New Hampshire Medicaid Care Management Quality Performance Report

Behavioral Health Parity Monitoring Report – 2019

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

April 2020

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

Following the demonstration of parity compliance by New Hampshire's two Managed Care Organizations (MCOs) in October 2017, the NH Department of Health and Human Services (DHHS) initiated an ongoing parity compliance monitoring plan. The revised full monitoring plan titled *Appendix D: NH DHHS Compliance Monitoring Plan* can be found at: https://www.dhhs.nh.gov/ombp/medicaid/parity.htm.

In the revised plan DHHS leverages the existing Medicaid Care Management (MCM) contract compliance monitoring program to monitor for potential parity issues. Monitoring focuses on access to care for Mental Health (MH) and Substance Use Disorder (SUD) services, which include both lead and lagging indicators. Access to care indicators are established industry standard methods to identify potential issues that may be impacted by MCO policy and process changes. Substantiated access to care issues were evaluated to determine impacts to MCO parity compliance demonstrated in October 2017. The 2019 Behavioral Health Parity Monitoring Report serves as a baseline for annual behavioral health parity reporting in future years.

Contributing to the Department's parity compliance are long-standing New Hampshire Medicaid program features, and recent enhancements.

They include:

1) **Zero-dollar copays for physical and behavioral health services** – State Plan physical and behavioral health services (excluding medications) are available to members at no cost. In addition, migration of the State's Medicaid Expansion program from the Marketplace Exchange to the Department's Medicaid Care Management Program in January 2019 resulted in a significant reduction in member out-of-pocket costs for incoming members.
2) **Low and zero-dollar member drug copays** - Low-cost $1-$2 prescriptions and zero-dollar drug copays for eligible members help contain parity compliance. State Medicaid policy requires pharmacies to fill member medications without regard to a member's ability to pay for their medications. Zero-dollar drug copays are available to self-attesting members.
3) **Behavioral health prescription drug prior authorizations** – Simplified prior authorizations and specialized peer support streamline administrative practices for Community Mental Health Centers. In addition, prior authorization is lifted for certain opioid addiction treatment medication dosing resulting in faster prescription fills for vulnerable members.
4) **Provider rate increases** – In an effort to improve access to care for vulnerable members, recent Medicaid rate enhancements benefit the State's behavioral health providers and helps ensure access to care for the members they serve.

This report for the period demonstrates members do not experience a significant parity variance within the program.

Behavioral Health Parity Certification

The New Hampshire Medicaid Care Management (MCM) contract requires all Managed Care Organizations (MCOs) to submit an annual attestation form signed by the chief executive officer and the chief medical officer in which they certify that the MCO is in compliance with the relevant provisions of the Federal Mental Health Parity Law, regulations, and guidance issued by state and federal entities. All three contracting MCOs submitted this attestation to DHHS for CY2019 in April 2020.

Behavioral Health Parity Monitoring Report

The *Behavioral Health Parity Monitoring Report* provides results and analysis of the leading and lagging indicators from the quality domains that are included in NH's Behavioral Health Parity Compliance Monitoring Plan. The quality domains are described below:

- **Provider Network Adequacy** – These lead indicators can identify when there is a substantial change in the number of specific providers that offer NH Medicaid required services. Changes to the number of providers offering a service can impact NH Medicaid members' ability to access care.
- **Grievance and Appeals** – These lead indicators can identify early warning signs of an access to care issue based on members' satisfaction with the MCO and challenges to an MCO's decision to cover services.
- **Member Access to Care Outcomes** – These lagging indicators are specifically focused on the results of NH Medicaid members accessing care. The measures are a combination of member experience of care surveys and health outcome measures.

Domain Data Periods

The *Behavioral Health Parity Monitoring Report* includes the most recent data available.

Report Domain	NH BH Parity Report 2019
Provider Network Adequacy	Calendar Year 2019
Grievance and Appeals	Calendar Year 2019
Member Access to Care Outcomes	Calendar Year 2018

Notable Results (Overall Report Summary)

Overall data in the 2019 NH Behavioral Health Parity Monitoring Report does not suggest changes to the MCO's initial demonstration of BH parity compliance. Through the report, DHHS has identified the following notable results in each quality domain. See the detailed report for more information:

- **Provider Network Adequacy:** Overall there no concerning results in the provider network domain. Existing gaps in MCO network adequacy exist for acute psychiatric care in Coos county

and methadone treatment in Carrol, Coos, and Grafton counties. Each MCO has a plan for assuring network adequacy for members seeking services in these counties and DHHS will continue to monitor;

- **Grievance and Appeals:** Overall there are no concerning results in the grievances and appeals domain. NH will continue to watch Pharmacy Appeals for SUD services that saw some fluctuation, which was likely due to changes in the NH Granite Advantage Program (Medicaid Expansion) population.
- **Member Access to Care Outcomes:** Overall there no concerning results in the member access to care outcomes domain. Many survey measures in the report only have one year of data, which will become the baseline data for comparison in next year's report.

DOMAIN: Provider Network Adequacy

Introduction

Provider Network Adequacy key indicators in the following area:

- Provider Network Adequacy Time and Distance Standard Evaluation.

Provider Network Adequacy

Figure 1-1: Provider Network Adequacy Time and Distance Standard Evaluation

	1/1/2019-6/30/2019	7/1/2019 – 12/31/2019
	Standard Met	**Standard Met**
Substance Use Disorder Providers -		
○ **Methadone Clinics**	Met – With Exceptions (Carroll, Coos, Grafton)	Met – With Exceptions (Carroll, Coos, Grafton)
○ **SUD Comprehensive Program**	Met – With Exceptions (Grafton)	Met
○ **SUD Master Licensed Alcohol & Drug Counselor**	Met	Met
○ **SUD Outpatient Program**	Met – With Exceptions (Coos, Grafton)	Met
Mental Health Providers –		
○ **Adult & Pediatric Psychiatrist**	Met	Met
○ **Psychologist**	Met	Met
○ **General Inpatient Psychiatric**	Met – With Exceptions (Coos)	Met – With Exceptions (Coos)
○ **Community Mental Health Centers**	Met	Met
○ **Emergency Mental Health Provider**	Met	Met

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

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 Substance Use Disorder and Mental Health provider types. Failure to meet time and distance standards could indicate inadequate member access to providers. A value of "Met" is used in the table when all MCOs have provider networks that meet time and distance standards for the specific types of provider. A value of "Met – With Exceptions" is used in the table when at least one MCO does not meet time and distance standards for the specific provider in a NH county; however, in these instances the MCO has a DHHS approved plan to assure members in the affected county can receive access to services from this provider type.

Notable Results (Provider Network Adequacy)

- In the second half of calendar year 2019, network gaps for SUD comprehensive and outpatient programs were closed. All MCOs are now meeting network adequacy standards statewide for these services (Figure 1-1).
- Network gaps continue to exist for inpatient psychiatric care in Coos county and methadone clinics in Carroll, Coos, and Grafton country. DHHS will continue to monitor the MCO's plans for addressing member access to care in these counties (Figure 1-1.)

DOMAIN: Grievances and Appeals

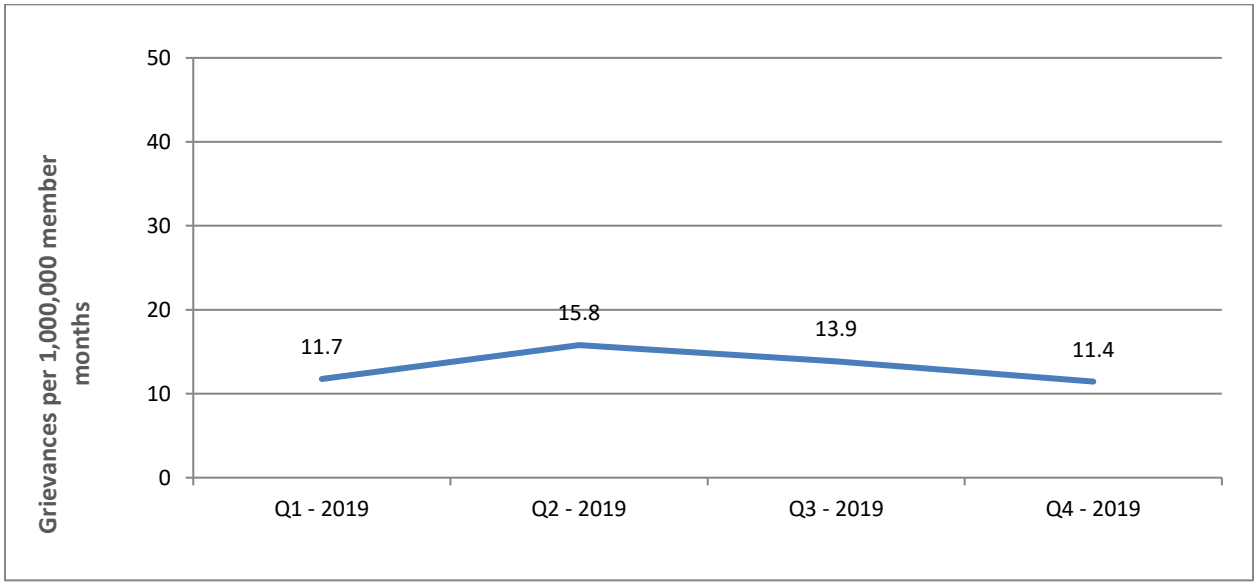
Introduction

Grievance and Appeals includes key indicators in the following areas:

- Grievances
- Appeals

Grievances

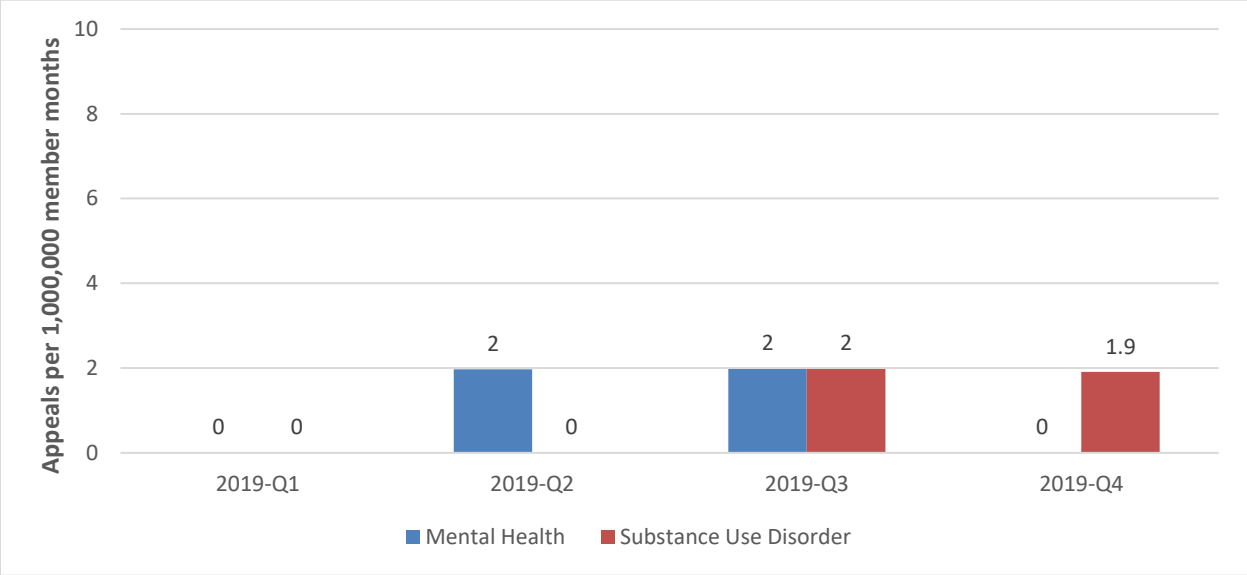
Figure 2-1: Grievances for Behavioral Health Services per 1,000,000 Member Months



Description: Grievances are counted when a member contacts the health plan with a concern and decides to file a formal 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 related to Behavioral Health Services (i.e., Mental Health or SUD) received each quarter. The rate is reported as the number of appeals divided by the number of member month. For ease of review, the result is then reported as a quarterly rate of grievances per 1,000,000 member months.

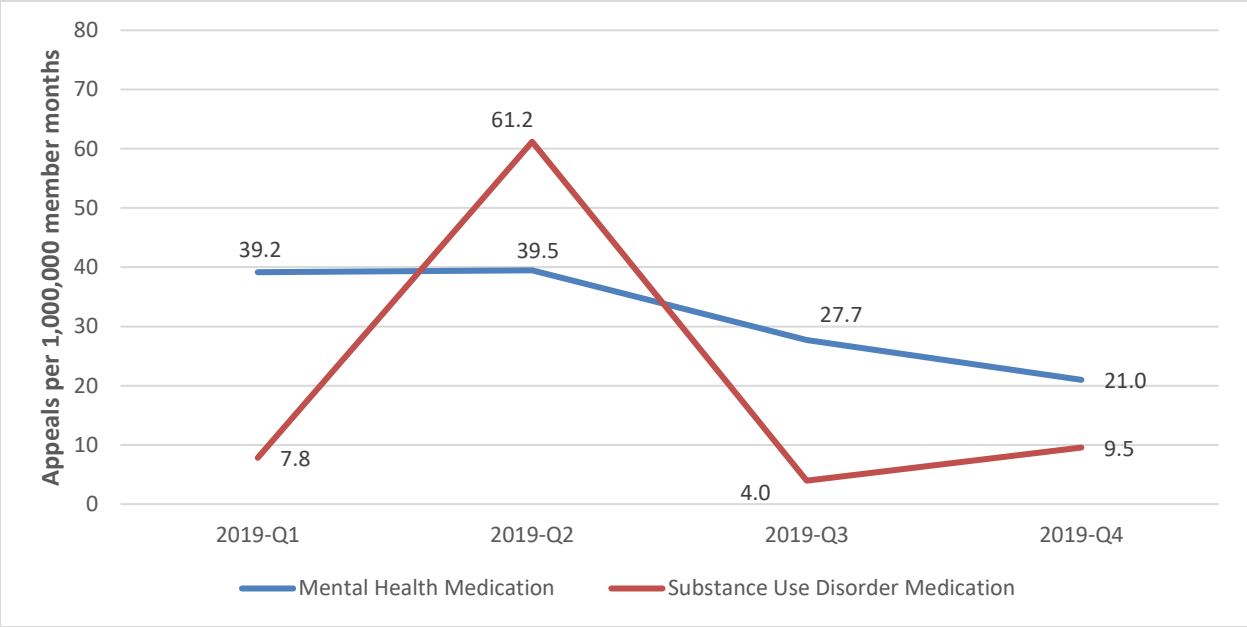
Appeals

Figure 2-2: Appeals Filed Per 1,000,000 Member Months



Description: Measuring the number of appeals of an MCO coverage decision 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. The rate reported is the number of appeals divided by the number of member months. For ease of review, the result is the quarterly rate of appeals per 1,000,000 member months.

Figure 2-3: Pharmacy Appeals Per 1,000,000 Member Months



Description: Measuring the number of appeals of an MCO coverage decision by type of health care service is a standard industry approach to better understand health care services utilization. Focusing specifically on pharmacy appeals is important because of the high utilization of these services for the behavioral health population. 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. The rate reported is the number of appeals divided by the number of member months. For ease of review, the result is the quarterly rate of appeals per 1,000,000 member months.

Notable Results (Grievance and Appeals Domain)

- Grievances and non-pharmacy appeals remain low (Figure 2-1 and Figure 2-2)
- Pharmacy appeals for Substance Use Disorder Medication significantly increased 2019-Q2. The increase was likely due to members of the Granite Advantage Health Program (Medicaid Expansion) moving from the Premium Assistance Program to Standard Managed Care. When transitioning from one health delivery system to another there is often a transitional period where members are learning how to access medications. The decrease in 2019-Q3 and 2019-Q4 suggests that the 2019-Q2 rate was due to the transition; however, DHHS will continue to monitor the data closely. (Figure 2-3).

DOMAIN: Member Access to Care Outcomes

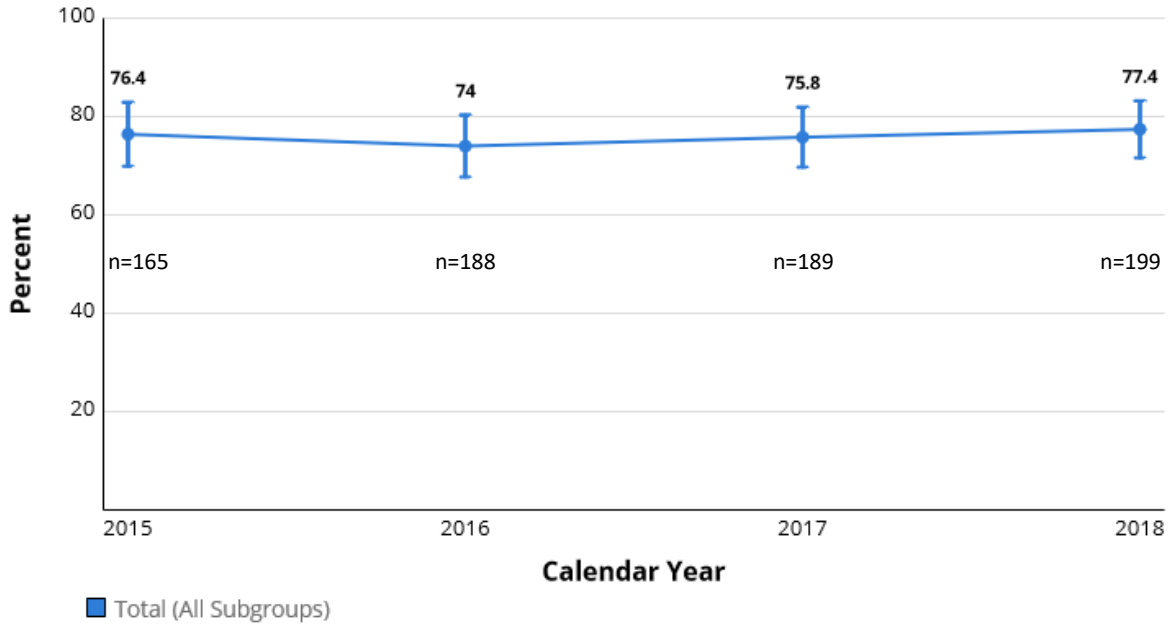
Introduction

Member Access to Care Outcomes includes key indicators in the following areas:

- Adult and Child Experience of Care Surveys; and,
- Healthcare Effectiveness Data & Information Set (HEDIS®)[1] Access to Care Measures.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®)[2]

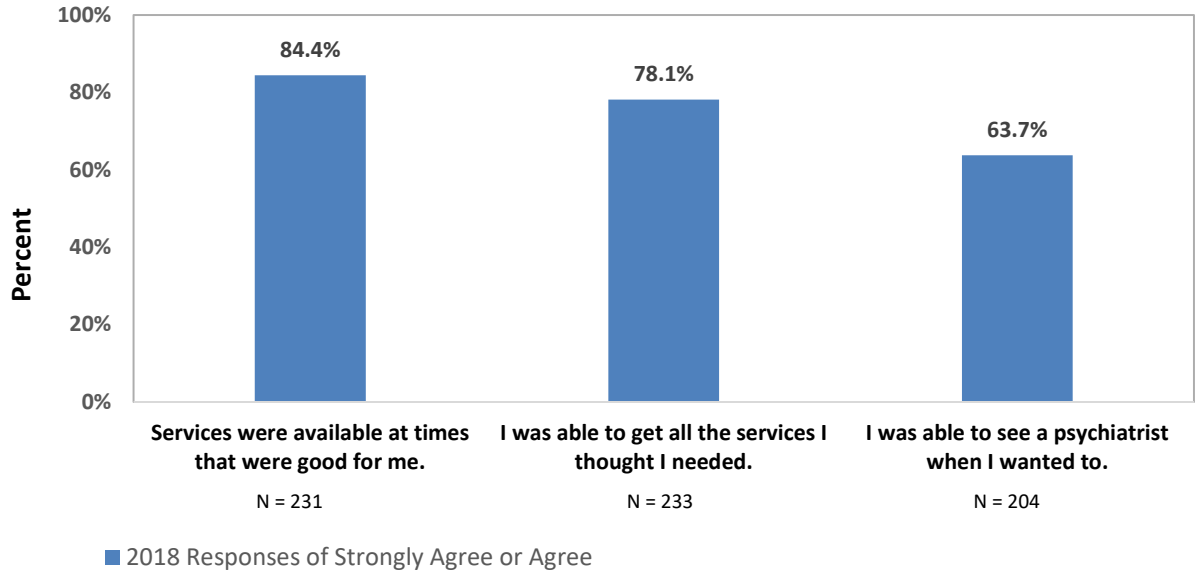
Figure 3-1: Ease in Getting Treatment or Counseling for their Child Usually or Always



Description: Member experience of care surveys are important to understand a member's perception of their access to care. Changes in the trend of a member's perception of their child's access to counseling or treatment can indicate a potential access to care issue that requires further evaluation. This measure evaluates the percent of caregivers reporting they got or tried to get treatment or counseling for their child and indicated in a survey that it was usually or always easy to get this service for their child.

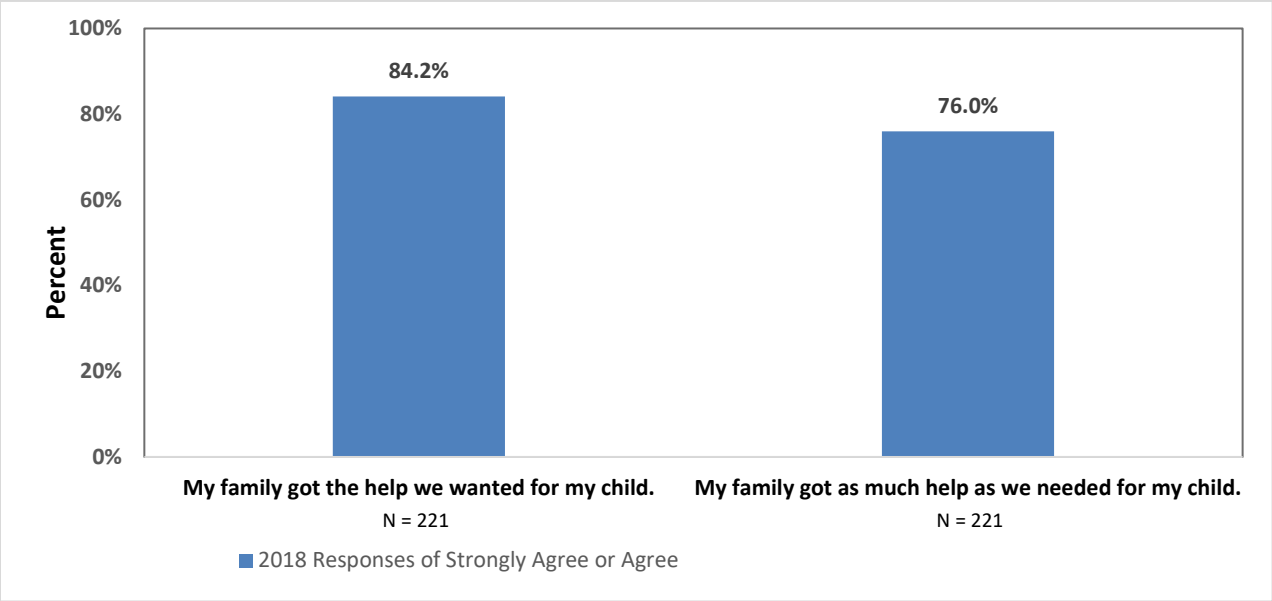
[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Figure 3-2: Responses of Strongly Agree or Agree to Behavioral Health Adult Survey Questions



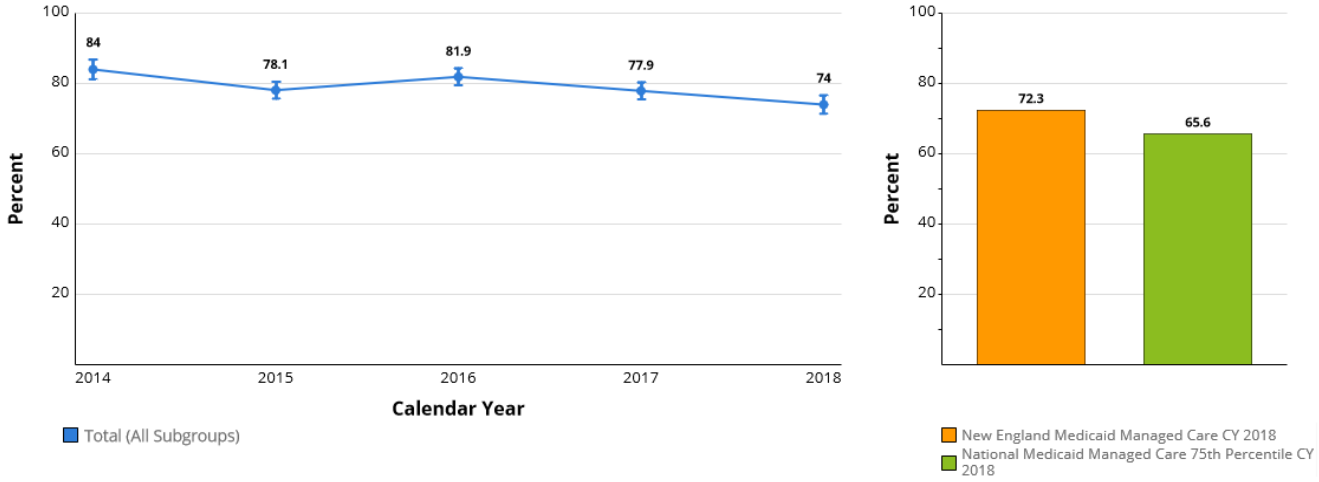
Description: Member experience of care surveys are important to understand a member's perception of their access to care. Changes in the trend of a member's perception of their access to care can indicate a potential access to care issue that requires further evaluation. This chart evaluates the percent of member who responded "Strongly Agree" or "Agree" to three different access to care statements divided by the total number of adults that responded to an annual behavioral health member survey. The statements are listed on the x-axis of the column chart.

Figure 3-3: Responses of Strongly Agree or Agree to Behavioral Health Adult Survey Questions



Description: Member experience of care surveys are important to understand a member's perception of their access to care. Changes in the trend of a member's perception of their child's access to care can indicate a potential access to care issue that requires further evaluation. This chart evaluates the percentage of adults who responded "Strongly Agree" or "Agree" to two different access to care statements about their child's care divided by the total number of adults that responded to an annual behavioral health member survey. The statements are listed on the x-axis of the column chart.

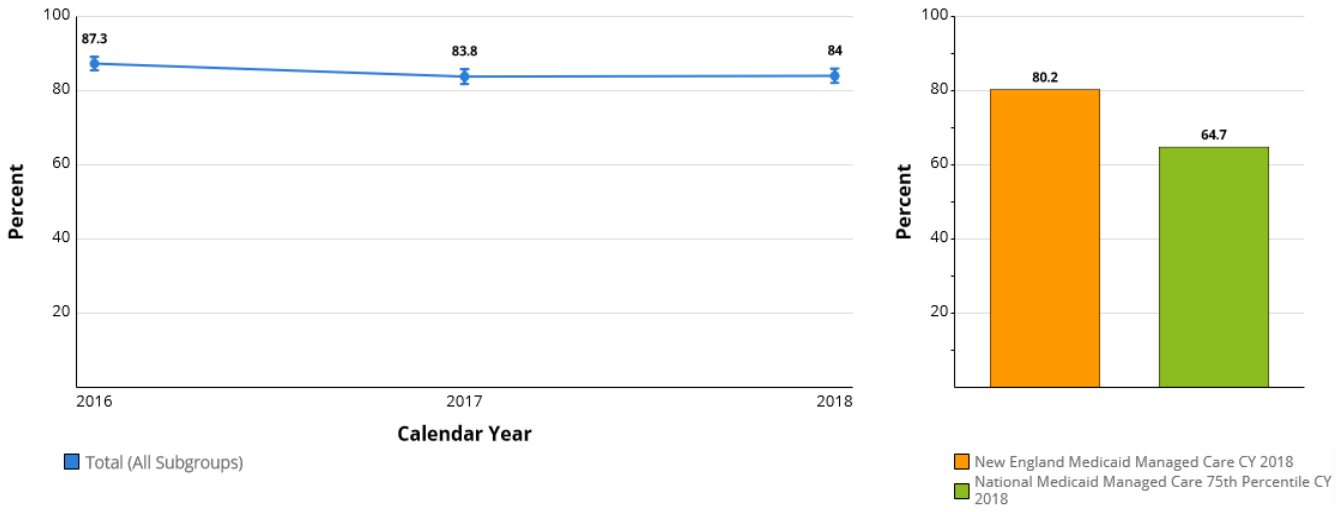
Figure 3-4: Follow-up After Hospitalization for Mental Illness in 30 Days [3]



Description: Timely follow up appointments after a hospitalization for mental illness are important to assist in successful transition back into the community. This measure captures the percent of children and adults 6 years of age and older that had a follow-up visit with a mental health practitioner within 30 days of discharge after hospitalization for mental illness. A low or falling rate indicates that children and adults may not be receiving follow up appointments within 30 days, and may be at greater risk for relapse and re-admissions. This measure is reported as the number of children and adults 6 years of age and older who had a follow-up visit with a mental health practitioner within 30 days of discharge after hospitalization for mental illness divided by the total eligible population, as a percentage.

[3] HEDIS FUH 30 Days

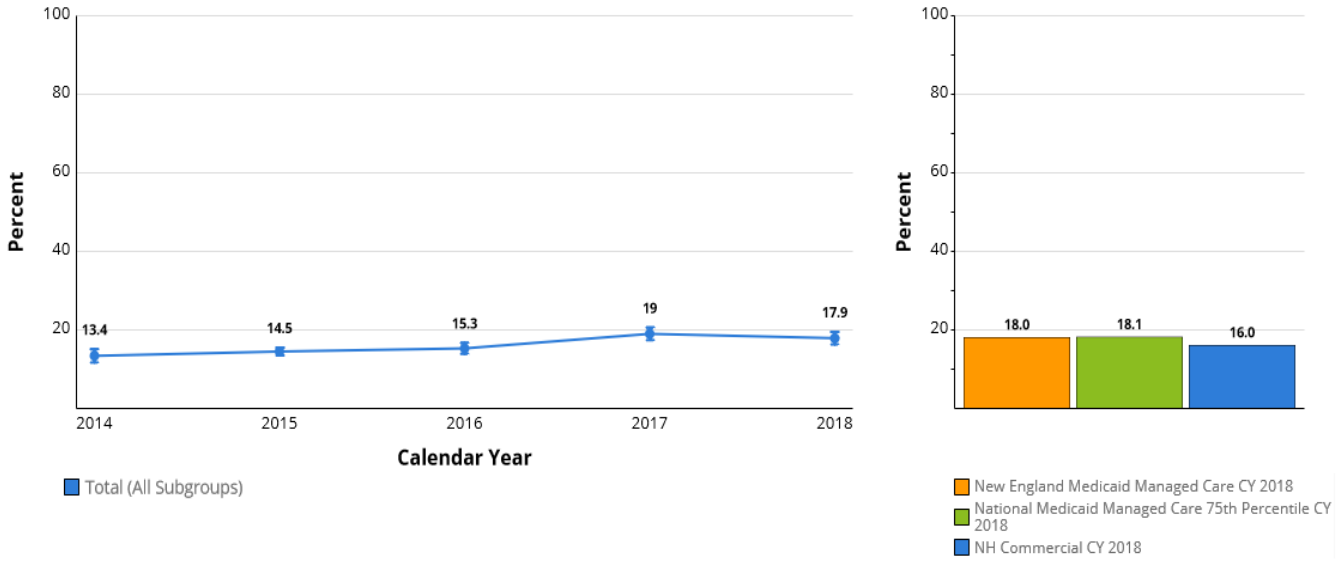
Figure 3-5: Follow-up After Emergency Department Visit for Mental Illness in 30 Days[4]



Description: Timely follow up appointments after an emergency department visit for mental illness are important to prevent additional emergency department visits or hospitalization. This measure captures the percent of children and adults 6 years of age and older that had a follow-up visit with a mental health practitioner within 30 days of emergency department visit for mental illness. A low or falling rate indicates that children and adults may not be receiving follow up appointments within 30 days, and may be at greater risk for relapse and re-admissions. This measure is reported as the number of children and adults 6 years of age and older who had a follow-up visit with a mental health practitioner within 30 days of an emergency department visit for mental illness divided by the total eligible population, as a percentage.

[4] HEDIS FUM 30 Days

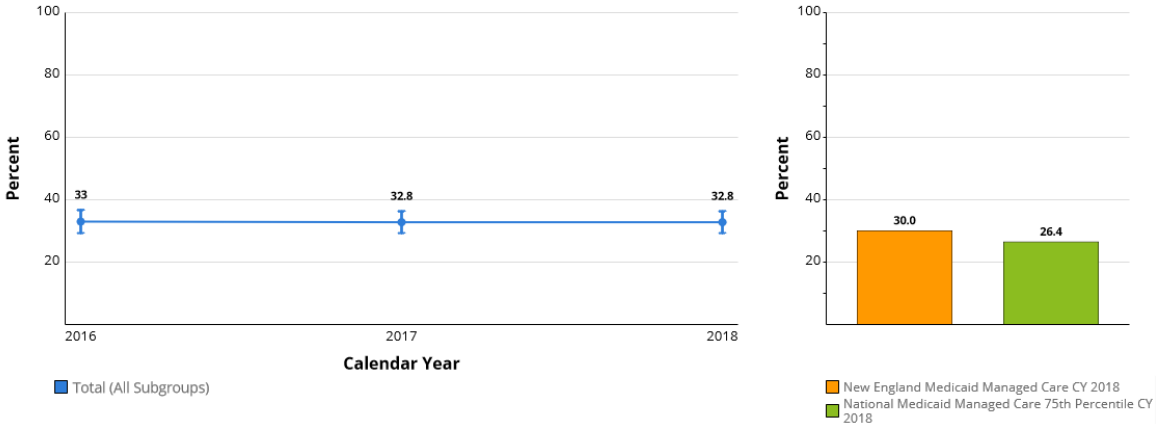
Figure 3-6: Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment Engagement[5]



Description: Continuing engagement in treatment is essential to managing an episode of alcohol abuse or drug dependence. This measure captures the percent of adolescents and adults 13 years of age and older that had a new episode of alcohol abuse or drug dependence who initiated treatment and had two or more AOD services (including Medication Assisted Treatment) within 34 day of the initial treatment visit. A low or falling rate indicates that adolescents and adults may not be receiving necessary treatment and may be at greater risk for relapse and negative outcomes associated with AOD dependence. This measure is reported as the number of adolescents and adults 13 years of age and older who had two or more AOD services within 34 days of the initial treatment visit, divided by the total eligible population of members who had a new episode of AOD, as a percentage.

[5] HEDIS IET Engagement

Figure 3-7: Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days[6]



Description: Timely follow up appointments after an emergency department visit for AOD services are important to prevent relapse or further negative outcomes associated with AOD dependence. This measure captures the percent of children and adults 13 years of age and older that had a follow-up visit with a practitioner within 30 days of emergency department visit for AOD dependence. A low or falling rate indicates that adolescents and adults may not be receiving necessary treatment and may be at greater risk for relapse and negative outcomes associated with AOD dependence. This measure is reported as the number of children and adults 13 years of age and older who had a follow-up visit with a practitioner within 30 days of an emergency department visit for AOD dependence divided by the total eligible population, as a percentage.

Notable Results (Member Access to Care Outcomes)

- CAHPS survey data does not suggest access to care issues (Figure 3-1).
- Behavioral Health Adult and Family Survey 2018 results will serve as a baseline to compare against future performance. The lowest rate in the baseline year was for Adults access to a psychiatrist, which will be further evaluated when the calendar year 2019 data is available (Figure 3-2 and Figure 3-3).
- Follow up for Hospitalization After Mental Illness continues to show a slight downward trend since 2016; however, the NH rate is higher than the New England Medicaid Average and the 75th percentile of National Medicaid health plans (Figure 3-4 and Figure 3-5).
- Engagement of Alcohol and Other Drug Dependence Treatment Engagement Continuing engagement in treatment continues to show a slight upward trend since 2016 and has almost reached the New England Medicaid Average and the 75th percentile of National Medicaid health plans (Figure 3-6). The increase was likely due to members of the Granite Advantage Health Program (Medicaid

[6] HEDIS FUA 30 Days

Expansion) moving from the Premium Assistance Program to Standard Managed Care. When transitioning from one health delivery system to another there is often a transitional period where members are learning how to access medications.

- Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days remains stable since 2016 and is higher than the New England Medicaid Average and the 75th percentile of National Medicaid health plans (Figure 3-7).