 2014 Q-1			
Inpatient Admissions (Non-surgical)	5,057	87.3	3.0
Inpatient Admissions (surgical)	4,054	82.0	4.9
PT/OT/ST	3,984	85.9	7.3
NEMT	17,104	99.9	0.1
Pharmacy	10,440	79.2	14.1
Private Duty Nursing	420	80.7	2.6
Personal Care Attendant	93	78.5	1.1

Figure 4-5: Generic Drug Utilization Adjusted for Preferred PDL brands

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.

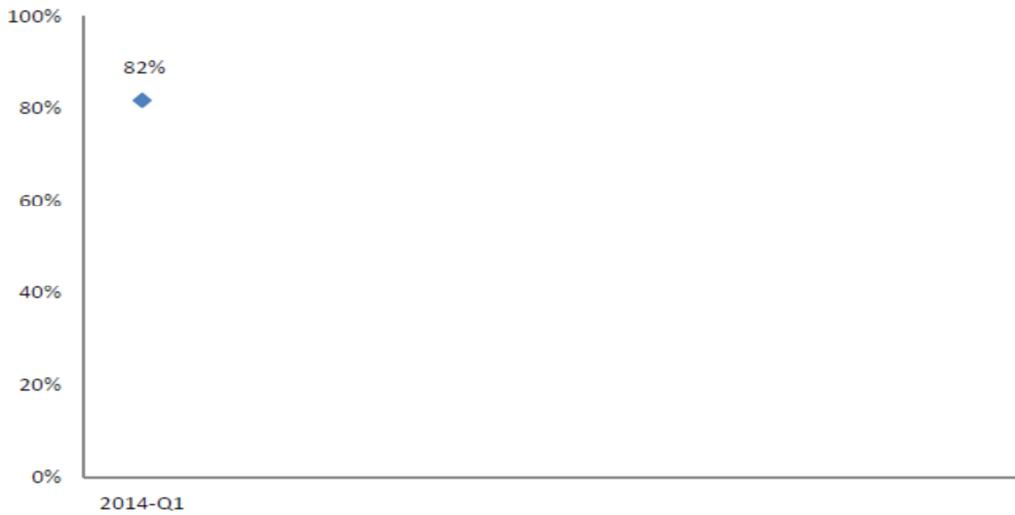


Figure 4-5

Notable Results

- Urgent and routine service authorizations are being processed within MCM contract standards.
- Pharmacy authorizations are not being processed within MCM contract standards. This has been discussed with the MCOs. Ad hoc May data from the MCOs shows an upward trend and improvement for this measure.
- Service authorizations and benefit decisions will be trended over time in future Key Indicator reports.

DOMAIN: Grievance & Appeals

Counts

Figure 5-1: Number of Grievances

This measure counts the total number of grievances received.

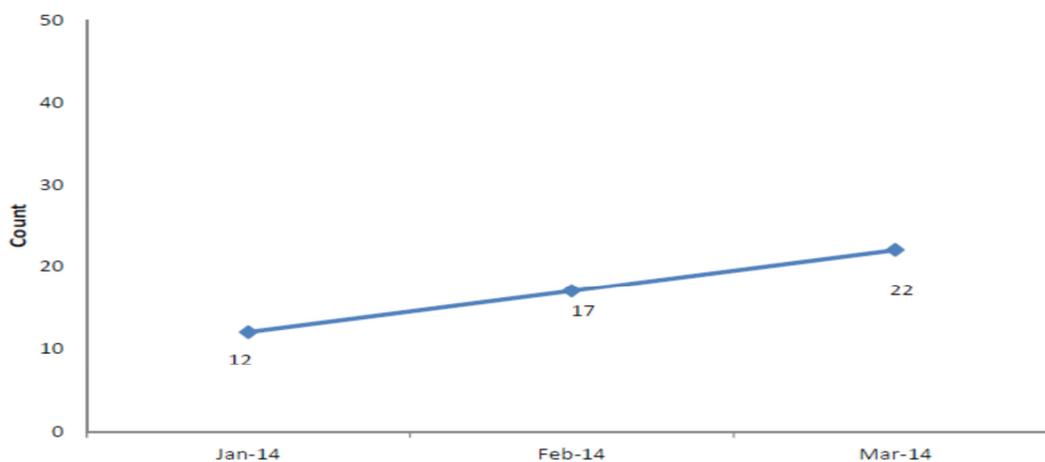


Figure # 5-1

Figure 5-2: Number of Appeals

The measures counts the total number of appeals received, by selected categories of service. It also includes a total of all appeals received.

	2014 Q-1
All Services	275
Selected Services	
Inpatient Admissions	15
PT/OT/ST	26
NEMT	0
Pharmacy	171
Private Duty Nursing	1
Personal Care Attendant	0

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

This measure counts the number of grievances resolved within 45 days, divided by the total number of grievances received, as a percentage. 100% is the MCM contract standard for this measure.

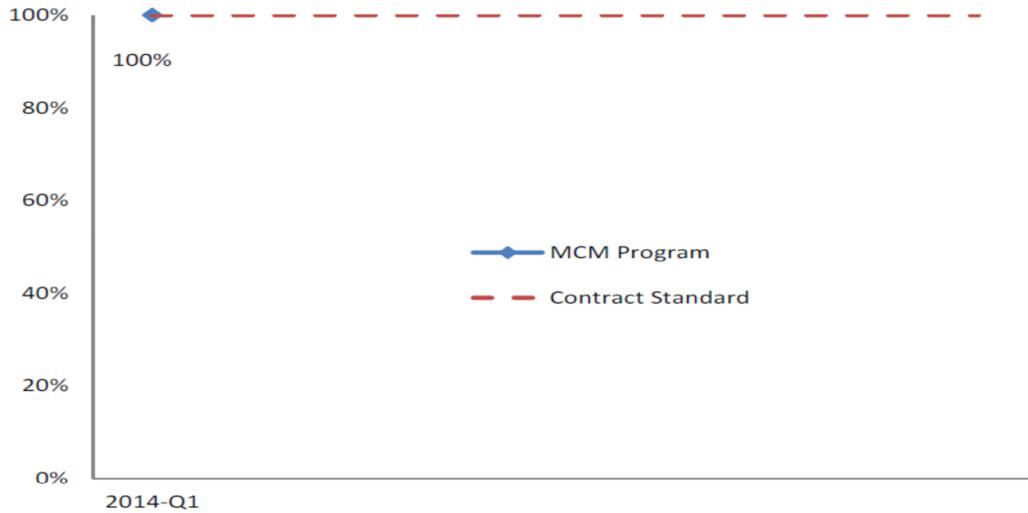


Figure 5-3

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

This measure counts the number of routine appeals resolved within 30 days, divided by the total number of appeals received, as a percentage. Standard appeals require a decision within 30 calendar days. 98% is the MCM contract standard for this measure.



Figure 5-4

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

This measure counts the number of expedited appeals resolved, divided by the total number of expedited appeals received, as a percentage. Expedited appeals require a decision within 3 calendar days. 100% is the MCM contract standard for this measure.

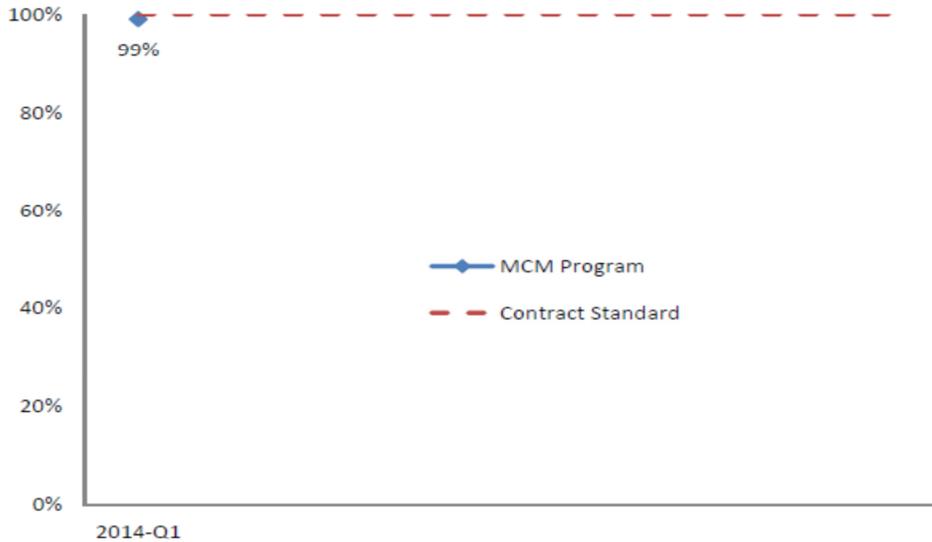


Figure 5-5

Notable Results

- The number of grievances is increasing over time. 57% of the grievances in the first quarter were related to transportation and pharmacy concerns. This upward trend is in part due to members redirecting their concerns to the MCO and not DHHS. The Department is currently engaged in a quality review of pharmacy appeals and grievances. The Department will continue to closely monitor this trend.
- The number of appeals by category of service will be trended in future reports.
- Grievances and appeals (standard and expedited) are being resolved within MCM contract standards.

Prevention Assessment

Figure 6-1: Health Risk Assessment Completions

This measure counts the total number of health risk assessments completed. A health risk assessment helps to describe what health services a member has received or may still need.

(Available March 2015)

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

The Annual Healthcare Effectiveness Data and Information Set (HEDIS) is a national standard tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, including preventive care and services. Altogether, HEDIS consists of 81 measures across 5 domains of care. The results, available annually in the summer, offer New Hampshire the ability to monitor and conduct performance improvement activities related to health outcomes. The 5 domains of care are:

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

Notable Results

Pharmacy

Figure 6-2: Maintenance Medication Gaps

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.

(Available October 2014)

Figure 6-3: Polypharmacy Monitoring for All Medications

This measure describes the number of members taking multiple medications, divided by the number of members, as a percentage. Multiple medications means that a member is taking more than one medication for any disease.

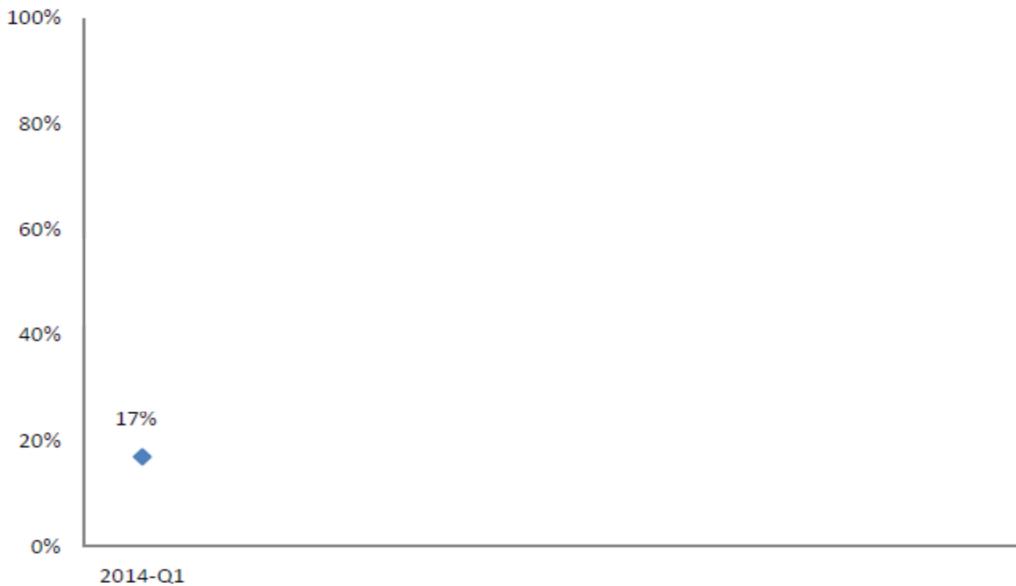


Figure 6-3

Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Measures

The Annual Healthcare Effectiveness Data and Information Set (HEDIS) is a national standard tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, including chronic care and services. Altogether, HEDIS consists of 81 measures across 5 domains of care. The results, available annually in the summer, offer New Hampshire the ability to monitor and conduct performance improvement activities related to health outcomes. The 5 domains of care are:

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

Notable Results

New Hampshire Hospital Discharges

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

The measure describes the number of adult members who were discharged from New Hampshire Hospital and followed-up with a doctor within 7 days of discharge, divided by the total number of members discharged from New Hampshire Hospital, as a percentage. 100% is the MCM contract standard for this measure.

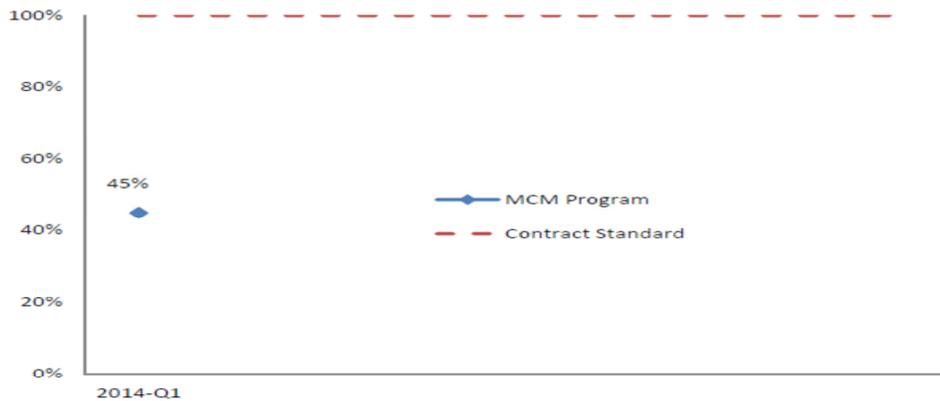


Figure 7-1

Figure 7-2: Readmission to New Hampshire Hospital at 30 days -Excluding NHHPP Members

The 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.

(Available October 2014)

Behavioral Health Survey

Annual Survey

(Available Summer 2015)

Notable Results

- Members discharged from New Hampshire Hospital are not seeing providers within the MCM contract standard of 7 days. Improving follow up with providers is a focus of a

Performance Improvement Project that is outlined in the MCM contract.

DOMAIN: Substance Use Disorder Care

Substance Use Disorder Services: Overall Rate of Users of Any SUD Service in New Hampshire Health Protection Program Population.

Substance use disorder (SUD) services will be initiated in phases with the start of the New Hampshire Health Protection Program.

(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

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

(Available February 2015)

Notable Results

External Quality Review Organization Technical Report

Annual Report: EQRO Technical Report

(Available Winter 2015)

An External Quality Review Organization is an independent entity to ensure 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 standalone document.

Notable Results
