

State Children's Health Insurance Program (SCHIP) Waiver Analysis and Evaluation

Final Report June 29, 2007

Revised September 5, 2007

Prepared for New Mexico
Human Services Department
Under PSC 06-630-8000-02

Table of Contents:

Executive Summary	1
Background.....	3
Methodology	3
Findings	5
SCHIP Enrollment Trend	6
Benefit Design & Co-payments.....	6
(1). HEDIS® Utilization Patterns	7
Well Child Visits in the First 15 months of Life.....	7
Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.....	12
Adolescent Well-Care Visits	14
Frequency of Selected Procedures (Myringotomy, Tonsillectomy).....	16
Inpatient Utilization – General Hospital Acute Care.....	19
Ambulatory Care.....	22
Inpatient Utilization – General Hospital Non-acute Care	25
Discharges and Average Length of Stay – Maternity Care & Cesarean Section Rate	28
Mental Health Utilization	29
Chemical Dependency Utilization	31
Outpatient Drug Utilization.....	33
(2). Health Status	35
Childhood Immunization Status	35
Adolescent Immunization Status	38
Use of Appropriate Medications for Children with Asthma	41
(3). Access	44
Annual Dental Visit	44
Children’s and Adolescents’ Access to Primary Care Practitioner	48
Recommendations	51
Conclusion	51

Executive Summary

New Mexico (NM) Human Services Department (HSD) operates a State Children's Health Insurance Program (SCHIP) Section 1115 demonstration project waiver under the authority of the Centers for Medicare & Medicaid Services (CMS), which covers children through age 18 in families with income from 185% to 235% of the Federal Poverty Level (FPL). This demonstration permits the state to implement co-payment requirements and a 6-month non-insurance waiting period for the demonstration population.

The objectives of this project are to demonstrate that: 1) co-payment requirements do not impede utilization of medical care for the SCHIP population and 2) to ensure that the state's six-month waiting period of uninsurance for applicants that have employer-sponsored or private health insurance effectively prevents crowd-out, or the substitution of SCHIP coverage for private group health plan coverage.

Approval by CMS to operate a SCHIP program includes compliance with "Special Evaluation Requirements". These requirements include the periodic review of use of health care services, effectiveness of health care services, and availability of health care services for SCHIP children (up to age 18). In accordance with CMS requirements, HSD issued Letter of Direction (LOD) No. 07-18 on October 17, 2006 to NMMRA to perform two Special Evaluation Requirements; the analysis of utilization patterns, health status and access of SCHIP consumers, and the evaluation of the impact of the six-month eligibility waiting period on SCHIP participation.

NMMRA compared age-specific utilization, health status and access patterns of the state's SCHIP consumers with those of the state's total managed care Medicaid population. NMMRA calculated selected Healthcare Effectiveness Data and Information Set (HEDIS®) indicators for the SCHIP population from SCHIP enrollment and encounter data using HEDIS® methodology for the reporting calendar years 2002 through 2005. HSD specified the selected HEDIS® indicators based on a demonstration evaluation design which had been submitted and approved in 2005. The design specified the date range for data review to be 2002-2005. For the completion of this report, 2006 data was not included. HSD monitors HEDIS® measures for the contracted managed care organizations (MCOs) that provider services to the managed Medicaid population as a means of assessing performance.

The first LOD deliverable included retrospective review of utilization patterns, health status and access to care for SCHIP children (up to age 18). The hypothesis of the analysis is that access to care is not impeded by the imposition of co-payments and the health status of SCHIP children is not compromised. The assessment looked at key HEDIS® indicators over a four year period. The key indicators were selected because they were age sensitive and are reported for "child" and "adolescent" populations.

The indicators which are limited to consumers who were continuously enrolled (as defined in the HEDIS® methodology) represent a smaller proportion of the SCHIP population being measured, which is a source of potential methodological bias. The first set of key HEDIS® indicators, selected to gauge the use of health care services, shows that the SCHIP population fell below in all of the measured indicators when compared to the MCOs' Medicaid population, and below the HEDIS® national average when reported. There were no data to suggest that the imposition of co-payments, which were required for some of the services reported in this data set, had an unfavorable impact on the use of health care services. However, several HEDIS® indicators were limited to consumers who were continuously enrolled, which may have resulted in bias.

The second set of key HEDIS® indicators, selected to gauge the effectiveness of health care services and evaluate health status, shows that SCHIP children and adolescents received fewer immunizations when compared to the state's managed Medicaid population. The SCHIP rates fell below the rates reported by the contracted MCOs and the national HEDIS® metrics. The findings were primarily driven by the continuous enrollment requirements and not the imposition of co-payments. The use of appropriate medications for SCHIP children with asthma measured higher than the HEDIS® national average and within the reported MCOs' rates for the managed Medicaid population. Immunization and asthma health services are exempt from co-payment requirements.

The final set of key HEDIS® indicators, selected to gauge access and availability of health care services, shows that the percentage of children and adolescents who saw a dental care provider within the measurement year measured significantly lower than the HEDIS® national average and the contracted MCOs' rates. These findings were primarily driven by the continuous enrollment requirements. Dental services for all managed Medicaid programs, including SCHIP, requires a \$5 co-payment for services. The percentage of children and adolescents who saw a health care provider for primary care within specified time frames measured slightly lower than the HEDIS® national average and the contracted MCOs' rates. As identified in the first and second data sets, the findings for this data set were primarily driven by the continuous enrollment requirements, and not the imposition of co-payments.

While the data and comparisons presented in this report show some differences in utilization, health status and access patterns for SCHIP consumers compared with regular Medicaid consumers, there is little evidence to suggest that the differences are due to the imposition of co-payments or waiting periods. There are many other factors which also influence children's healthcare utilization. The findings for the first objective reflect that access to care is not impeded nor is the health status of SCHIP children compromised by the imposition of co-payments.

A second objective was to review the impact of the six-month eligibility waiting period on enrollment in the SCHIP program. Application and denial data due to other insurance or other insurance dropped within the last six months was reviewed back to 2002. Only five cases were identified that met the above denial criteria, a number too small to draw statistically valid conclusions. In agreement with HSD, NMMRA did not complete this portion of the LOD requirement.

Background

On June 14, 2004, CMS informed the Medical Assistance Division (MAD) of the NM HSD of the renewal of the state's title XXI section 1115 demonstration project. The three year extension was granted on January 1, 2005 and expires on December 31, 2007. The program permits NM to continue their SCHIP demonstration with co-payment requirements and a six-month waiting period for the population.

Co-payments are applicable to families with children incomes from 185% through 235% of the federal poverty level. The co-payment schedule applies to physician visits, outpatient services, urgent care visits, emergency room visits, inpatient hospital admissions, outpatient hospital services, prescriptions, dental visits and missed appointments. Prenatal and preventive health services are exempt from co-payment requirements. Services provided at Indian Health Services facilities, Urban Indian providers, and tribal 638s are also exempt from co-payments. Per federal requirements, Native American children are exempt from paying all co-payments to access covered Medicaid and SCHIP services.

The "crowd-out" or "waiting period" provision requires a six-month period of un-insurance for applicants that have employer-sponsored or private health insurance, and who voluntarily terminated coverage within the six-months of application for SCHIP.

CMS approval of operating a SCHIP is conditional upon compliance with specified "Special Terms and Conditions". These terms and conditions include special evaluation requirements. The evaluation requirements are:

1. The state will submit a formal research plan for review and approval by CMS within 120 days of approval. At a minimum, the research plan will include plans for the analysis of:
 - a. Utilization Patterns
 - b. Health Status, and
 - c. Access, including the tracking and resolution of situations involving non-payment of co-payments.
2. The state's formal research plan to evaluate the impact of the six-month waiting period.

Methodology

The methodology was developed using CMS protocol for SCHIP performance. The final methodology consisted of the following sections:

- rationale (understanding of the regulations and LOD specifications)
- evidence required (HEDIS® Administrative data)
- interpretive guidelines

The first deliverable included retrospective review of utilization patterns, health status and access to care for SCHIP children (up to age 18). Since published data available did not distinguish Medicaid and SCHIP children, it was decided by HSD that HEDIS® technical specifications – administrative data from the three contracted MCOs that serve all NM managed Medicaid enrollees (and treat all members equally, including SCHIP) would be used for comparison with SCHIP Administrative data. NMMRA used SCHIP encounter and enrollment records from the State's MMIS data warehouse to calculate HEDIS® indicators for comparison with available Medicaid managed care HEDIS® reports for the years 2002 through 2005.

The hypothesis of the analysis is that access to care is not impeded by the imposition of co-payments and the health status of SCHIP children is not compromised.

The assessment used key HEDIS® indicators over several years. The key indicators, summarized in Exhibit 1, were selected because they were age sensitive and are reported for “child” and “adolescent” populations.

Exhibit 1: HEDIS® Key Indicators	
Element	Indicators
Utilization Patterns	<p>HEDIS®</p> <ul style="list-style-type: none"> • Well-Child Visits in the 1st 15 months of Life • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Frequency of Selected Procedures (Myringotomy and Tonsillectomy) • Inpatient Utilization – General Hospital and Acute Care • Inpatient Utilization – Non-acute Care • Discharges and Average Length of Stay – Maternity Care • Cesarean Section Rate • Mental Health Utilization • Chemical Dependency Utilization • Outpatient Drug Utilization
Health Status	<p>HEDIS®</p> <ul style="list-style-type: none"> • Childhood Immunization Status • Adolescent Immunization Status • Use of Appropriate Medications for Children with Asthma
Access	<p>HEDIS®</p> <ul style="list-style-type: none"> • Annual Dental Visits • Children’s and Adolescents’ Access to Primary Care Practitioners

Rationale for HEDIS® Indicator Selection – Referring to Exhibit 1 above:

Utilization Patterns: HEDIS® measures that gauge the use of health care services were selected to evaluate utilization:

- Well-Child Visits in the First 15 months of Life – Regular well child visits can detect problems and offer an opportunity for guidance and counseling. Early childhood visits are of particular importance. This indicator measures the percentage of children who had six or more well child visits by the time they are 15 months of age
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits – Well care visits are crucial for ensuring continued good health and early diagnosis of potential illness. This indicator measures the percentage of children/adolescents who had at least one well care visit in the measurement year

- Frequency of Selected Procedures (Myringotomy and Tonsillectomy) – These indicators report the frequency of common pediatric procedures
- Inpatient Utilization – General Hospital and Acute Care – This indicator describes the extent of which children and adolescents receive acute inpatient treatments
- Inpatient Utilization – Non-acute Care – This indicator describes the extent to which children and adolescents receive inpatient treatment in non-acute settings
- Ambulatory Care – This indicator describes the frequency of selected ambulatory care services including emergency department visits
- Discharge and Average Length of Stay – Maternity Care – This indicator describes how many adolescent females gave birth during the reporting year
- Cesarean Section Rate – This indicator describes the cesarean section rate for adolescent females who gave birth during the reporting year
- Mental Health Utilization – This indicator reports the percentage of members receiving care for mental illness
- Chemical Dependency Utilization – This indicator reports the percentage of members receiving care for chemical dependency
- Outpatient Drug Utilization – Managing the use and cost of prescription medications is one aspect of managing utilization. This indicator reports the average number of prescriptions and the average cost of prescriptions.

Health Status: HEDIS® measures that gauge the effectiveness of health care services were selected to evaluate health status:

- Childhood Immunizations Status and Adolescent Immunization Status – Immunizations protect children adolescents against preventable and serious illness and are an example of primary prevention. This indicator measures the percents of children and adolescents who received selected immunization within specified time frames
- Use of Appropriate Medications for Children with Asthma – Asthma is a common chronic childhood disease. This indicator measures the percentage of children and adolescents with asthma who are prescribed appropriate medications.

Access: Measures that gauge the access and availability of health care services were selected to evaluate access.

- Annual Dental Visits – This indicator measures the percentage of children and adolescents who saw a dental care provider within the measurement year
- Children's and Adolescents' Access to Primary Care Practitioners – This indicator measures the percentage of children and adolescents who saw a health care provider for primary care within specified time frames.

Findings

The following series of tables provides a review of NMMRA's findings for the first objective; the retrospective review of (1) Utilization Patterns, (2) Health Status and (3) Access to Care for SCHIP children (up to age 18) for the CY 2002 through 2005, to assess that access to care is not impeded by the imposition of co-payments and the health status of SCHIP children is not compromised.

The denominator (reported as “N”) in all calculations included in the data tables through the remainder of this report represents the number of continuously enrolled SCHIP consumers for the reported CY.

SCHIP Enrollment Trend

Participation in the SCHIP program requires periodic recertification. The average annual SCHIP enrollment, calculated by using member-month data, has increased slightly year-to-year since 2002. SCHIP total enrollment, represented by any member enrolled during the CY, has increased more than 7,000 consumers over the past four CYs. Exhibit 2 shows the enrolled SCHIP population from CY 2002-CY2005. CY 2006 data was not included in the study design, therefore, the data is not included in the analysis.

Exhibit 2: SCHIP Eligible Population by Calendar Year				
Calendar Year	Average Monthly Enrollment (Unduplicated)	Total Enrolled At Any Time (Unduplicated)	Continuously Enrolled (Unduplicated)	Percent Continuously Enrolled
2002	10,393	18,560	4,139	22.3%
2003	11,168	20,020	4,623	23.1%
2004	11,843	22,781	3,920	17.2%
2005	11,848	26,093	3,133	12.0%

Benefit Design & Co-payments

The SCHIP program offers a comprehensive benefit plan that covers preventive and medically necessary care, and the program matches the covered benefits of NM’s managed Medicaid program (SALUD!) with the exception of a few co-payment differences, which are due at the time of service. A co-payment is required for the following SCHIP services:

- \$2 per Prescription
- \$5 for Urgent Care and Office Visits
- \$5 Outpatient Therapy
- \$5 Dental Office Visits
- \$15 Emergency Room Visits
- \$25 Inpatient Admission

There are no co-payments for preventive, prenatal care and family planning/contraception. Also, Native American members are exempt for all co-payments per federal guidelines. A co-payment maximum is determined by the family/household combined unit. Once the co-payment maximum is reached, family/household members are not required to make co-payments for the remainder of the CY. The maximum co-payment per family/household is:

- families/households with income from 185% to 200% of the FPL – three percent of income
- families/households with income from 201% to 215% of the FPL – four percent of income
- families/households with income from 216% to 235% of the FPL – five percent of income

(1). HEDIS® Utilization Patterns

The following series of tables presents the retrospective review of utilization patterns for SCHIP members, which are represented in light blue, compared to the three contracted MCOs; Lovelace Community Health Plan (Lovelace) represented in red; Molina Health Care of New Mexico, Inc. (Molina) represented in dark blue and Presbyterian Salud (Presbyterian) represented in yellow. The following HEDIS® measures were selected to gauge the use of health care services to evaluate utilization patterns:

Well Child Visits in the First 15 months of Life

Rationale

Regular well child visits can detect problems and offer an opportunity for guidance and counseling. Early childhood visits are of particular importance. This indicator measures the percentage of children who had six or more well child visits by the time they are 15 months of age.

HEDIS® Description

This indicator measures the percentage of continuously enrolled members who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner during their first 15 months of life: zero; one; two; three; four; five; six or more.

Findings

Table 1 through 4 report the percentage of continuously enrolled SCHIP participants who had well-child visits in their first 15 months of life, compared with the managed Medicaid participants continuously enrolled with MCOs. *Caveat: the number of eligible SCHIP participants for each reported CY is too small to draw statistically valid conclusions.* There were fewer than 25 such SCHIP participants in any of the reported years, and only 48 in total over the 4 year study period, less than 2.5% of SCHIP participants who turned 15 months old while covered by SCHIP. Under the *HEDIS® Technical Specification Guide* the SCHIP results would not be reportable.

The numbers of continuously enrolled contracted MCO and SCHIP consumers by reported CY were:

MCO / Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	1701	1932	1932	1610
Lovelace	1373	1777	1952	1706
Presbyterian	3287	3259	3545	3320
SCHIP	1	21	20	6

Table 1: Well Child Visits First 15 Months - CY2005

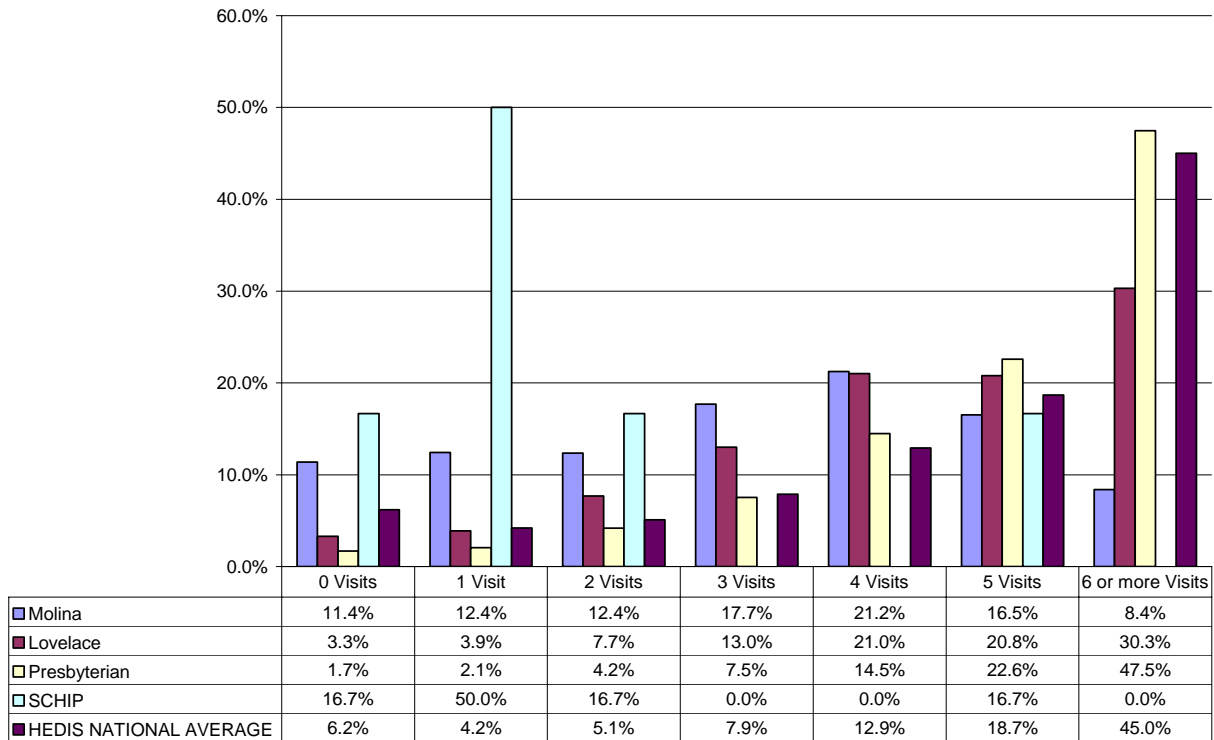


Table 1 reports the percentage of continuously enrolled SCHIP participants who had well-child visits in their first 15 months of life during CY 2005, compared with Medicaid participants continuously enrolled with MCOs.

Table 2: Well Child Visits First 15 Months - CY2004

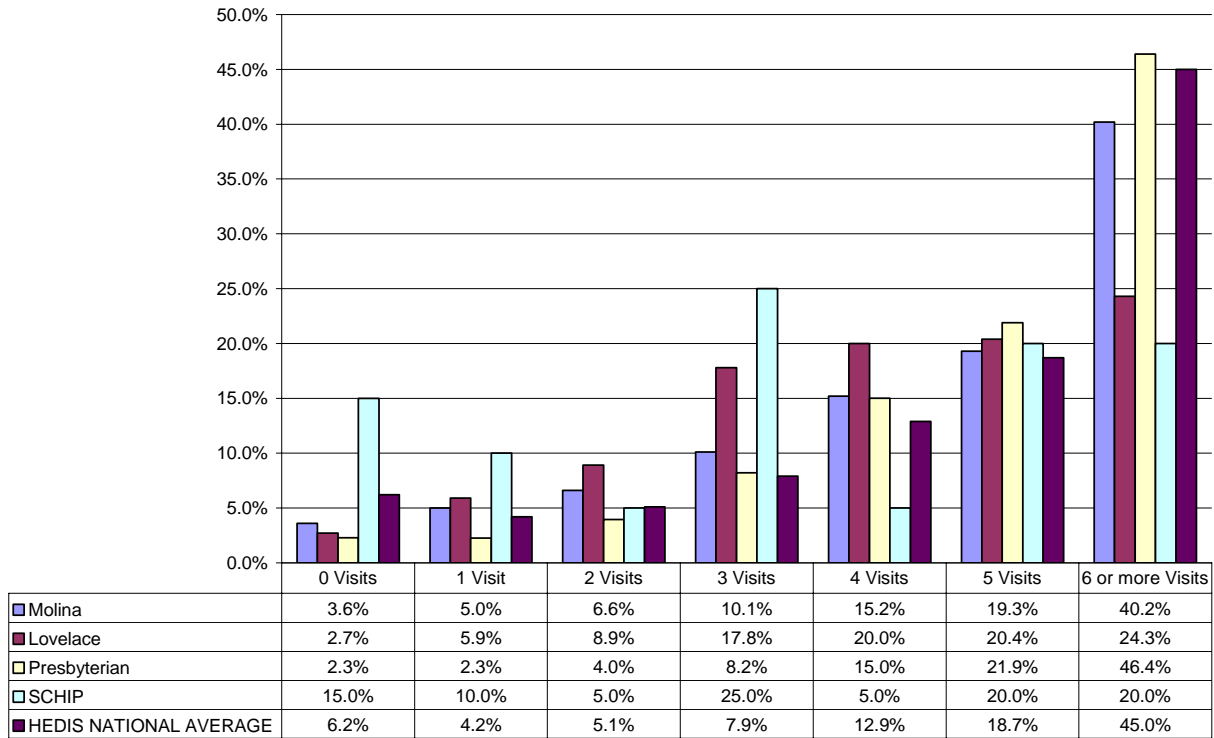


Table 2 reports the percentage of continuously enrolled SCHIP participants who had well-child visits in their first 15 months of life during CY 2004, compared with Medicaid participants continuously enrolled with MCOs.

Table 3: Well Child Visits First 15 Months - CY2003

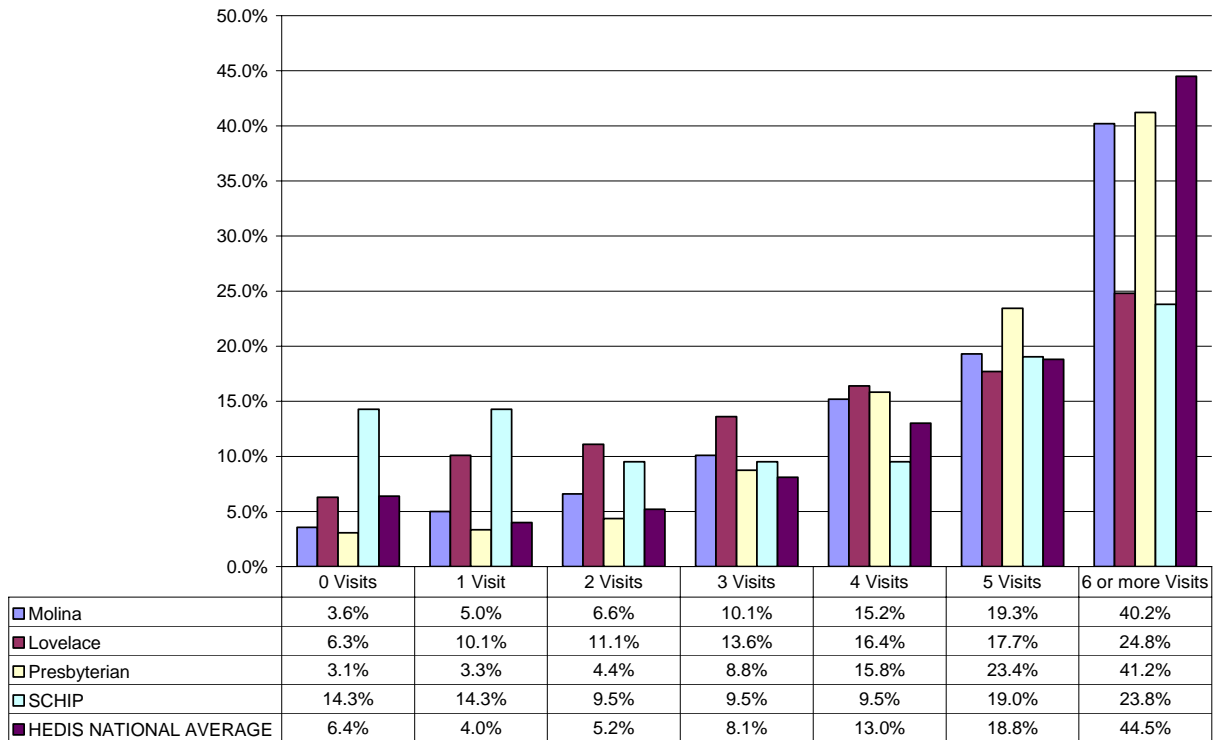


Table 3 reports the percentage of continuously enrolled SCHIP participants who had well-child visits in their first 15 months of life during CY 2003, compared with Medicaid participants continuously enrolled with MCOs.

Table 4: Well Child Visits First 15 Months - CY2002

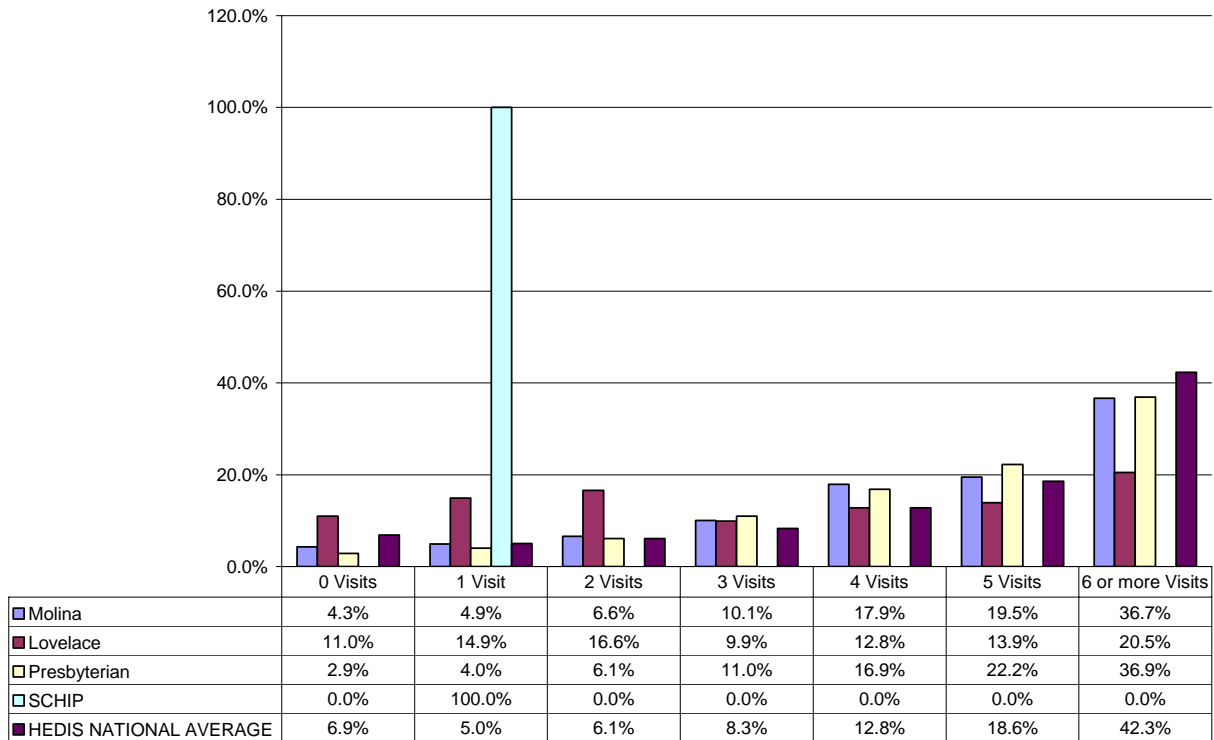


Table 4 reports the percentage of continuously enrolled SCHIP participants who had well-child visits in their first 15 months of life during CY 2002, compared with Medicaid participants continuously enrolled with MCOs.

Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Rationale

Well care visits are crucial for ensuring continued good health and early diagnosis of potential illness. This indicator measures the percentage of children who had at least one well care visit in the measurement year.

HEDIS® Description

This indicator measures the percentage of enrolled members who were three, four, five or six years of age during the measurement year and who received one or more well-child visit with a primary care practitioner during the measurement year.

Findings

The percent of well child visits for the third, fourth, fifth and sixth years of life (refer to Table 5) for the SCHIP population measured below the HEDIS® National Average, but fell within the contracted MCOs' measured performance rates for all of the CYs reported. Each of the MCOs and SCHIP comparable performance measures rates improved from CY 2002 to CY 2005. The numbers of continuously enrolled contracted MCOs and SCHIP consumers by reported CY were:

MCO / Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	8871	9100	8527	7061
Lovelace	7759	8597	8501	7190
Presbyterian	16761	17904	17673	14231
SCHIP	894	954	759	571

Table 5: Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

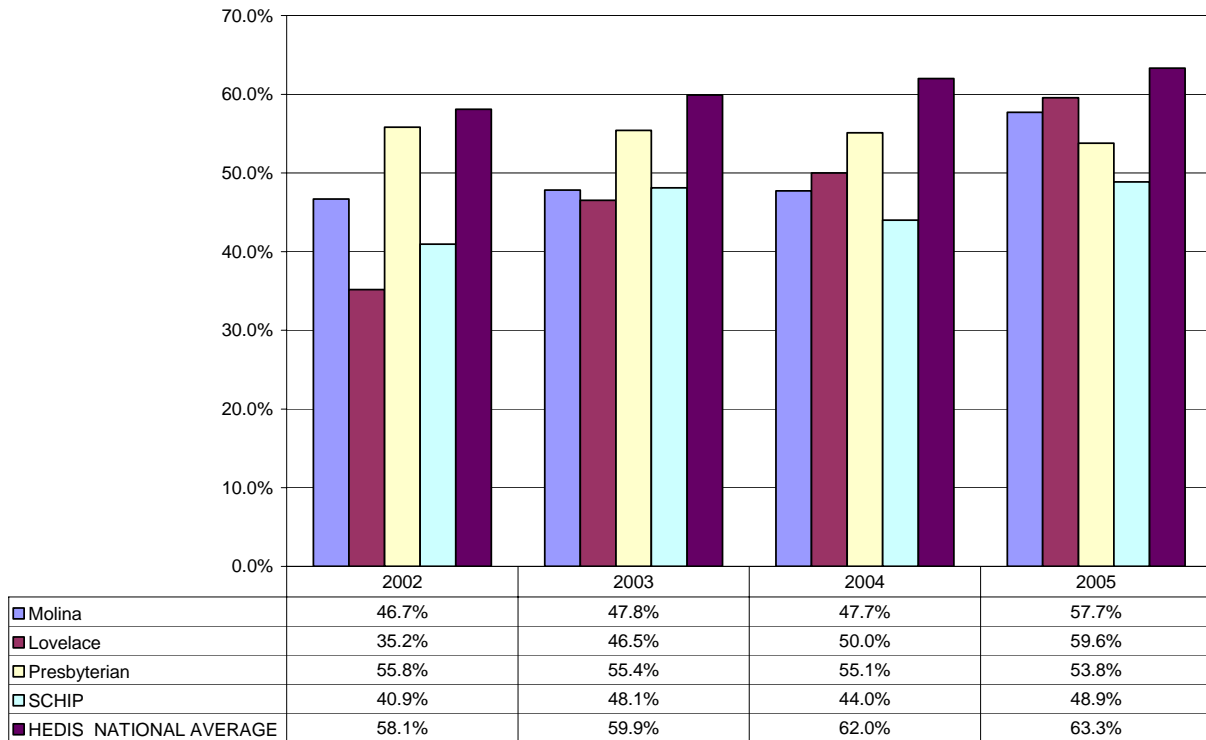


Table 5 shows the percent of well child visits for the third, fourth, fifth and sixth years of life for the SCHIP population measured below the HEDIS® National Average, but fell within the contracted MCOs' measured performance rates for all of the CYs reported. Each of the MCOs and SCHIP comparable performance measures rates improved from CY 2002 to CY 2005.

Adolescent Well-Care Visits

Rationale

Well care visits are crucial for ensuring continued good health and early diagnosis of potential illness. This indicator measures the percentage of adolescents who had at least one well care visit in the measurement year.

HEDIS® Description

This indicator measures the percentage of enrolled members who were 12 through 21 years of age who had at least one comprehensive well- care visit with a primary care practitioner or an obstetrician/ gynecologist (OB/GYN) practitioner during the measurement year.

Findings

Table 6, on the following page, shows the percent of adolescents who had a well care visit for the SCHIP population measured below the HEDIS® National Average, but fell within the contracted MCOs measured rates for the reported periods. There was marginal improvement across the contracted MCOs and SCHIP performance measure rates from CY 2002 to CY 2005. The numbers of continuously enrolled contracted MCO and SCHIP consumers by reported CY were:

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	10941	11726	11137	9406
Lovelace	10724	12433	12082	10311
Presbyterian	23881	26531	26230	21964
SCHIP	1986	2251	1973	1651

Table 6: Adolescent Well-Care Visits

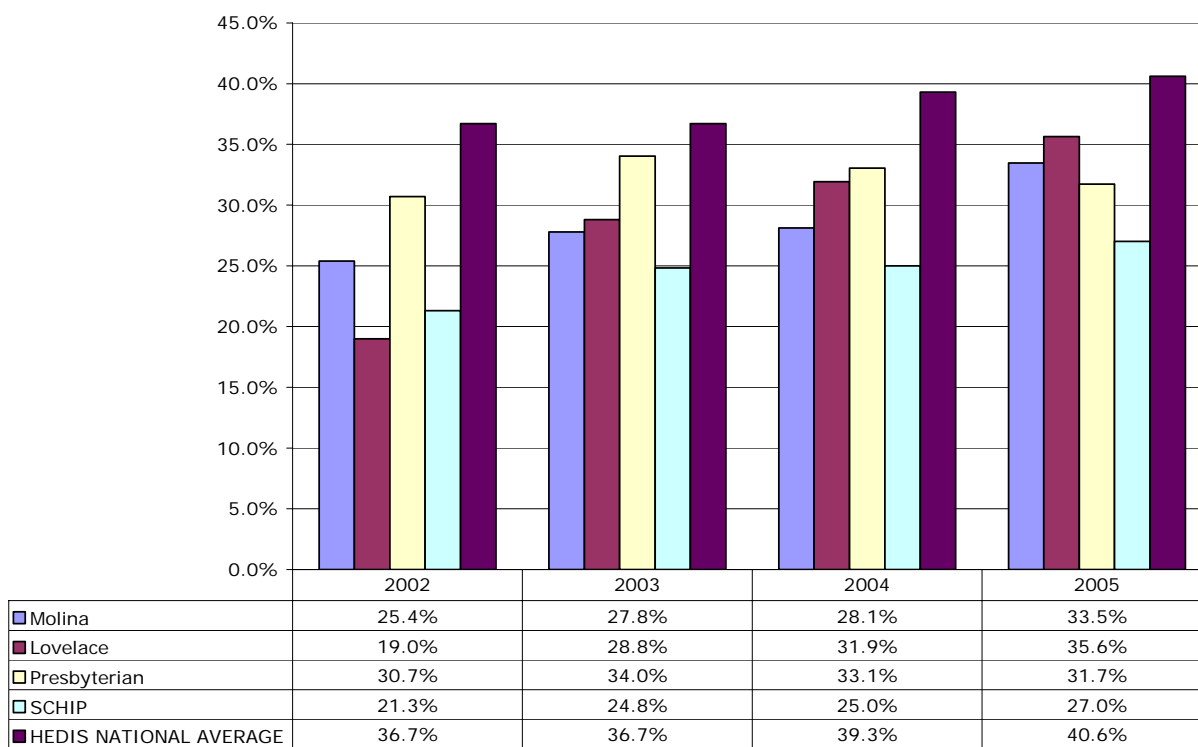


Table 6 shows the percent of adolescents who had a well care visit for the SCHIP population measured below the HEDIS® National Average, but fell within the contracted MCOs measured rates for the reported periods. There was marginal improvement across the contracted MCOs and SCHIP performance measure rates from CY 2002 to CY 2005.

Frequency of Selected Procedures (Myringotomy, Tonsillectomy)

Rationale

Myringotomy and tonsillectomy indicators report the frequency of common pediatric procedures.

HEDIS® Description

This indicator measure provides a summary of the number and rate of several frequently performed procedures. These procedures often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Findings

Tables 7 and 8, beginning on the next page, show that the number of myringotomy procedures per 1,000 member months for the SCHIP population measured slightly lower than the contracted MCOs' measured rates for the reported CYs. For ages 0 – 4 the SCHIP utilization rate was lower across all reported CYs, and for ages 5 – 19 the SCHIP utilization was slightly higher for CYs 2002 and 2003 and lower for CYs 2004 and 2005.

Tables 9 and 10 show the number of tonsillectomy procedures per 1,000 member months for the SCHIP population measured higher than the contracted MCOs' rates. The tables show that for tonsillectomy ages 0 – 9 the SCHIP utilization was within the same range as the contracted MCOs' rate, while in contrast the tonsillectomy age 10 – 19 years utilization for SCHIP was higher in all of the reported CYs. The numbers of continuously enrolled member-months for the contracted MCOs and SCHIP consumers by reported CY were:

Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	210869	205321	201517	181450
Lovelace	181720	197544	208315	200172
Presbyterian	361329	388395	401739	368700
SCHIP	28231	29394	31077	31950

Table 7: Procedures / 1000 Member Months - Myringotomy 0-4

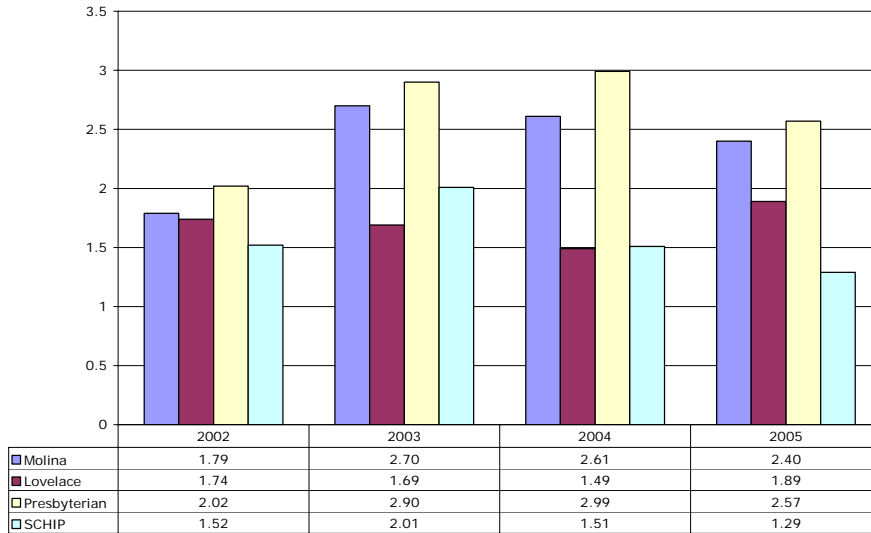
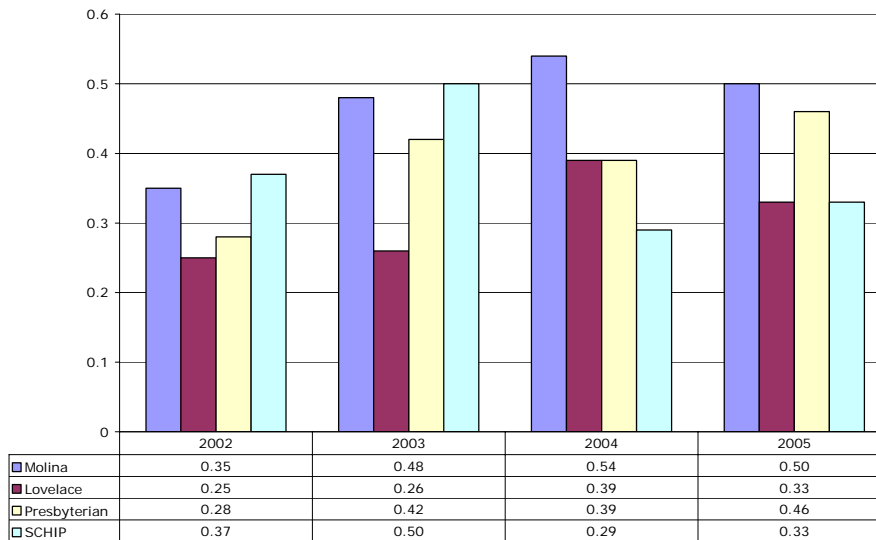


Table 8: Procedures / 1000 Member Months - Myringotomy 5-19



Tables 7 and 8 show that the number of myringotomy procedures per 1,000 member months for the SCHIP population measured slightly lower than the contracted MCOs' measured rates for the reported CYs. For ages 0 – 4 the SCHIP utilization rate was lower across all reported CYs, and for ages 5 – 19 the SCHIP utilization was slightly higher for CYs 2002 and 2003 and lower for CYs 2004 and 2005.

Table 9: Procedures / 1000 Member Months - Tonsillectomy 0-9

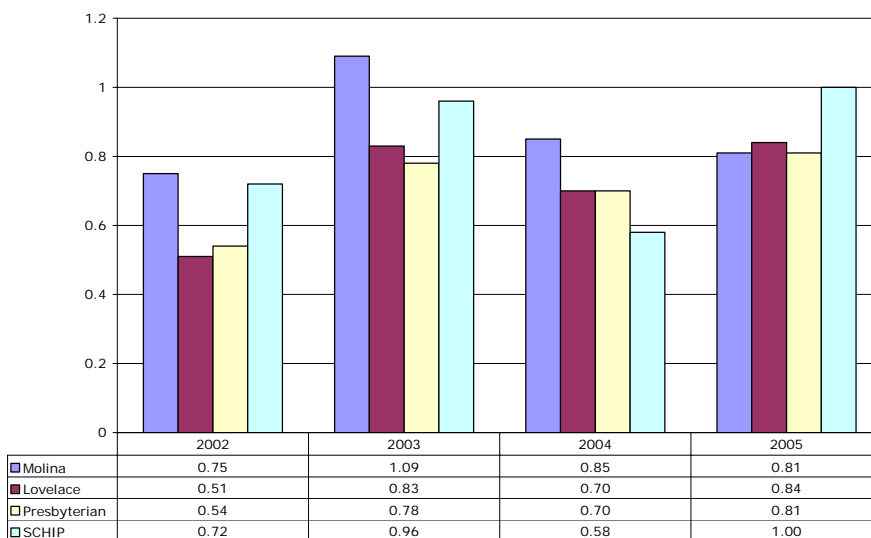
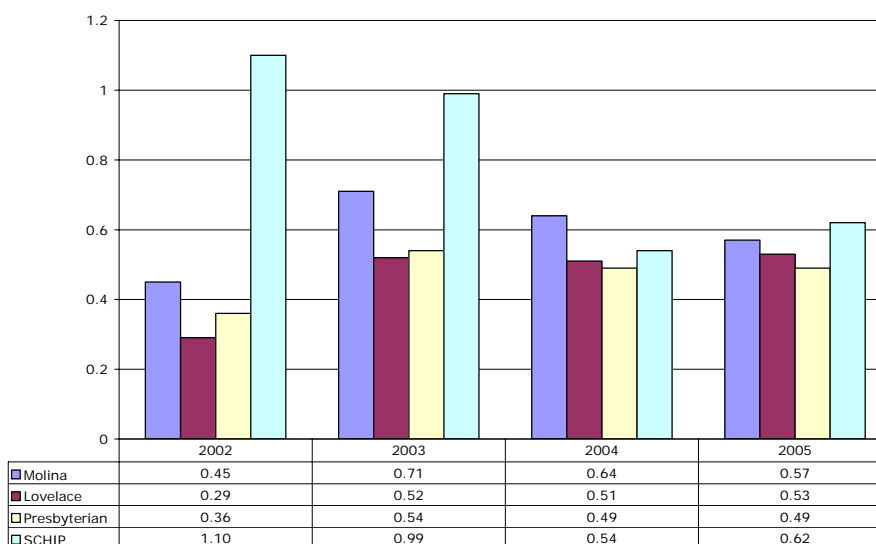


Table 10: Procedures / 1000 Member Months - Tonsillectomy 10-19



Tables 9 and 10 show the number of tonsillectomy procedures per 1,000 member months for the SCHIP population measured higher than the contracted MCOs' rates. The tables show that for tonsillectomy ages 0 – 9 the SCHIP utilization was within the same range as the contracted MCOs' rate, while in contrast the tonsillectomy age 10 – 19 years utilization for SCHIP was higher in all of the reported CYs.

Inpatient Utilization - General Hospital Acute Care

Rationale

This indicator describes the extent to which children and adolescents receive acute inpatient treatments.

HEDIS® Description

This measure summarizes utilization of acute inpatient services in the following categories: total services, medicine, surgery and maternity. Non-acute care, mental health and chemical dependency services, as well as newborn care, are excluded. Medical and surgical services are reported separately because the factors influencing utilization in these two categories vary. This method also facilitates comparisons between ambulatory surgery utilization (refer to the Ambulatory Care measure) and inpatient surgery utilization.

Findings

The first table for this key indicator, Table 11, shows the total of inpatient discharges per 1,000 member months for the SCHIP population measured below the contracted MCOs rate for all of the reported age categories for each reported CY. Likewise, the total number of inpatient days per 1,000 member months, reflected in Table 12, for the SCHIP population measured below the contracted MCOs' rates except for the 10 – 19 years of age category for CY 2005. Table 13 Total Inpatient Average Length of Stay, shows that the utilization for SCHIP enrollees fell within the reported MCOs' measured performance, with the exception of the age 10 – 19 years category which was higher in each of the reported CYs. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Age = <1 year of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	49247	45491	44973	44234
Lovelace	42998	46218	48285	488558
Presbyterian	79210	85711	89471	84329
SCHIP	2579	1646	1710	1919

Age = 1 – 9 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	325844	322099	318057	281040
Lovelace	289092	309449	325184	307273
Presbyterian	594431	633234	650861	589630
SCHIP	60255	64780	68276	68701

Age = 10 – 19 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	235881	237711	237878	207539
Lovelace	232922	247665	254902	234959
Presbyterian	479743	525454	541338	487712
SCHIP	61874	67597	72133	71541

Table 11: Total Inpatient Discharges / 1,000 Member Months

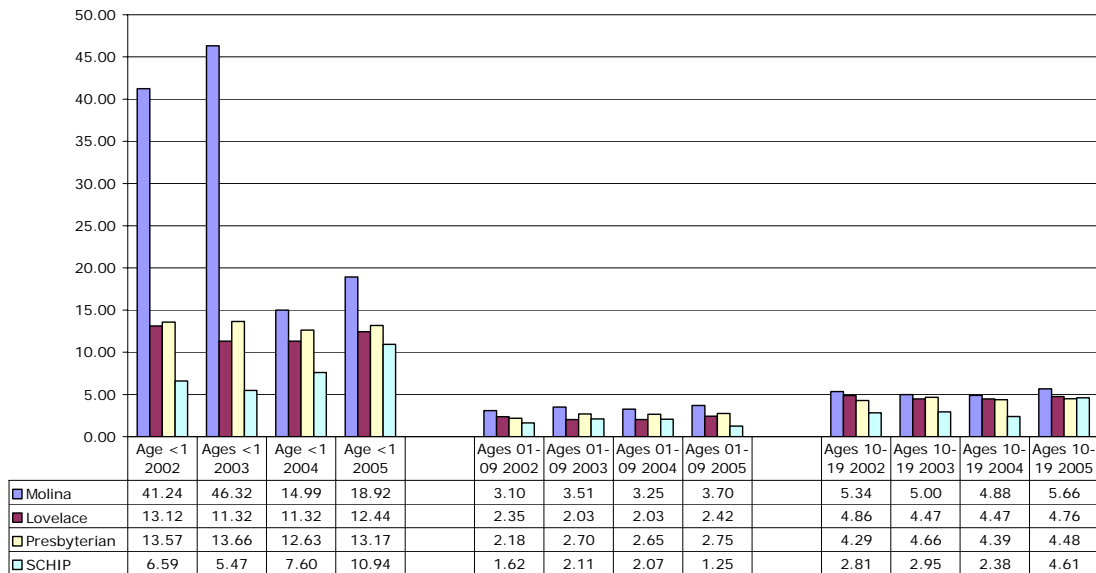
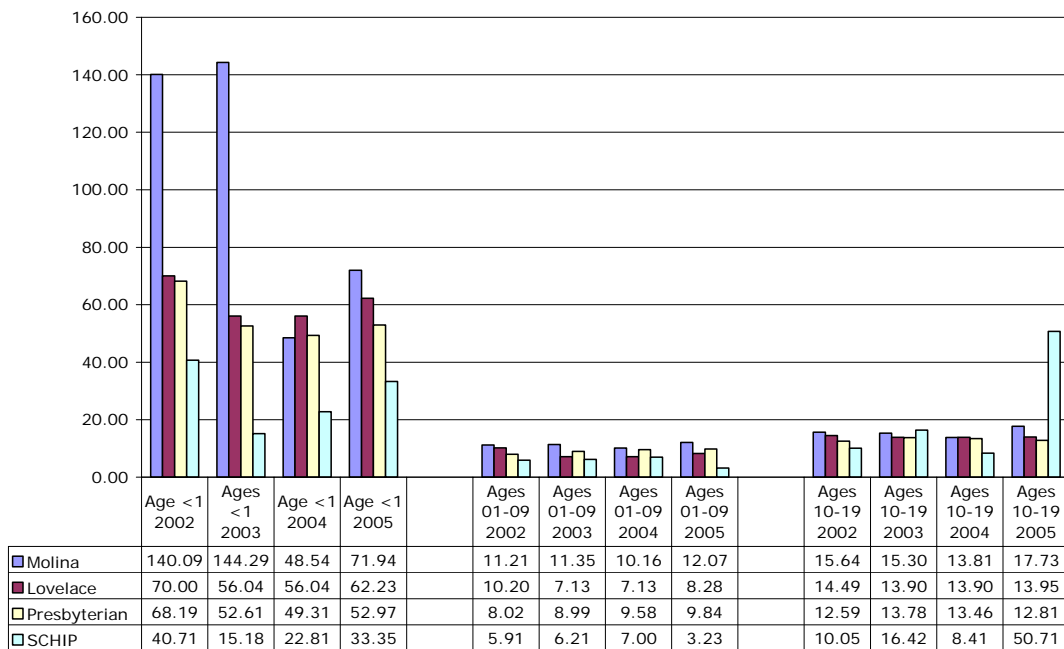


Table 12: Total Inpatient Days / 1,000 Member Months



The first table for this key indicator, Table 11, shows the total of inpatient discharges per 1,000 member months for the SCHIP population measured below the contracted MCOs rate for all of the reported age categories for each reported CY. Likewise, the total number of inpatient days per 1,000 member months, reflected in Table 12, for the SCHIP population measured below the contracted MCOs' rates except for the 10 – 19 years of age category for CY 2005.

Table 13: Total Inpatient Average Length of Stay

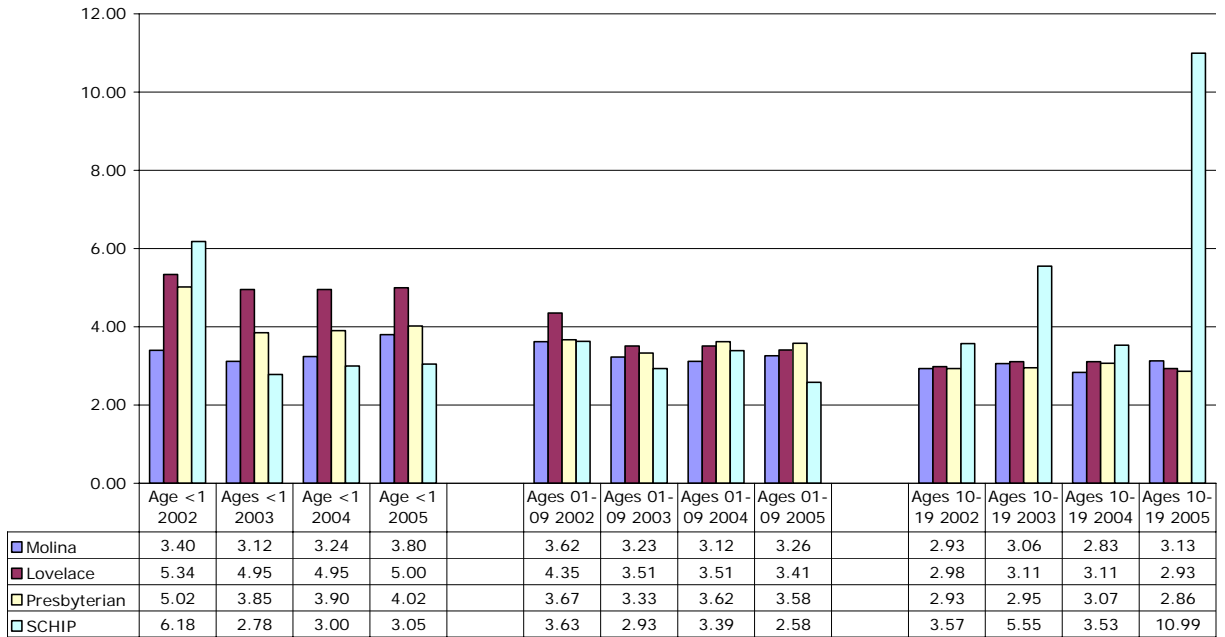


Table 13 Total Inpatient Average Length of Stay, shows that the utilization for SCHIP enrollees fell within the reported MCOs' measured performance, with the exception of the age 10 – 19 years category which was higher in each of the reported CYs.

Ambulatory Care

Rationale

This indicator describes the frequency of selected ambulatory care services including emergency department visits.

HEDIS® Description

This measure summarizes utilization of ambulatory services in the following categories: outpatient visits, emergency department visits, ambulatory surgery/procedures performed in the hospital, outpatient facilities or freestanding surgical centers, and observation room stays that result in discharge (observation room stays resulting in an inpatient admission and counted in the Inpatient Utilization – General Hospital/Acute Care measure).

Findings

Table 14 for this key indicator shows the total of ambulatory care outpatient visits for every 1,000 member months for the SCHIP population fell within the measured performance of the contracted MCOs for all of the reported age categories for each reported CY. The total number of emergency room visits for 1,000 member months, as shown in Table 15, for the SCHIP population measured within or below the contracted MCOs' rates for each of the reported CYs. Table 16, Ambulatory Surgical Visits, shows that SCHIP utilization measured within the contracted MCOs' measured performance with the exception of ages 10 – 19; which was higher in CYs 2003, 2004 and 2005. The last table in this section, Table 17, shows the rate of observation room stays resulting in discharge. The SCHIP population measured performance fell within the contracted MCOs' measured performance. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Age = <1 year of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	49247	45491	44973	44234
Lovelace	42998	46218	48285	488558
Presbyterian	79210	85711	89471	84329
SCHIP	2579	1646	1710	1919

Age = 1 – 9 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	325844	322099	318057	281040
Lovelace	289092	309449	325184	307273
Presbyterian	594431	633234	650861	589630
SCHIP	60255	64780	68276	68701

Age = 10 – 19 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	235881	237711	237878	207539
Lovelace	232922	247665	254902	234959
Presbyterian	479743	525454	541338	487712
SCHIP	61874	67597	72133	71541

Table 14: Ambulatory Care Outpatient Visits / 1,000 Member Months

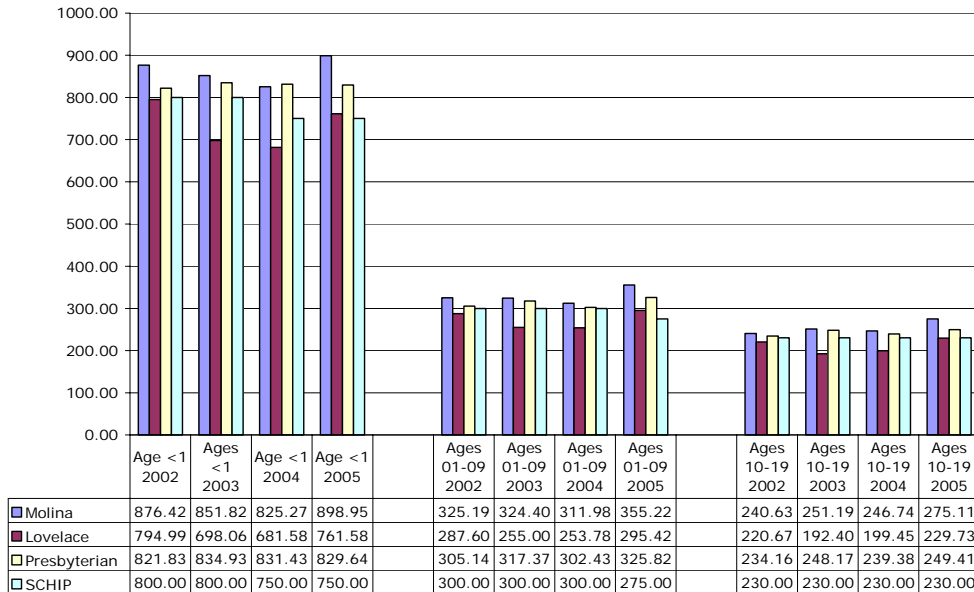


Table 15: Ambulatory Care Emergency Room Visits / 1,000 Member Months

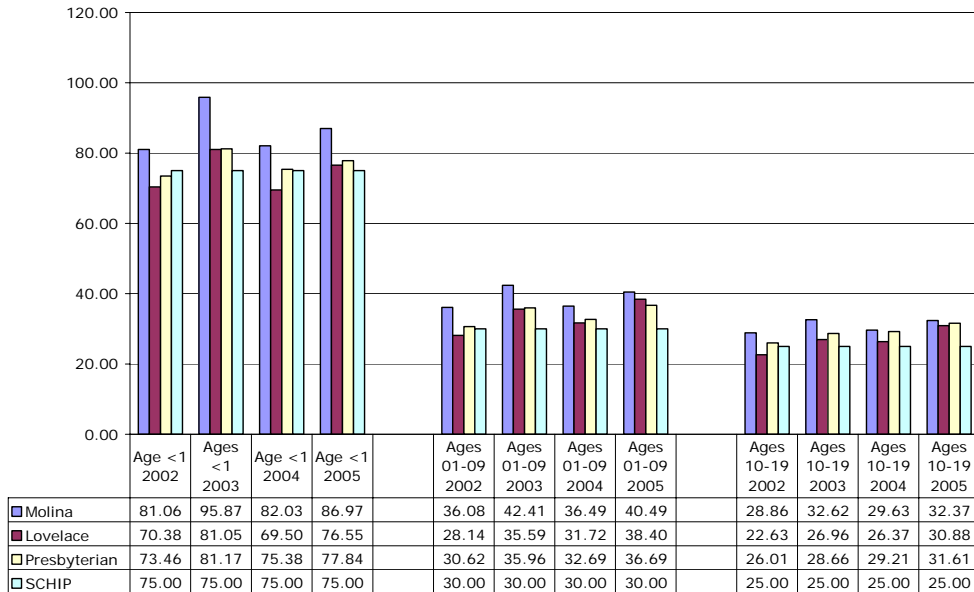


Table 14 for this key indicator shows the total of ambulatory care outpatient visits for every 1,000 member months for the SCHIP population fell within the measured performance of the contracted MCOs for all of the reported age categories for each reported CY.

The total number of emergency room visits for 1,000 member months, as shown in Table 15, for the SCHIP population measured within or below the contracted MCOs' rates for each of the reported CYs.

Table 16: Ambulatory Surgical Visits / 1,000 Member Months

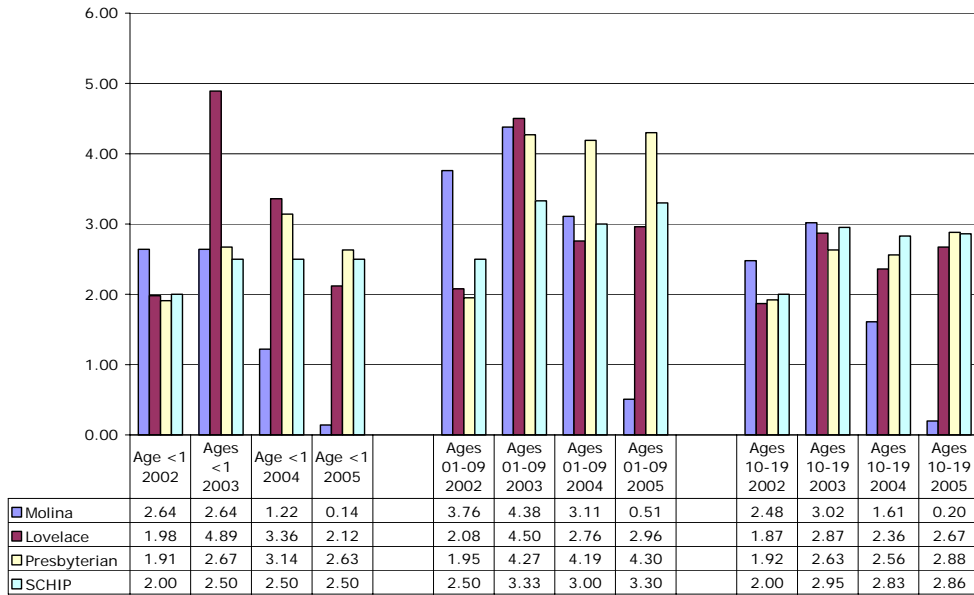


Table 17: Observation Room Stays Resulting in Discharge / 1,000 Member Months

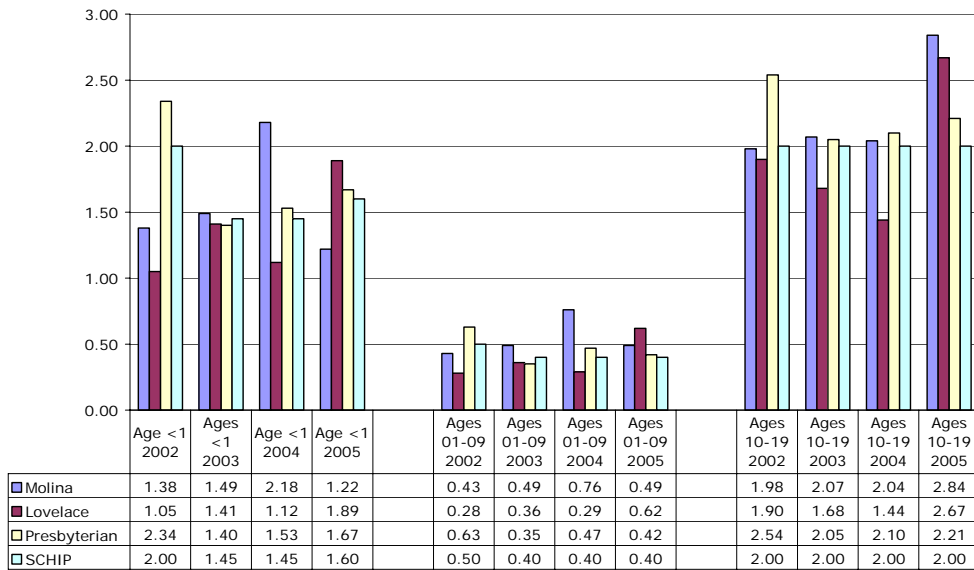


Table 16, Ambulatory Surgical Visits, shows that SCHIP utilization measured within the contacted MCOs' measured performance with the exception of ages 10 – 19; which was higher in CYs 2003, 2004 and 2005. The last table in this section, Table 17, shows the rate of observation room stays resulting in discharge. The SCHIP population measured performance fell within the contracted MCOs' measured performance.

Inpatient Utilization - General Hospital Non-acute Care

Rationale

This indicator describes the extent to which children and adolescents receive inpatient treatment in non-acute settings.

HEDIS® Description

This measure summarizes utilization of non-acute inpatient care in hospice, nursing home, rehabilitation, SNF, transitional care and respite. These data exclude services with a principal diagnosis of mental health and chemical dependency.

Findings

Table 18 shows the inpatient non-acute care discharges for every 1,000 member months for the SCHIP population measured within the performance of the contracted MCOs' rates for all of the reported age categories for each reported CY. Likewise, the total number of inpatient non-acute care days for 1,000 member months, as shown in Table 19, for the SCHIP population measured below the contracted MCOs' rate for each of the reported CYs. Table 20, Inpatient Non-acute Care Average Length of Stay, reflects that SCHIP utilization fell within or below the contracted MCOs' measured performance for the CYs reported. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Age = <1 year of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	49247	45491	44973	44234
Lovelace	42998	46218	48285	488558
Presbyterian	79210	85711	89471	84329
SCHIP	2579	1646	1710	1919

Age = 1 – 9 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	325844	322099	318057	281040
Lovelace	289092	309449	325184	307273
Presbyterian	594431	633234	650861	589630
SCHIP	60255	64780	68276	68701

Age = 10 – 19 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	235881	237711	237878	207539
Lovelace	232922	247665	254902	234959
Presbyterian	479743	525454	541338	487712
SCHIP	61874	67597	72133	71541

Table 18: Inpatient Nonacute Care Discharges / 1,000 Member Months

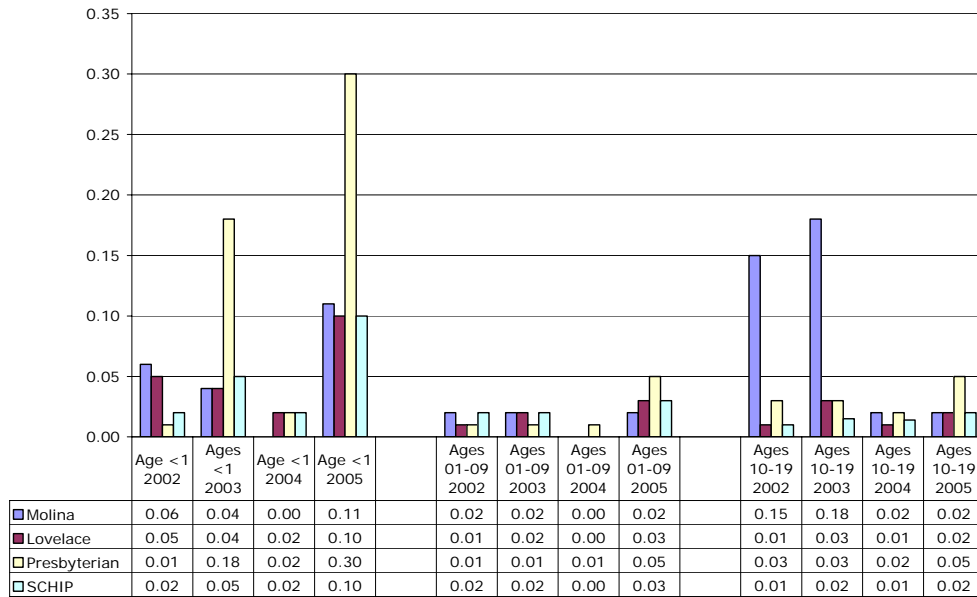


Table 19: Inpatient Nonacute Care Days / 1,000 Member Months

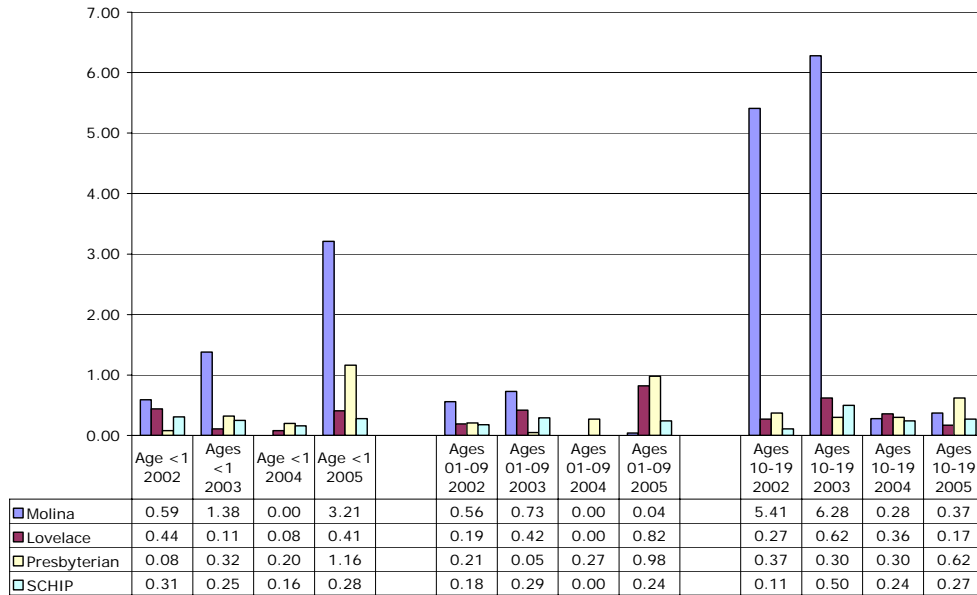


Table 18 shows the inpatient non-acute care discharges for every 1,000 member months for the SCHIP population measured within the performance of the contracted MCOs' rates for all of the reported age categories for each reported CY. Likewise, the total number of inpatient non-acute care days for 1,000 member months, as shown in Table 19, for the SCHIP population measured below the contracted MCOs' rate for each of the reported CYs.

Table 20: Inpatient Nonacute Care Average Length of Stay

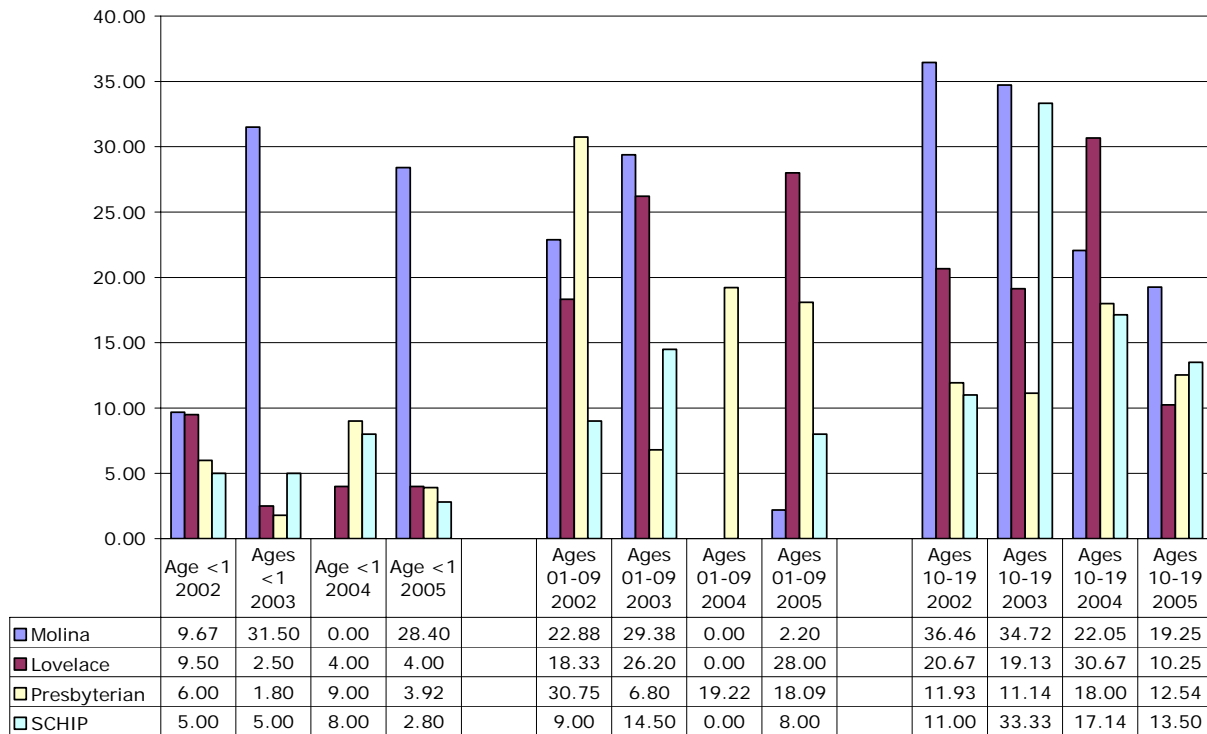


Table 20, Inpatient Non-acute Care Average Length of Stay, reflects that SCHIP utilization fell within or below the contacted MCOs' measured performance for the CYs reported.

Discharges and Average Length of Stay - Maternity Care & Cesarean Section Rate

Rationale

Discharges and Average Length of Stay – Maternity: This indicator describes how many adolescent females gave birth during the reporting year.

Cesarean Section Rate Rationale: This indicator describes the cesarean section rate for adolescent females who gave birth during the reporting year.

HEDIS® Description

This indicator measures the utilization of maternity-related care for enrolled females who had live births during the measurement year, reported for total deliveries, vaginal deliveries and Cesarean section (C-section) deliveries.

Finding

There were no Maternity encounters in the reported New Mexico SCHIP experience for the calendar years 2002 – 2005 inclusive. No comparison data is shown for these measures.

Mental Health Utilization¹

Rationale

This indicator reports the percentage of members receiving care for mental illness.

HEDIS® Description

This measure summarizes utilization of inpatient mental health services, stratified by age and sex.

Findings

Table 21 for this key indicator shows the total of mental health inpatient discharges per every 1,000 member months for the SCHIP population measured below the performance of the contracted MCOs for all of the reported age categories for each reported CYs with one exception; female age 13 – 17 for CYs 2003 and 2004 measured performance fell within the contracted MCOs measured performance. Table 22 shows the mental health inpatient average length of stay. The SCHIP measured performance scored within the contracted MCOs' performance for all age categories and CYs with the exception of CY 2004; the SCHIP measured performance was higher than the reported MCOs' rates. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Male age 0 – 12

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	236488	232602	228937	N/A
Lovelace	210284	225316	234032	N/A
Presbyterian	435419	465404	477874	N/A
SCHIP	43272	46640	48758	49040

Female age 0 - 12

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	226808	222977	220425	N/A
Lovelace	208003	221602	230893	N/A
Presbyterian	419729	449126	457387	N/A
SCHIP	42204	44220	46232	45840

Male age 13 – 17

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	61245	61704	62364	N/A
Lovelace	60919	64667	67820	N/A
Presbyterian	123934	136531	143225	N/A
SCHIP	17654	19194	20988	21306

Female age 13 - 17

Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	60543	61574	62273	N/A
Lovelace	60031	64054	67011	N/A
Presbyterian	126369	138386	144361	N/A
SCHIP	16721	18464	19836	19996

¹ In July 2005 a new statewide entity was contracted to provide behavioral health services previously delivered by the three MCOs. Therefore none of the MCOs completed HEDIS® reporting on these measures for the partial year 2005 and no comparisons were developed for CY 2005.

Table 21: Mental Health Inpatient Discharges / 1,000 Member Months

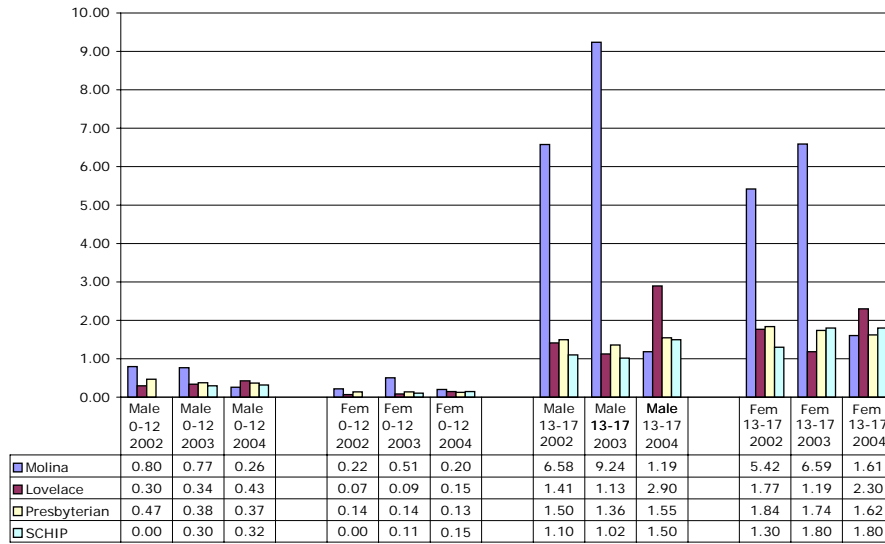


Table 22: Mental Health Inpatient Average Length of Stay

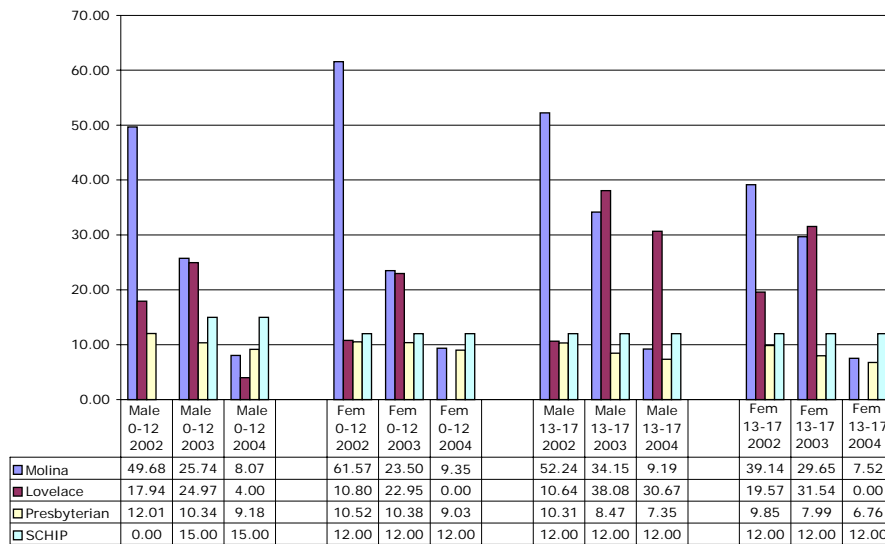


Table 21 shows the total of mental health inpatient discharges per every 1,000 member months for the SCHIP population measured below or within the performance of the contracted MCOs for all of the reported age categories for each reported CY. Table 22 shows the mental health inpatient average length of stay. The SCHIP measured performance scored within the contracted MCOs' performance for all age categories and CYs with the exception of CY 2004; the SCHIP measured performance was higher than the reported MCOs' rates.

Note: In July 2005 a new statewide entity was contracted to provide behavioral health services previously delivered by the three MCOs. Therefore none of the MCOs completed HEDIS® reporting on these measures for the partial year 2005 and no comparisons were developed for CY 2005

Chemical Dependency Utilization²

Rationale

This indicator reports the percentage of members receiving care for chemical dependency.

HEDIS® Description

This measure summarizes utilization of inpatient chemical dependency services, stratified by age and sex.

Findings

Table 23 shows the total chemical dependency inpatient discharges per every 1,000 member months for the SCHIP population measured below the performance of the contracted MCOs for the Male age 13 – 17 category for all of the reported CYs. In contrast, the SCHIP population measured significantly higher in the Female age 13 – 17 for all of the CYs reported. Table 24 shows that the chemical dependency inpatient average length of stay for SCHIP measured within the contracted MCOs measured performance. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Male age 0 – 12 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	236488	232602	228937	N/A
Lovelace	210284	225316	234032	N/A
Presbyterian	435419	465404	477874	N/A
SCHIP	43272	46640	48758	49040

Female age 0 – 12 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	226808	222977	220425	N/A
Lovelace	208003	221602	230893	N/A
Presbyterian	419729	449126	457387	N/A
SCHIP	42204	44220	46232	45840

Male age 13 – 17 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	61245	61704	62364	N/A
Lovelace	60919	64667	67820	N/A
Presbyterian	123934	136531	143225	N/A
SCHIP	17654	19194	20988	21306

Female age 13 – 17 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	60543	61574	62273	N/A
Lovelace	60031	64054	67011	N/A
Presbyterian	126369	138386	144361	N/A
SCHIP	16721	18464	19836	19996

² In July 2005 a new statewide entity was contracted to provide behavioral health services, including chemical dependency services, previously delivered by the three MCOs. Therefore the contracted MCOs reported partial year CY 04 HEDIS®, and no comparisons were developed for CY 2005.

Table 23: Chemical Dependency Inpatient Discharges / 1,000 Member Months

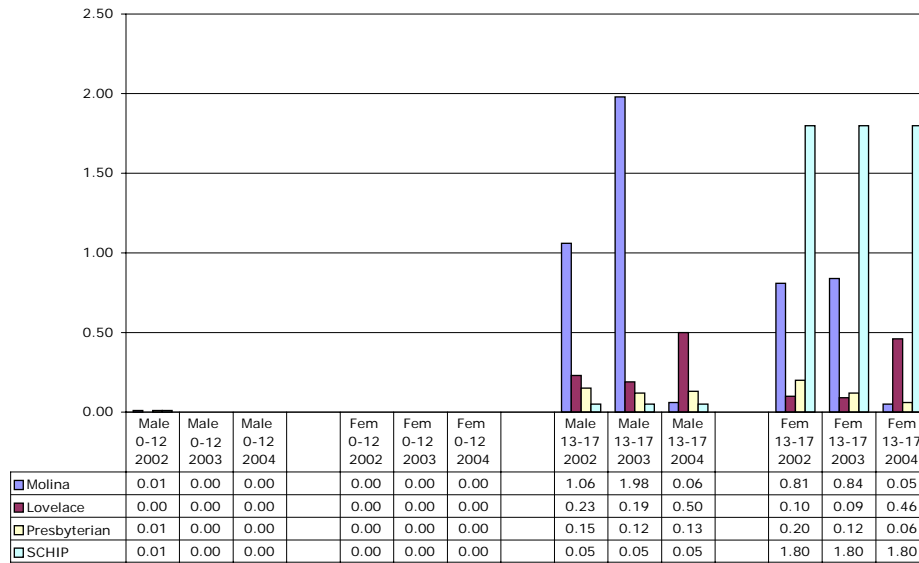


Table 24: Chemical Dependency Inpatient Average Length of Stay

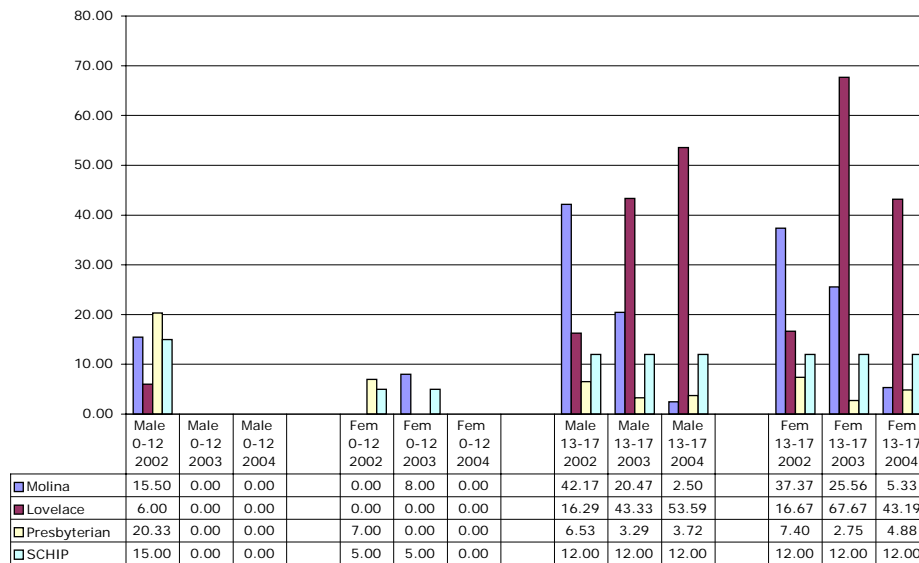


Table 23 shows the total chemical dependency inpatient discharges per every 1,000 member months for the SCHIP population measured below the performance of the contracted MCOs for the Male age 13 – 17 category for all of the reported CYs. In contrast, the SCHIP population measured significantly higher in the Female age 13 – 17 for all of the CYs reported. Table 24 shows that the chemical dependency inpatient average length of stay for SCHIP measured within the contracted MCOs measured performance.

Note: In July 2005 a new statewide entity was contracted to provide behavioral health services previously delivered by the three MCOs. Therefore none of the MCOs completed HEDIS® reporting on these measures for the partial year 2005 and no comparisons were developed for CY 2005

Outpatient Drug Utilization

Rationale

Managing the use and cost of prescription medications is one aspect of managing utilization. This indicator reports the average number of prescriptions and the average cost of prescriptions.

HEDIS® Description

This measure provides the data on outpatient utilization of drug prescriptions (total cost of prescriptions; average cost of prescriptions per member per month (PMPM); total number of prescriptions; average number of prescriptions per member per year (PMPY) during the measurement year, stratified by age.

Findings

The first table for this key indicator, Table 25, shows the average cost of prescription PMPM for the SCHIP population measured less than the contracted MCOs for all of the reported categories, except for the measurement period CY 2003 Age 0 – 9. In the most recent CY, 2005, the reported cost of prescription is notably less than the MCOs' rates. Likewise the SCHIP average number of prescriptions PMPM, shown in Table 26, was the lowest when compared to the contracted MCOs for all categories reported. The numbers of continuously enrolled member-months, by age category, for the contracted MCOs and SCHIP consumers by reported CY were:

Age 0 - 9

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	375091	367590	363030	325274
Lovelace	332090	355667	373469	355831
Presbyterian	673641	718945	740332	673959
SCHIP	62834	66426	69986	70620

Age 10 - 19

Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	235881	237711	237878	207539
Lovelace	232922	247665	254902	234959
Presbyterian	479743	525454	541338	487712
SCHIP	61874	67597	72133	71541

Table 25: Average Cost of Prescriptions PMPM

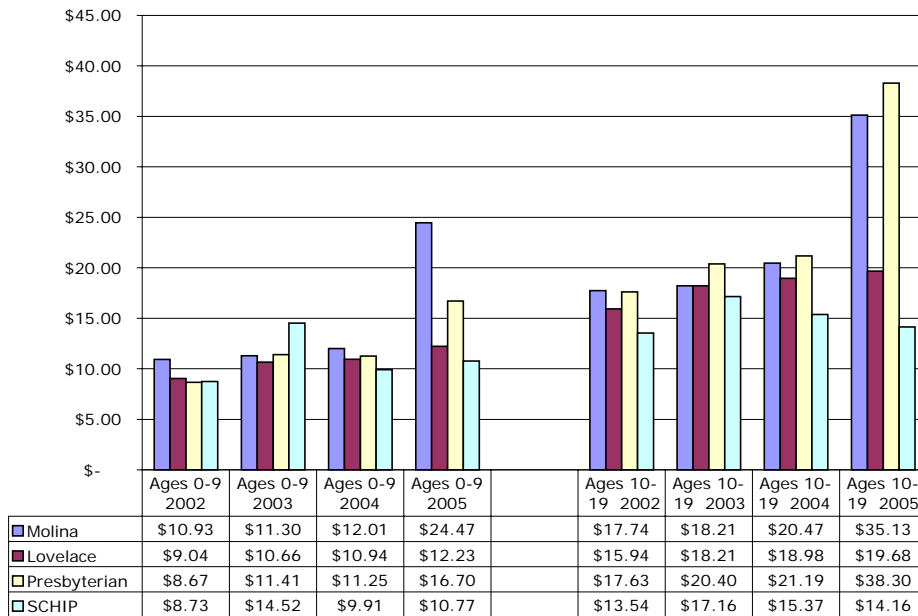


Table 26: Average Number of Prescriptions PMPM

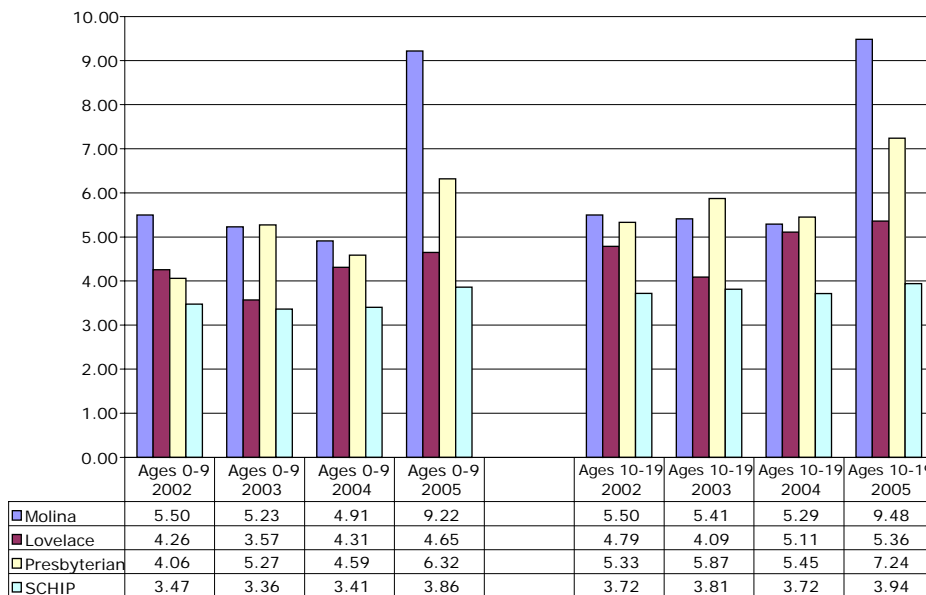


Table 25 shows the average cost of prescription PMPM for the SCHIP population measured less than the contracted MCOs for all of the reported categories, except for the measurement period CY 2003 Age 0 – 9. In the most recent CY, 2005, the reported cost of prescription is notably less than the MCOs' rates. Likewise the SCHIP average number of prescriptions PMPM, shown in Table 26, was the lowest when compared to the contracted MCOs for all categories reported.

(2). Health Status

The following series of tables presents the retrospective review of utilization patterns for SCHIP members, which are represented in light blue, compared to the three contracted MCOs; Lovelace Community Health Plan (Lovelace) represented in red; Molina Health Care of New Mexico, Inc. (Molina) represented in dark blue and Presbyterian Salud (Presbyterian) represented in yellow. The following HEDIS® measures were selected to gauge health status:

Childhood Immunization Status

Rationale

Immunizations protect children and adolescents against preventable and serious illness and are an example of primary prevention. This indicator measures the percents of children and adolescents who received selected immunization within specified time frames.

HEDIS® Description

This indicator measures the percent of enrolled children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Findings³

Beginning on the next page, Tables 27 through 30 show the childhood immunization status rates for the SCHIP population measured well below the contracted MCOs and HEDIS national average for all reported categories. The tables show that the percentages range from a low of zero percent for five of the six required immunizations (DtaP/DPT, IPV, HIB, HEP B and VZV) in CY 2002 to 2.2 percent for three of required immunizations (DtaP/DPT, IPV, PC) and significant improvement for the following immunizations; MMR 54.3 percent, and VZV 52.2 percent for SCHIP enrollees.

During the study period, SCHIP children were less than half as likely to be continuously enrolled during a calendar year measurement period as were other Medicaid consumers. For these indicators, which are limited to consumers who were continuously enrolled (as defined in the HEDIS® methodology), a much smaller proportion of the SCHIP population is being measured, which is a source of potential methodological bias. The numbers of continuously enrolled members for the contracted MCOs and SCHIP consumers by reported CY were:

Age 0 - 9

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	2084	2231	2126	1724
Lovelace	2018	1991	2220	1937
Presbyterian	3968	4339	4202	3546
SCHIP	15	102	106	46

³ HEDIS defines the eligible denominator population for this measure as children continuously enrolled for the 12 months immediately prior to their second birthday, but considers all immunizations from birth to the second birthday in computing the numerators. Because of the SCHIP 6 month waiting period, available encounter data is not generally available for the first 6 months of life for SCHIP enrollees, and so the SCHIP numerators are significantly understated. This measure should be evaluated with caution.

Table 27: Childhood Immunization Status CY2005

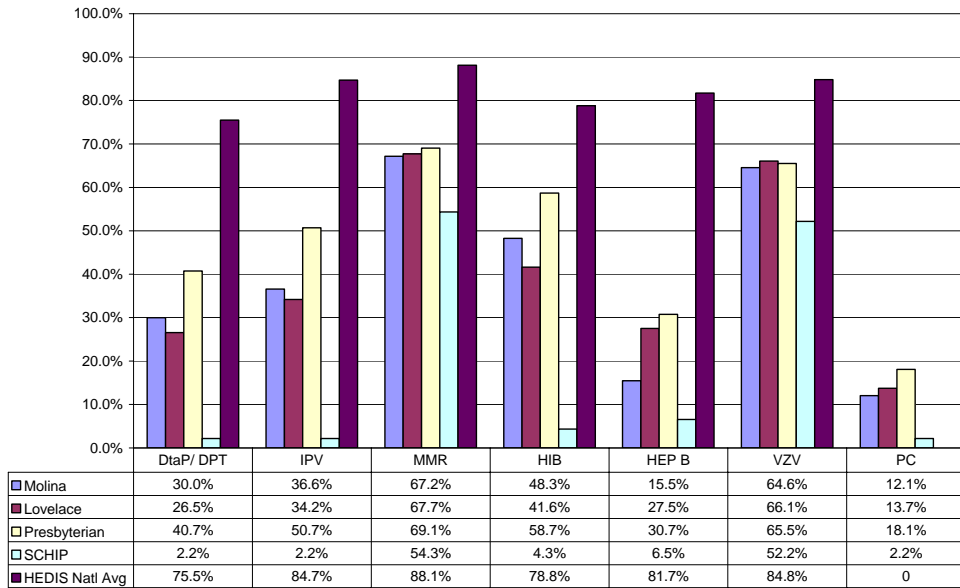
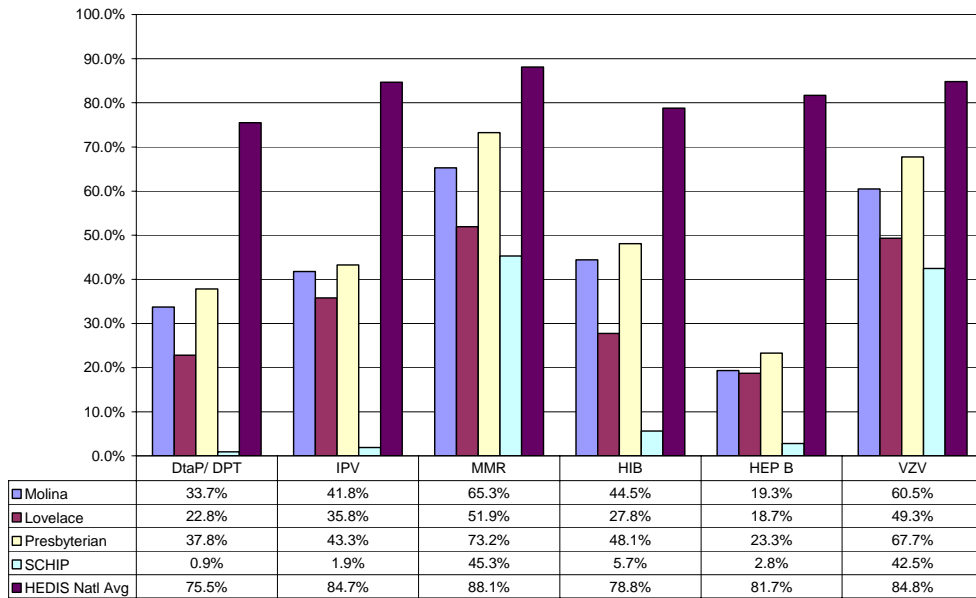


Table 28: Childhood Immunization Status CY2004



Tables 27 and 28 show the childhood immunization status rates for the SCHIP population measured well below the contracted MCOs and HEDIS national average for all reported categories.

Table 29: Childhood Immunization Status CY2003

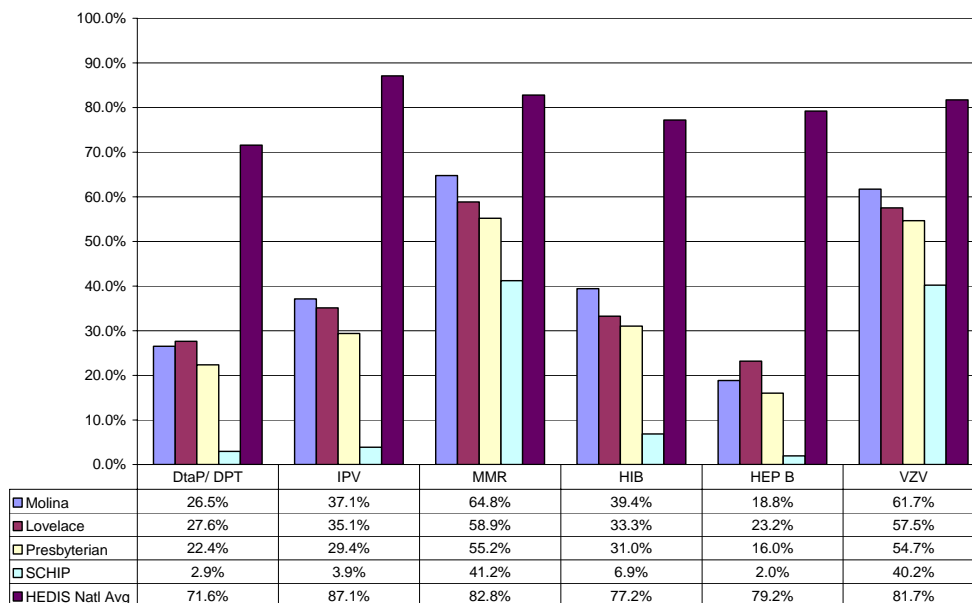
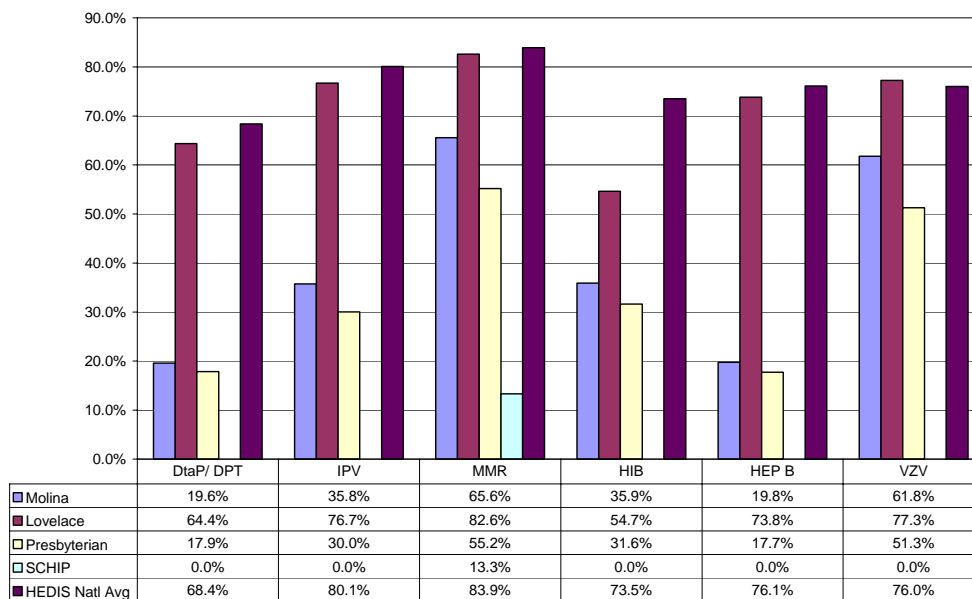


Table 30: Childhood Immunization Status CY2002



Tables 29 and 30 show the childhood immunization status rates for the SCHIP population measured well below the contracted MCOs and HEDIS national average for all reported categories.

Adolescent Immunization Status

Rationale

Immunizations protect adolescents against preventable and serious illness and are an example of primary prevention. This indicator measures the percents of children and adolescents who received selected immunization within specified time frames.

HEDIS® Description

This indicator measures the percentage of enrolled adolescents 13 years of age who had a second dose of MMR, three hepatitis B and one chicken pox (VZV) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Findings⁴

Beginning on the next page, Tables 31 through 34 reflect the adolescent immunization status rates for the SCHIP population measured well below the contracted MCOs' reported rates for all of the categories.

The numbers of continuously enrolled members for the contracted MCOs and SCHIP consumers by reported CY were:

Age 0 - 13

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	1534	1745	1729	1466
Lovelace	1586	1717	1926	1543
Presbyterian	3554	3812	4150	3491
SCHIP	18	160	176	76

⁴ HEDIS methodology for this measure is highly dependent on access to each qualifying member's complete lifetime immunization records. Because this individual medical history information was not available to NMMRA, and because of the small numbers of qualifying SCHIP members (members had to be continuously enrolled for the 12 months preceding their 13th birthday), this HEDIS measure was not calculated.

Table 31: Adolescent Immunization Status - CY2005

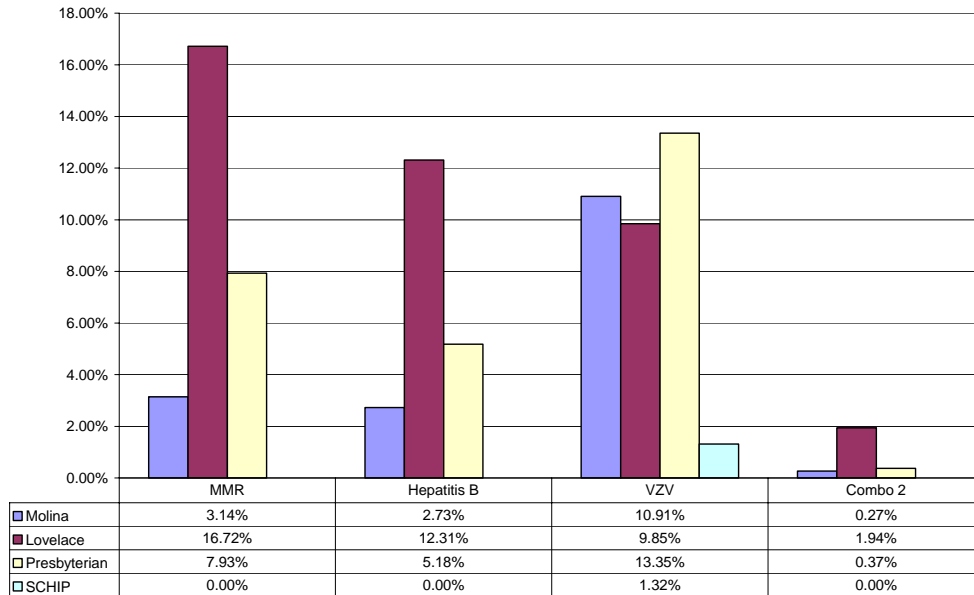
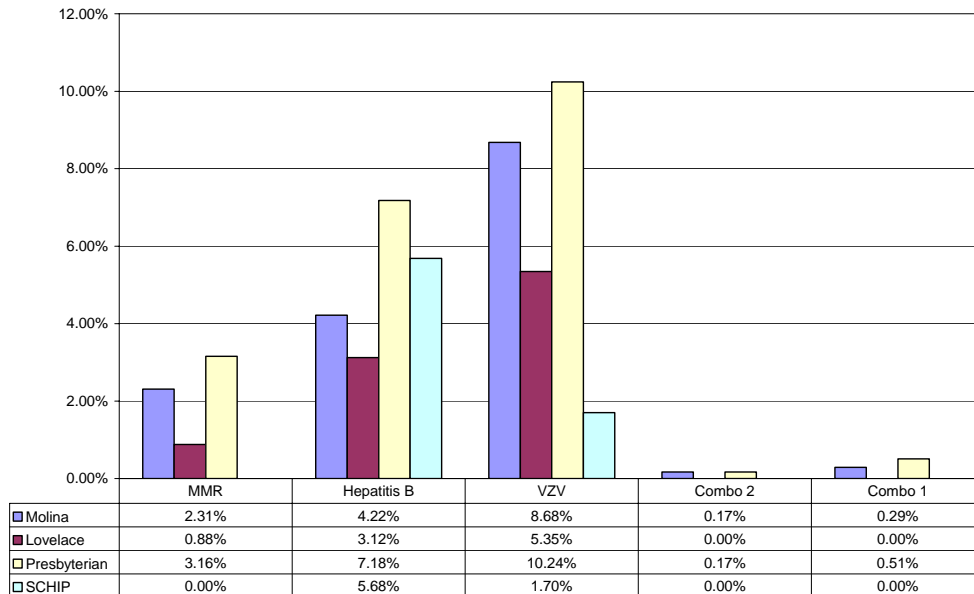


Table 32: Adolescent Immunization Status - CY2004



Tables 31 through 32 reflect the adolescent immunization status rates for the SCHIP population measured well below the contracted MCOs' reported rates for all of the categories.

Note: HEDIS methodology for this measure is highly dependent on access to each qualifying member's complete lifetime immunization records. Because this individual medical history information was not available to NMMRA, and because of the small numbers of qualifying SCHIP members (members had to be continuously enrolled for the 12 months preceding their 13th birthday), this HEDIS measure was not calculated.

Table 33: Adolescent Immunization Status - CY2003

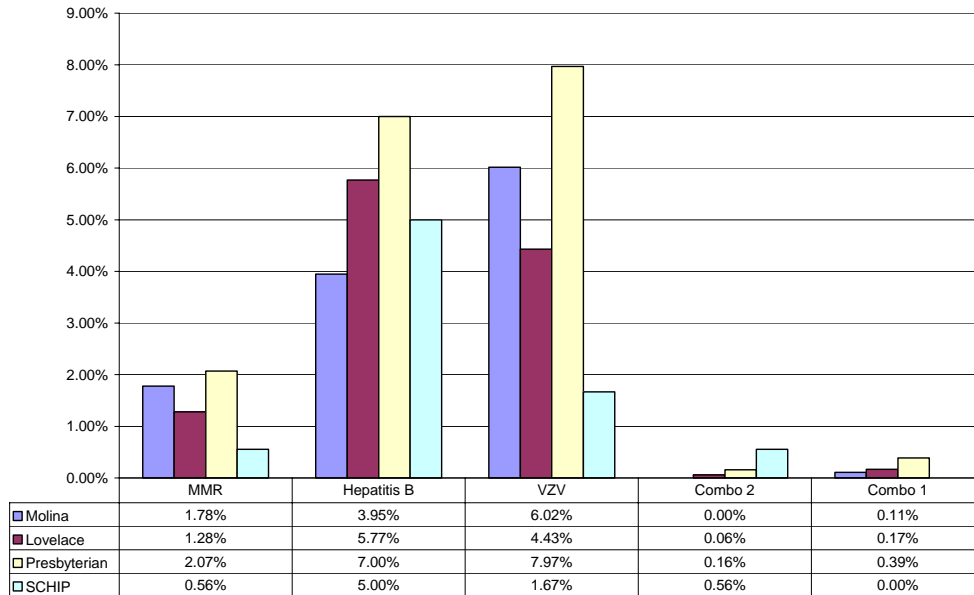
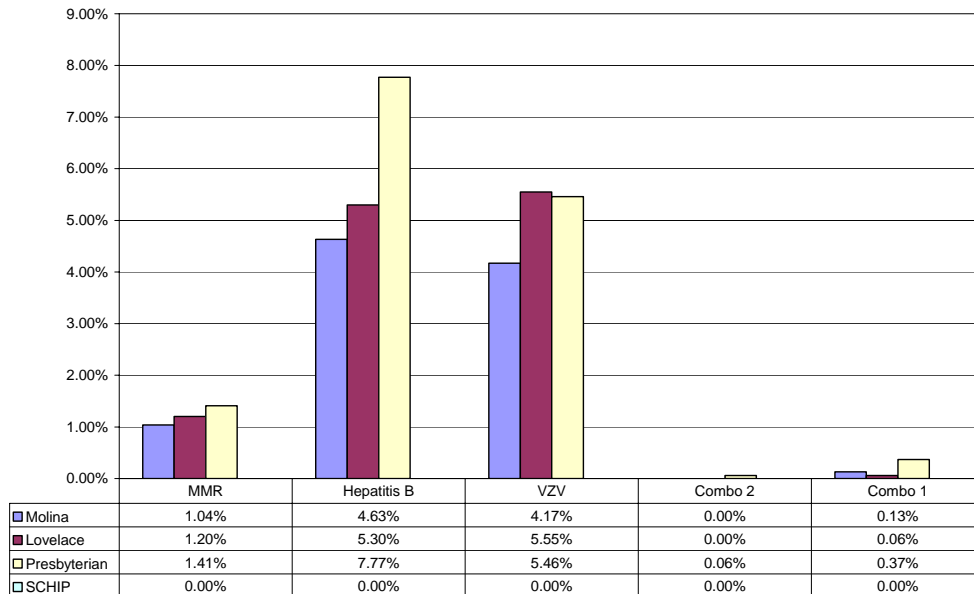


Table 34: Adolescent Immunization Status - CY2002



Tables 33 and 34 reflect the adolescent immunization status rates for the SCHIP population measured well below the contracted MCOs' reported rates for all of the categories.

Note: HEDIS methodology for this measure is highly dependent on access to each qualifying member's complete lifetime immunization records. Because this individual medical history information was not available to NMMRA, and because of the small numbers of qualifying SCHIP members (members had to be continuously enrolled for the 12 months preceding their 13th birthday), this HEDIS measure was not calculated.

Use of Appropriate Medications for Children with Asthma⁵

Rationale

Asthma is a common chronic childhood disease. This indicator measures the percentage of children and adolescents with asthma who are prescribed appropriate medications.

HEDIS® Description

This indicator measures the percentage of enrolled members 5 – 17 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Findings

As shown in Tables 35 through 38, the percentage rate of appropriate medications for children with asthma for the SCHIP population measured higher than the HEDIS® National Average and within the reported MCOs' rates. The numbers of continuously enrolled members for the contracted MCOs and SCHIP consumers by reported CY were:

Age 5 – 9 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	375	440	378	195
Lovelace	287	360	341	208
Presbyterian	703	725	761	426
SCHIP	0	32	44	46

Age 10 – 17 years of age

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	485	524	463	245
Lovelace	440	562	543	360
Presbyterian	990	1055	975	391
SCHIP	0	75	74	77

⁵ This measure requires a diagnosis of persistent asthma based on treatment in the current and preceding calendar years, and continuous enrollment in the current and preceding calendar years. Since SCHIP began in New Mexico in calendar year 2002, there were no members that year who were continuously enrolled in the prior year. Therefore this indicator was not calculated for SCHIP for 2002.

Table 35: Appropriate Medications for Children with Asthma - CY 2005

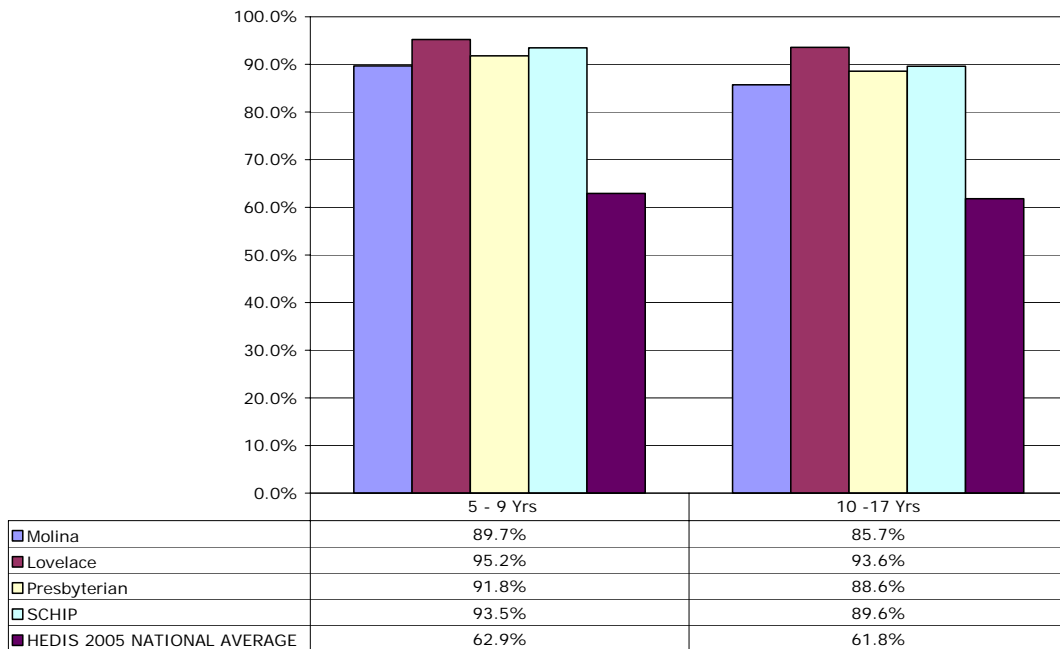
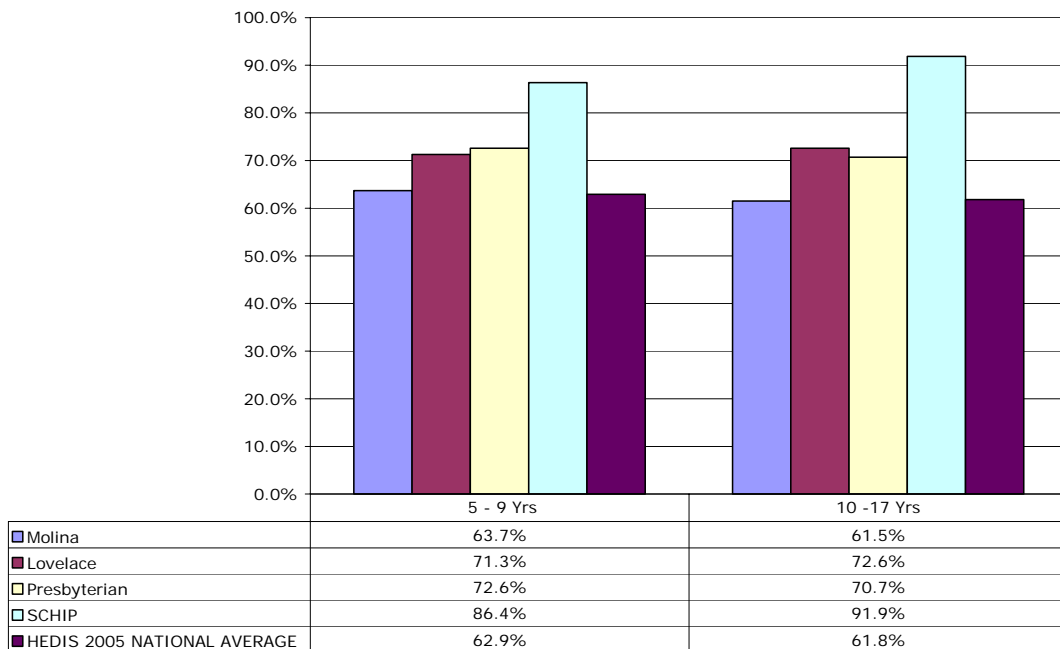


Table 36: Appropriate Medications for Children with Asthma - CY 2004



As shown in Tables 35 and 36, the percentage rate of appropriate medications for children with asthma for the SCHIP population measured higher than the HEDIS® National Average and within the reported MCOs' rates.

Table 37: Appropriate Medication for Children with Asthma - CY2003

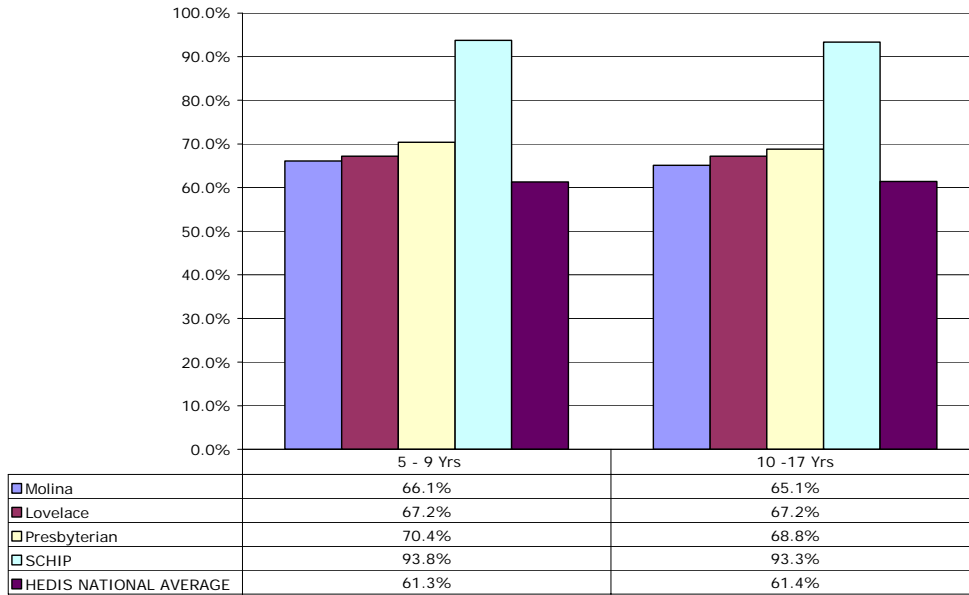
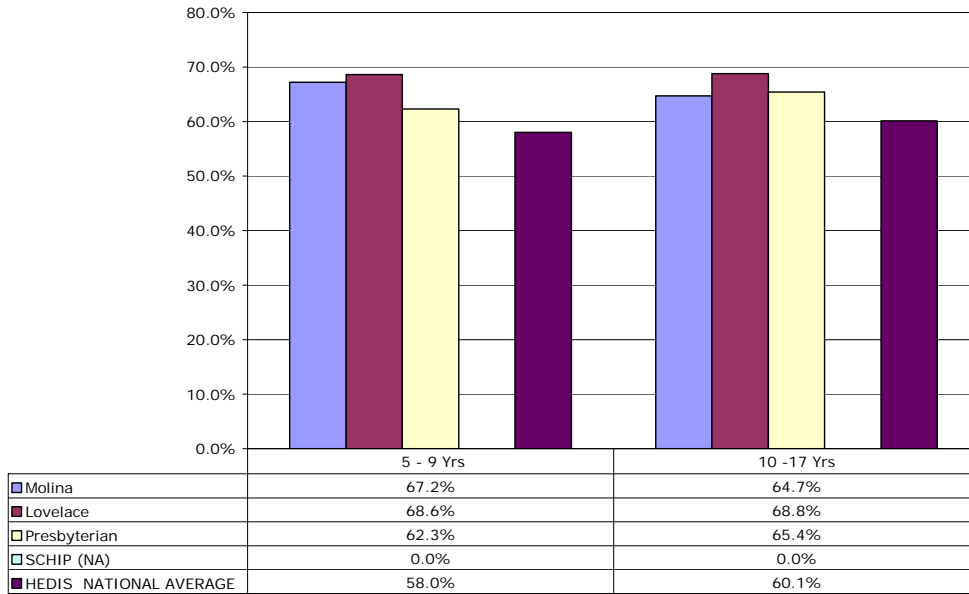


Table 38: Appropriate Medication for Children with Asthma - CY2002



In Tables 37, the percentage rate of appropriate medications for children with asthma for the SCHIP population measured higher than the HEDIS® National Average and within the reported MCOs' rates.

Regarding Table 38, this measure requires a diagnosis of persistent asthma based on treatment in the current and preceding calendar years, and continuous enrollment in the current and preceding calendar years. Since SCHIP began in New Mexico in calendar year 2002, there were no members that year who were continuously enrolled in the prior year. Therefore this indicator was not calculated for SCHIP for 2002.

(3). Access

The following series of tables presents the retrospective review of utilization patterns for SCHIP members, which are represented in light blue, compared to the three contracted MCOs; Lovelace Community Health Plan (Lovelace) represented in red; Molina Health Care of New Mexico, Inc. (Molina) represented in dark blue and Presbyterian Salud (Presbyterian) represented in yellow. The following HEDIS® measures were selected to gauge access to health care services:

Annual Dental Visit

Rationale

This indicator measures the percentage of children and adolescents who saw a dental care provider within the measurement year.

HEDIS® Description

This indicator measures the percentage of enrolled members 2 through 21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCOs' Medicaid contract.

Findings

Tables 39 through 42 reflect the percentage of enrolled members 2 through 21 who had at least one dental visit for each CY. The rate for the SCHIP population measured significantly lower than the HEDIS® National Average and the contracted MCOs' performance rates. The numbers of continuously enrolled members for the contracted MCOs and SCHIP consumers by reported CY were:

Age 2 – 3 (new category)

MCO/Plan	CY 2005
Molina	3652
Lovelace	3941
Presbyterian	7224
SCHIP	259

Age 4 - 6

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	6403	6723	6293	5262
Lovelace	5753	6314	6329	5247
Presbyterian	12632	13229	13039	10614
SCHIP	686	722	593	438

Age 7 - 10

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	7715	7828	7316	6012
Lovelace	7150	7620	7231	6294
Presbyterian	15983	16612	15810	12640
SCHIP	949	1088	932	722

Age 11 - 14

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	6780	7174	6739	5623
Lovelace	6715	7334	7115	6040
Presbyterian	15172	16370	15691	12784
SCHIP	1058	1174	1030	872

Age 15 - 18

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	5167	5526	5240	4445
Lovelace	5097	5794	5772	4885
Presbyterian	11297	12630	12446	10563
SCHIP	909	1054	923	766

Age 19 - 21

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	784	926	892	765
Lovelace	752	989	998	860
Presbyterian	0	1845	1935	1631
SCHIP	19	23	20	13

Table 39: Annual Dental Visits - CY2005

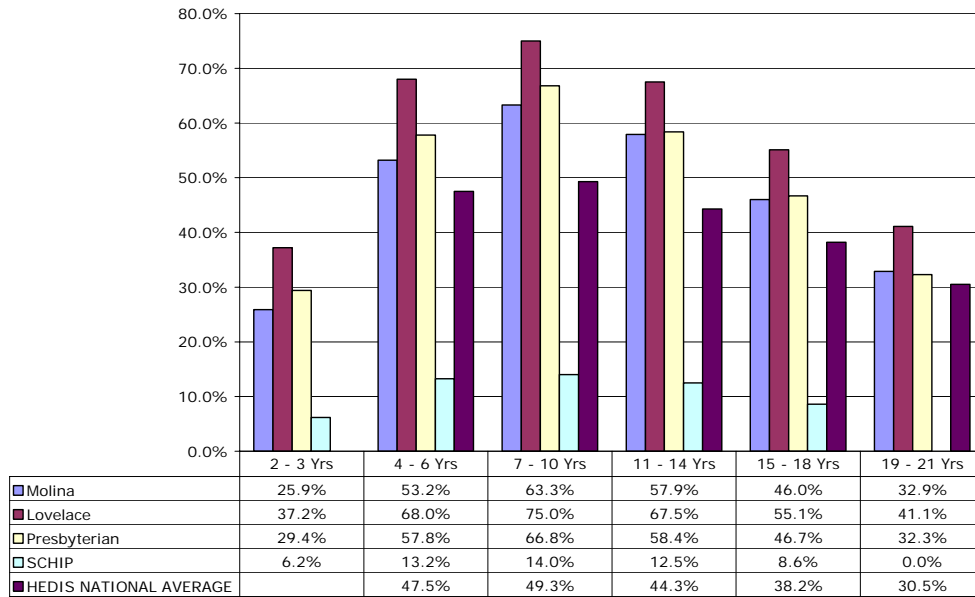
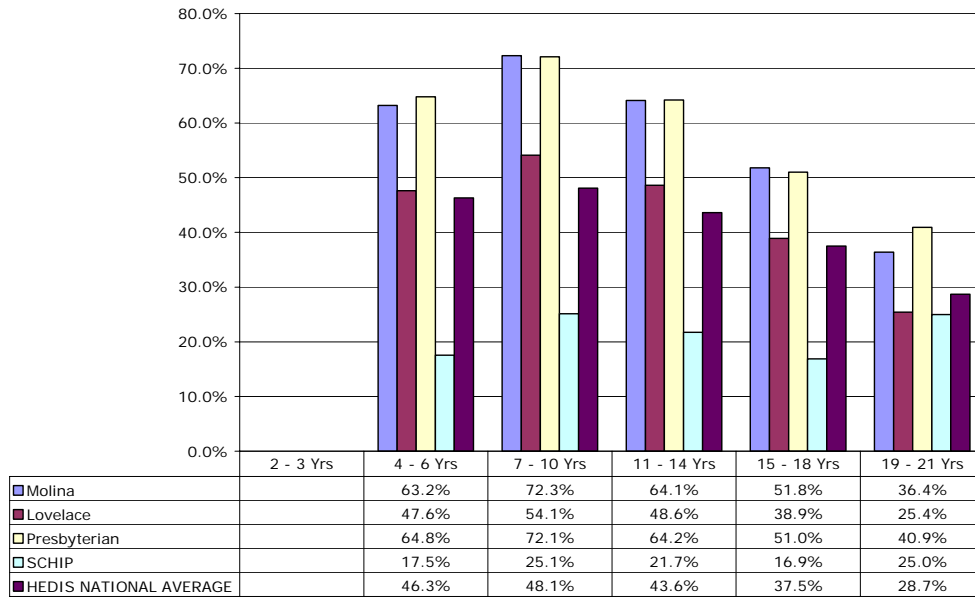


Table 40: Annual Dental Visits - CY2004



Tables 39 and 40 reflect the percentage of enrolled members 2 through 21 who had at least one dental visit for each CY. The rate for the SCHIP population measured significantly lower than the HEDIS® National Average and the contracted MCOs' performance rates.

Table 41: Annual Dental Visits - CY2003

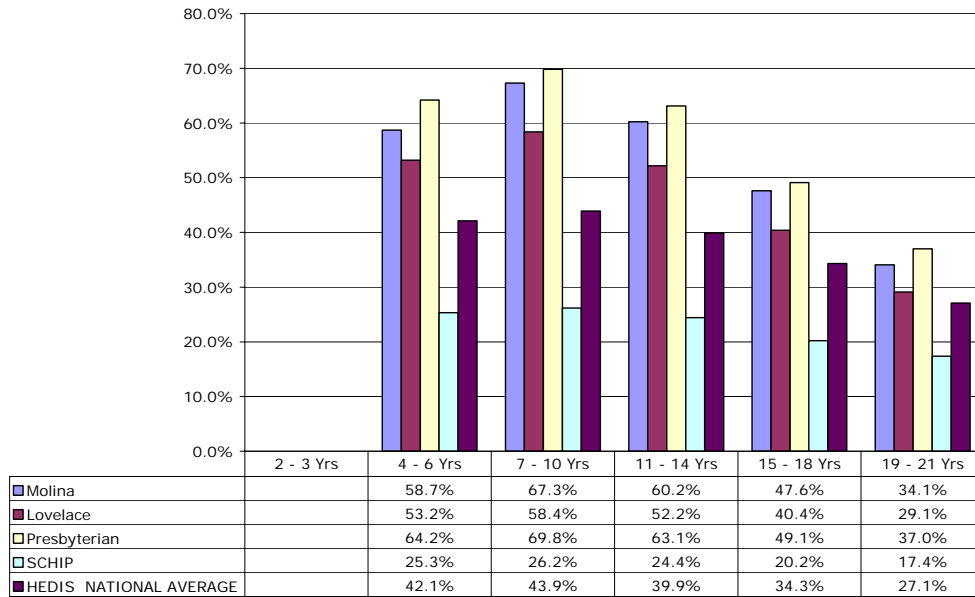
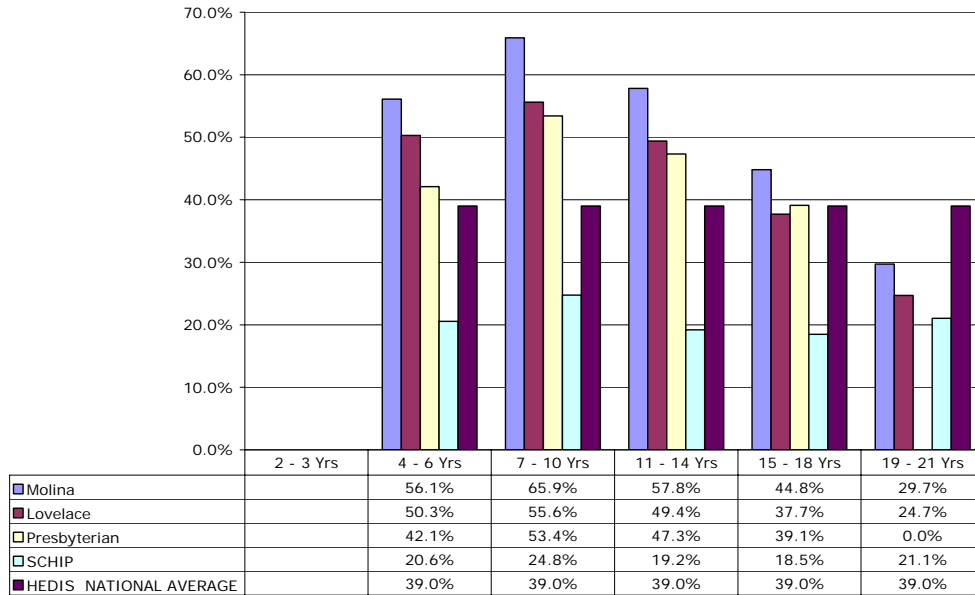


Table 42: Annual Dental Visits - CY2002



Tables 41 and 42 reflect the percentage of enrolled members 2 through 21 who had at least one dental visit for each CY. The rate for the SCHIP population measured significantly lower than the HEDIS® National Average and the contracted MCOs' performance rates.

Children's and Adolescents' Access to Primary Care Practitioner

Rationale

This indicator measures the percentage of children and adolescents who saw a health care provider for primary care within specified time frames.

HEDIS® Description

This indicator measures the percentage of enrolled 12 through 24 months, 25-months through six-years, seven through 11 years and 12 – 19 years of age who had a visit with an MCO primary care practitioner. The MCO reports four separate percentages for each product line: children 12 – 24 months and 25 months – 6 years who had a visit with an MCO primary care practitioner during the measurement year, and children 7 – 11 and adolescents 12 – 19 years of age who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year.

Findings

The percentage of enrolled SCHIP members 2 through 21 years in age who had a primary care practitioner visit measured lower than the HEDIS® National Average and lower than the contracted MCOs' performance rates for all of the CYs reported as shown in Tables 43 through 46. The numbers of continuously enrolled members for the contracted MCOs and SCHIP consumers by reported CY were:

Age 12 – 24 months

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	2282	2411	2182	2122
Lovelace	1902	2432	2413	2122
Presbyterian	4485	4462	4483	3738
SCHIP	120	118	103	68

Age 25 months – 6 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	11112	11295	10585	8751
Lovelace	9045	10682	10703	9016
Presbyterian	20854	22406	21916	17513
SCHIP	828	906	692	522

Age 7 – 11 years

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	6270	7267	912	5810
Lovelace	5982	6918	7032	5970
Presbyterian	14334	15710	6857	12701
SCHIP	1210	1386	15249	912

Age 12 – 19 years (added in CY 2003)

MCO/Plan	CY 2002	CY 2003	CY 2004	CY 2005
Molina	N/A	8167	8248	6979
Lovelace	N/A	8502	8823	7565
Presbyterian	N/A	19227	19519	16883
SCHIP	N/A	1953	1741	1461

Table 43: Children's Access to Primary Care Practitioner - CY2005

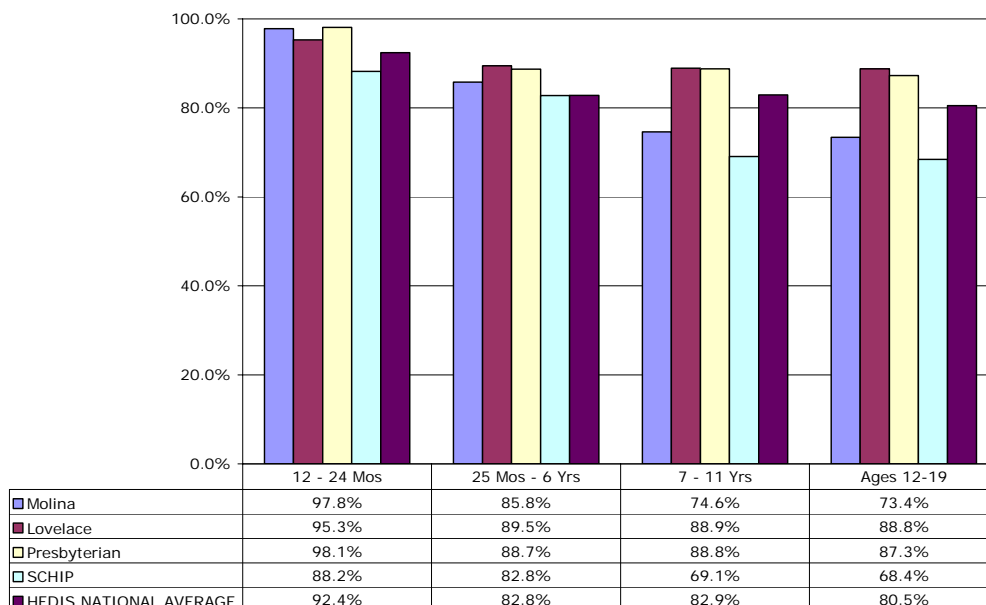
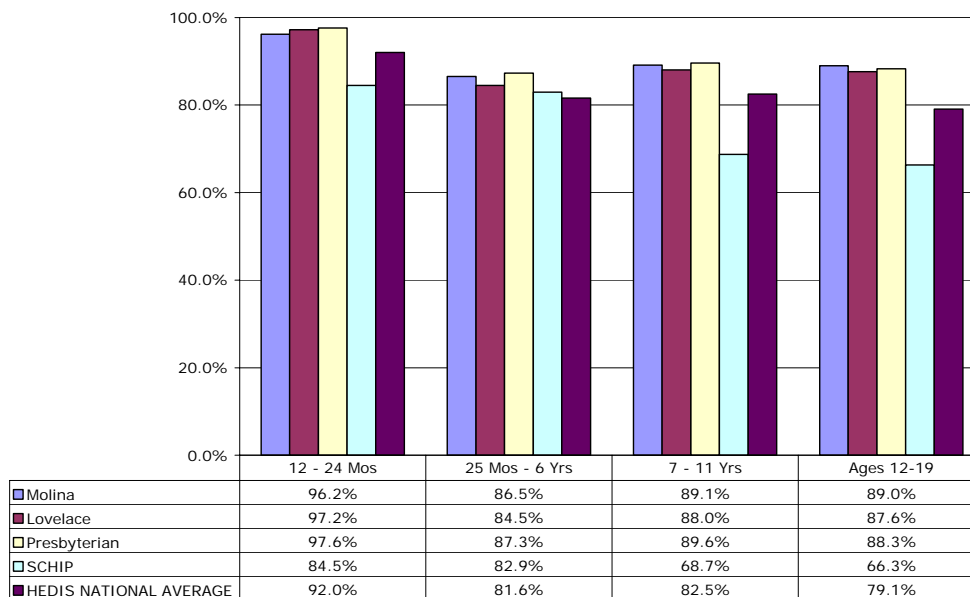


Table 44: Children's Access to Primary Care Practitioner - CY2004



The percentage of enrolled SCHIP members 2 through 21 years in age who had a primary care practitioner visit measured lower than the HEDIS® National Average and lower than the contracted MCOs' performance rates for all of the CYs reported as shown in Tables 43 and 44.

Table 45: Children's Access to Primary Care Practioner - CY2003

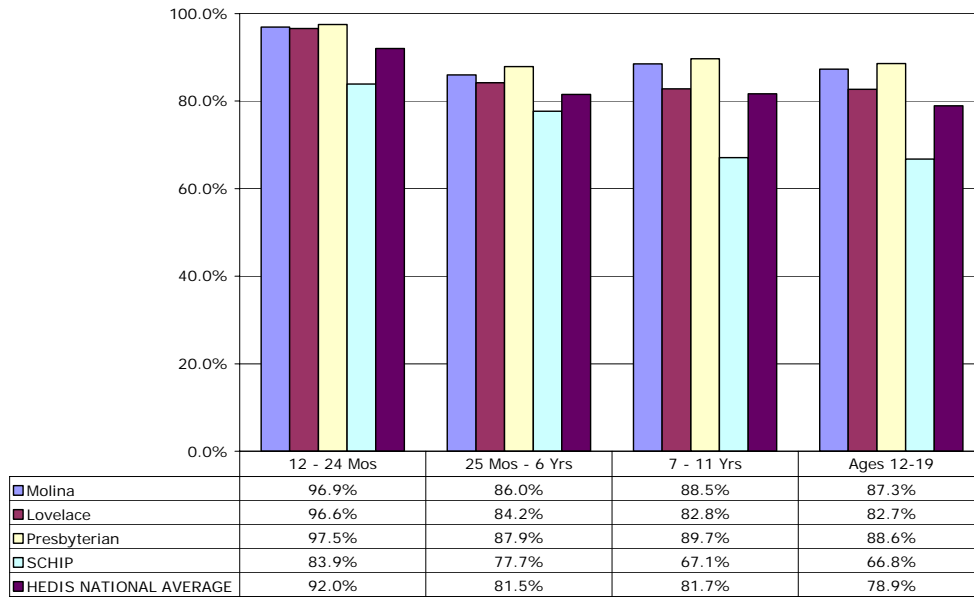
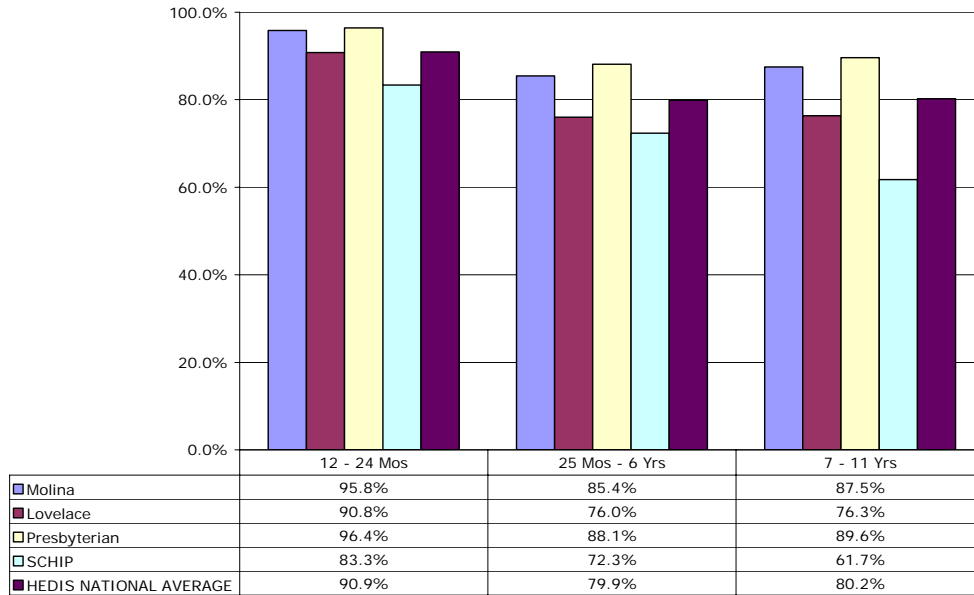


Table 46: Children's Access to Primary Care Practioner - CY2002



The percentage of enrolled SCHIP members 2 through 21 years in age who had a primary care practitioner visit measured lower than the HEDIS® National Average and lower than the contracted MCOs' performance rates for all of the CYs reported as shown in Tables 45 and 46.

Recommendations

The SCHIP program has undergone a number of changes. The state should continue to monitor the effects of all program changes; eligibility requirements, enrollment trends (ricochet in and out of coverage), covered benefits, co-payments and vendor performance.

The SCHIP program has been successful in providing health care services to children and adolescents. The program should continue educational and outreach programs to increase the percentage of immunizations, preventive care and dental services.

The SCHIP program has been popular and successful in providing needed health care coverage to an underserved segment of NM's population. It is recommended that the SCHIP program be continued.

Conclusion

While the data presented in this report show some differences in utilization patterns for SCHIP consumers compared with regular Medicaid consumers, there is little evidence to suggest that the differences are due to the imposition of waiting periods or co-payments. There are many other factors which also influence childrens' healthcare utilization.

The first set of HEDIS® measures were selected to gauge the use of health care services. The SCHIP population fell below in the measured metrics for all indicators when compared to the MCOs' Medicaid population, and below the HEDIS® national average when reported. There were no data or utilization patterns to suggest that the imposition of co-payments, which were required for some of the services reported in this data set, had an unfavorable impact on the use of health care services. However, several HEDIS® indicators were limited to consumers who were continuously enrolled, which may have resulted in bias.

The second set of HEDIS® measures were selected to gauge the effectiveness of health care services and evaluate health status. The findings reflect that SCHIP children and adolescents received fewer immunizations when compared to the state's managed Medicaid population. The SCHIP rates fell well below the rates reported by the contracted MCOs and the national HEDIS® metrics. The findings were primarily driven by the continuous enrollment requirements, as explained above, and not the imposition of co-payments. Immunization health services are exempt from co-payment requirements. The use of appropriate medications for SCHIP children with asthma measured higher than the HEDIS® national average and within the reported MCOs' rates for the managed Medicaid population. Asthma health services are exempt from co-payment requirements.

The final set of HEDIS® measures were selected to gauge access and availability of health care services. The findings reflect that the percentage of children and adolescents who saw a dental care provider within the measurement year measured significantly lower than the HEDIS® national average and the contracted MCOs' rates. The findings were primarily driven by the continuous enrollment requirements. Dental services for all managed Medicaid programs, including SCHIP, requires a \$5 co-payment for services. The percentage of children and adolescents who saw a health care provider for primary care within specified time frames measured slightly lower than the HEDIS® national average and the contracted MCOs' rates. The findings were primarily driven by the continuous enrollment requirements, and not the imposition of co-payments. Primary care services are exempt from co-payment requirements.