Independent Assessment of New Mexico’s Medicaid Managed Care Program – Coordination of Long Term Services

Final Report
June 28, 2013

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I. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) requires regular and periodic independent assessment for all state-waivered Medicaid managed care systems by an External Quality Review Organization (EQRO). The New Mexico Human Services Department (HSD) has oversight of the state’s managed care system, which is currently split into three programs: Physical Health (PH) Salud!, Behavioral Health (BH) Statewide Entity (SE), and the Coordination of Long Term Services (CoLTS). HSD has contracted with HealthInsight New Mexico as its EQRO to perform the assessments for these three programs on a biennial basis. The following report is the assessment of the CoLTS program, which operates under a 1915(c) waiver of the Social Security Act granted by CMS, and serves the aged, disabled, and acutely ill population in New Mexico.¹

During the assessment period, two managed care organizations (MCOs) were under contract with HSD to serve the CoLTS population:

- Amerigroup Community Care of New Mexico, Inc. (AMG)
- UnitedHealthcare Community Plan (formerly Evercare of New Mexico) (UHC)

The assessment period covered in this report is the state Fiscal Year (FY) 2012: July 1, 2011 to June 30, 2012.

This Independent Assessment report is an in-depth analysis of quantitative and qualitative information obtained regarding the two MCOs and the CoLTS program in general. It focuses on:

- Access to care
- Quality of care
- Cost-effectiveness

The findings of the analysis for each section are summarized below. A full description of the analysis is provided in the main body of the report.

Access Findings

Based on an analysis of the information provided by HSD, it appears that the CoLTS program met the requirements for access.

The overall CoLTS program distribution of total provider groups or services compared to total member population appeared to be closely matched. Individual MCO access was also examined, but they could not be compared to each other because of differences in what was measured by each MCO. AMG measured three categories of provider groups/services and UHC measured seven.

Access for urban members was excellent for all categories measured (91 to 100 percent had access to providers and/or services). Access for rural members was good, ranging from 81 to 97 percent in the categories measured. Frontier access was excellent for

¹ It should be noted that only the CoLTS aspects of New Mexico managed care and the MCOs associated with this program were included in this report. Separate independent assessments have been prepared for the PH Salud! and BH SE programs.
primary care physicians (PCPs) and pharmacies (99 percent for both categories), but access to specialists, such as otolaryngology and cardiology, was between 51 and 64 percent. Access to these specialty services in frontier locations was an area where there was opportunity to improve.

A maximum of 1,500 Medicaid members are allowed to be assigned to a single provider. The provider-to-member ratio in the CoLTS program was very low. AMG had an average of 1.2 members for each provider and UHC had an average of 3.4 members for each provider. This indicates a high potential for CoLTS Medicaid members to obtain care from the provider of choice.

Customer satisfaction was measured using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)\textsuperscript{2} 4.0H Adult Medicaid Survey. Two of the composite questions on the survey related to access and the remainder of the composites addressed quality topics. In the access-related section of the survey, members were asked several questions about their satisfaction with “Getting Needed Care” and “Getting Care Quickly.” The MCOs scored between 76 and 85 percent satisfaction on the access-related questions, which when compared to national results, were at or above the national means and placed them in the 50\textsuperscript{th} percentile or higher.

Call answering timeliness and call abandonment rates were also examined as a measurement of customer satisfaction. The standard was 90.0 percent of all calls would be answered within 30 seconds and no more than 5.0 percent of the calls waiting would be abandoned. Neither MCO met the standard for answering timeliness (87.1 percent of AMG’s calls were answered within 30 seconds, and 79.5 percent of UHC’s), thus creating an opportunity for improvement. However, both MCOs were well within the 5.0 percent abandonment threshold.

Access to information was abundant and found through the following sources: websites, member handbooks, provider network listings, and service support call centers. Information was available to all members and caregivers (including non-English speakers and hearing impaired) and could be accessed via oral, written, and electronic avenues.

**Quality Findings**

All applicable quality reports and documents provided by HSD were reviewed, and based on this information, it appears that the CoLTS program met the requirements for quality of care.

Each MCO had a comprehensive Quality Management/Quality Improvement (QM/QI) program and a corresponding plan to carry it out. Sensitivity to cultural needs was evidenced by the Cultural Competency Plans that each MCO had created and followed. The MCOs used various methods to communicate with stakeholders and maintain transparency, such as open committee meetings and newsletters.

Performance measures (PMs) and performance improvement projects (PIPs), established in FY 2009, continued to be carried out and results remained at acceptable levels.

\textsuperscript{2} CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Harmful or potentially harmful events, known as critical incidents, averaged one (1) incident for every eight (8) members. Although high, this rate is not unexpected due to the fragile health condition of many of the CoLTS members. The largest percentage of incidents (67.5 percent) occurred around Emergency Services.

Overall CoLTS service utilization averaged eight (8) healthcare service visits per member during FY 2012. The rate of denial of services or claims payments was very low (0.02 percent), which corresponded to the small amount of provider grievances and appeals.

There was a total of only eight (8) provider grievances filed (zero [0] for AMG and eight [8] for UHC). The amount of member grievances totaled 731 and the ratios were one (1) out of every 116 members filed a member grievance at AMG and one (1) out of every 35 members filed at UHC. The top reason cited for both member and provider grievances related to ground transportation for emergent and/or non-emergency situations.

The ratio for member appeals averaged one (1) out of every 25 members. The majority (89.3 percent) of the member appeals filed were related to personal care options (PCO) hours being reduced by the MCO. Provider appeals filed for AMG averaged one (1) out of 4,135 members, which was very low (only five [5] appeals filed in FY 2012). UHC had a ratio of one (1) out of 80. Reasons for provider appeals were varied.

AMG and UHC completed the annually required provider and member satisfaction surveys. The response rate for the provider survey was low (15.5 percent for AMG and 4.0 percent for UHC), and AMG only provided a summary data report containing minimal data to HSD. Consequently, only one question could be compared between the two MCOs. About 50 percent of both AMG and UHC providers rated their health plan/MCO “About the Same” as other health plans/MCOs; 18.0 percent of AMG providers and 27.1 percent of UHC providers felt their plan was “Significantly/Somewhat Better” than others.

Conversely, the response rates for the member surveys were significantly higher (34.7 percent for AMG and 35.3 percent for UHC) than the national average of 29 percent. Both MCOs surveyed their members via the CAHPS® 4.0H Adult Medicaid Survey. Members rated their MCOs at or above the national averages for all composite measures relating to “Experience with Care” and “Effectiveness of Care.”

Although not required, both MCOs applied for National Committee for Quality Assurance (NCQA) accreditation. Two requirements must be completed prior to receiving accreditation: 1) meet the minimum requirements for CAHPS® consumer satisfaction scores and HEDIS® performance measures related to prevention and treatment, and 2) undergo an on-site inspection by NCQA-certified team members. Both MCOs have submitted their CAHPS® results and HEDIS® performance measures and received passing scores. They are awaiting their on-site audits.

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3 HEDIS® is the acronym for Healthcare Effectiveness Data and Information Set and is a registered trademark of NCQA.
AMG and UHC submitted to annual external quality review audits required by CMS for regulation/contract compliance, PMs evaluation, and PIPs evaluation. Both AMG and UHC earned the rating of Full Compliance on all of their FY 2012 audits.

**Cost-effectiveness Findings**

After reviewing all available financial reports provided by HSD and comparing the data to national reports, the CoLTS program appeared to be cost-effective and actuarially sound.

The MCOs demonstrated fiscal responsibility by maintaining financial viability and stability and meeting all contract requirements.

The program’s average operating margin in FY 2012 showed a slight gain (4.5 percent). Although this is a small percentage, it is considered high when compared to the national average of -5.0 percent (operating loss). A comparison of the total program expenses to the premium revenue received from the state showed the annual average cost per member to be $1,709 per person and the annual allowable payment amount per member to be $1,788. The results of these two measurements indicate that the CoLTS MCOs were being fiscally responsible with the state funds.

HSD contracted with Mercer Government Services Consulting (Mercer) as an external, independent organization to provide actuarial rate certification. Mercer established the capitation rate ranges and certified that the rates were developed in accordance with generally accepted actuarial practices and principles, and in accordance with the rate-setting guidelines established by CMS. The methodology of the rate development was detailed, and an overview of the analyses was provided along with the rate tables as evidence of actuarial soundness.

**Overall Findings**

The findings of this assessment are that the CoLTS program met the requirements for access, quality of care, and cost-effectiveness as outlined in the New Mexico Administrative Code (NMAC) regulations and the HSD/MCO contracts, based upon review and analysis of all available data.

**II. Background**

In 2007, the New Mexico HSD and the Aging and Long-Term Services Department (ALTSD) jointly proposed a new initiative called Coordination of Long Term Services (CoLTS) to meet the physical and behavioral healthcare needs of the aging, disabled, and seriously ill members of the state since the special needs of these individuals were not being met adequately under the existing PH Salud! managed care program.

The goal of CoLTS was to address these acute physical health and long-term care needs in a planned and coordinated fashion, with a focus on community-based services rather than institutional care. One of the key principles of the program was that it would establish a consumer-focused, continuous care plan throughout the member’s lifespan. HSD and ALTSD believed that by using community-based services, it would reduce the number of members in nursing facilities, thus creating a cost savings for the state. The CoLTS program was designed to:

- Facilitate the coordination of healthcare for the program members
- Allow patients to take part in their care plan
- Provide help with the members’ daily lives
- Promote regular check-ups

After the waiver approval was obtained from CMS, a request for proposals (RFP) was released to choose health plans within the state to serve as the CoLTS managed care organizations (MCOs). AMG and UHC (known as Evercare at the time) were selected as the two MCOs and were contracted to implement the CoLTS program in New Mexico. The contract was a three-year long, prepaid capitation agreement that began in FY 2009.

As large, nationwide companies, the expertise of AMG and UHC with long-term care management was helpful in establishing the CoLTS program in New Mexico. In addition to HSD, ALTSD, and the MCOs, there were many other stakeholders brought in to share their knowledge and assist in designing the program to meet the needs of the state’s elderly, disabled, and seriously ill members. Representatives from various provider groups, consultants, Native Americans, and members of other cultural groups were invited to participate. Since one of the main goals of the program was to allow members freedom to choose their location and get the proper care right in their own communities, it was important to consider cultural aspects to make them feel comfortable with the care and coordination of services being provided under the CoLTS program. After the initial set up, the stakeholders also assisted with making the transition to the new program a seamless one for the members, and they aided in communication and outreach to the communities.

At the time of implementation, it was estimated that 38,000 individuals would be eligible for this plan. In 2010, there were 39,002 New Mexicans enrolled and 39,853 in 2012. To be eligible for the program, individuals needed to meet one or more of the following requirements, as outlined by the contracts:

- Receive full Medicaid and Medicare benefits (also known as being dual-eligible)
- Be age 21 years or older and receive (or are eligible for) Medicaid State Plan PCO services
- Reside in a nursing home and receive and/or qualify for Medicaid
- Receive and/or qualify for Medicaid Disabled and Elderly (D & E) Home and Community Based Waiver Services (HCBS)
- Are a member of Mi Via 1915(c) waiver that meets D & E or Brain Injury (BI) eligibility

Future Plans
The CoLTS MCO contracts were extended past the contract end date to coincide with the end of calendar year 2013. Beginning in 2014, a new program known as Centennial Care will replace the existing three-prong managed care system. Under Centennial Care, the PH Salud!, BH SE, and CoLTS programs will be recombined into one comprehensive program designed to improve cost-effectiveness without reducing needed services to the Medicaid members in New Mexico. Using the RFP method, four MCOs have been selected to start providing services under Centennial Care effective January 1, 2014: Blue Cross Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, and UnitedHealthcare Community Plan.
III. Assessment Methodology

Pertinent information was reviewed from a variety of sources to assess the accessibility and availability of care, the quality of care, and the cost-effectiveness of the CoLTS program during the assessment period of July 2011 to June 2012. Current data were also compared to previous findings, when appropriate, to look for trends or patterns. The results of this detailed analysis are provided in narrative form in this report, as well as visually displayed in tables, charts, and figures.

The CoLTS enrollment consisted of 83 percent dual-eligible (for Medicare and Medicaid coverage) managed care members and 17 percent Medicaid-only (also known as non-dual) members. Information and data reported in this assessment pertains to both dual-eligible and Medicaid-only members, unless otherwise stated.

The information for the access and quality of care assessments were obtained from the following sources:

- HSD-required monitoring reports
- State contracts
- HSD/Medical Assistance Division (MAD) managed care standards
- NMAC regulations, 8.307 series
- CMS 42 Code of Federal Regulations (CFR) 438
- CMS and HSD websites
- Local, state, and federal statistical reports
- Member and provider satisfaction surveys
- MCO educational and marketing materials
- EQRO audit reports
- Quantitative analysis reports
- PMs
- PIPs
- Quality and process improvement initiative results

Several sources were used to evaluate the cost-effectiveness of the CoLTS program through review and analysis of:

- Financial reports and statements provided to HSD by the MCOs
- Independently audited financial reports provided by MCOs, HSD, and other state agencies
- Input from HSD/Administrative Services Division (ASD) Budget Bureau staff
- State and federal financial benchmarks
- Actuarial Rate Certifications required under 42 CFR 438.6(c) for the CoLTS program
- CoLTS capitation rate history, prior to and after BH SE and CoLTS carve-outs from PH Salud!
- Publically-reported state and federal Medicaid spending data
IV. Access Assessment

A. Introduction
Having adequate availability of providers and services, along with convenient access to them, is essential in order for the MCOs to meet the needs of the CoLTS members. State regulations, plus the HSD/MCO contracts, spell out in detail what the requirements for access are, but they are not prescriptive in how to meet any given part of the standard. Instead, the MCOs may choose their own methods for achievement.

Systems and processes of each MCO were assessed and performance results reviewed looking for suitable and sufficient accessibility and availability of providers and services. Each MCO, along with the overall CoLTS program, was evaluated for how well it met its regulatory and contractual requirements. Specific factors examined were:

- Geographical access (geoaccess) of members
- Proximity of providers and services to members
- Provider-to-member ratios
- Customer satisfaction with access
- Timeliness of obtaining information
- Avenues of informational access

B. NMAC Regulations and Contract Requirements
A requirement of MCO participation includes compliance with the NMAC Medicaid Managed Care Regulations. These conform to the CMS 42 CFR 438 and stipulate the standards for:

- Access
- Structure and operations
- Timeliness
- Quality measurement and improvement

Two of these standards were used in the access assessment: the Standards for Access (found in NMAC 8.307.8.18 and in the HSD/MCO contracts in Article 3, 3.5, J) and the Standards for Member Education (found in NMAC 8.307.2.9 and in the HSD/MCO contracts in Article 3, 3.4, B.). The requirements outlined in the standards and contracts that the MCOs are expected to meet can be broken down into three categories:

Physical Access

- Full array of covered services
- Sufficient number of PCPs, dentists, and pharmacy providers to allow for a reasonable choice among providers
- Service locations and pharmacies in close proximity to member’s place of residence
- Hospital or other licensed emergency facility usage, regardless if the provider is or is not contracted with the MCO, in the event of an emergency
- Transportation services for medically necessary needs
Timely Access

- Appointment time for Routine, Urgent, and Crisis Event services set within the contract scheduling criteria
- No clinically significant delay caused by the MCO’s Utilization Management control measures
- In-person prescription fill time no longer than 40 minutes and the provider phone-in prescription filled within 90 minutes
- Timing consistent with clinical need for scheduled follow-up outpatient visits with practitioners
- Medically necessary pharmaceutical agents provided in a clinically timely manner
- Coordinated and uninterrupted continuity of care provided for needed treatment and support services

Informational Access

- Enrollment and benefit information available regarding the various plans in the CoLTS program
- Provider directory and member handbook of the chosen plan offered in a variety of formats, languages, cultural sensitivity needs, and appropriate reading levels
- 24/7 toll-free communication system established for providers, members, and other interested parties to include:
  - Access for non-English speaking or hearing impaired
  - Health information or assistance from a qualified clinical staff member
  - Health education opportunities at no cost to member
  - Member notification of changes in providers or services

C. Accessibility of Providers and Services

Geoaccess Distribution

New Mexico is the fifth largest state by landmass, consisting of 121,598 square miles. The population is just over two million, with 43 percent living in cities or large towns. The remaining 57 percent is spread throughout the rural and frontier areas of the state. Counties are classified by the state based on the density of the population per square mile as:

- Urban: 40 or more persons
- Rural: 7-39 persons
- Frontier: 6 or less persons

Figure 1 illustrates the New Mexico counties by state classification.
Figure 1: Map of New Mexico Counties by Geographic Assess Category

The breakdown of CoLTS member distribution throughout the state is shown in the following two tables. Table 1 shows the count of members and Table 2 shows the percentage of members in each geoaccess category.

Table 1: CoLTS Member Population Distribution

<table>
<thead>
<tr>
<th>Geoaccess Category</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>8,437</td>
<td>7,860</td>
<td>16,297</td>
</tr>
<tr>
<td>Rural</td>
<td>9,459</td>
<td>8,889</td>
<td>18,348</td>
</tr>
<tr>
<td>Frontier</td>
<td>2,780</td>
<td>2,428</td>
<td>5,208</td>
</tr>
<tr>
<td>TOTALS</td>
<td>20,676</td>
<td>19,177</td>
<td>39,853</td>
</tr>
</tbody>
</table>
Table 2: Percentage of Member Population per Geoaccess Category

<table>
<thead>
<tr>
<th>Geoaccess Category</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>40.8%</td>
<td>41.0%</td>
<td>40.9%</td>
</tr>
<tr>
<td>Rural</td>
<td>45.7%</td>
<td>46.4%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Frontier</td>
<td>13.4%</td>
<td>12.7%</td>
<td>13.1%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Enrollment changed each month as members came in and went out of the program or switched MCOs, but the CoLTS member population was fairly evenly split between the two MCOs during the assessment period, with AMG having 52 percent and UHC having 48 percent. Less than half of the overall member population resided in an urban area (40.9 percent), and 13.1 percent lived in frontier communities. The largest portion of the CoLTS population (46.0 percent) was located in rural locations.

Distance to Providers and Services
The MCOs measure their geoaccess for members through the Managed Care Accessibility Analysis report. This report is completed quarterly by each MCO. It tracks the percentage of members with access to a set of selected provider groups/services measured against the distance standard.

NMAC has established the standards for access to PCPs and pharmacies (identified in Table 3), but not for specialists and other services, thus allowing the MCOs to set their own standards. Although the CoLTS MCOs have adopted the PCP/pharmacy standards for many of the specialist or service categories, not all of them were the same across the MCOs.

Table 3: NMAC Access Standards

<table>
<thead>
<tr>
<th>GeoAccess Category</th>
<th>Number of PCPs to Medicaid Members</th>
<th>Percent of Members with Access</th>
<th>NMAC Standard - Distance to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1 per 1,500</td>
<td>90.0%</td>
<td>30 miles or less</td>
</tr>
<tr>
<td>Rural</td>
<td>1 per 1,500</td>
<td>90.0%</td>
<td>45 miles or less</td>
</tr>
<tr>
<td>Frontier</td>
<td>1 per 1,500</td>
<td>90.0%</td>
<td>60 miles or less</td>
</tr>
</tbody>
</table>

In FY 2012, AMG monitored and reported on the accessibility of three provider groups/services:
- Laboratories
- Obstetricians/Gynecologists
- Orthopedic Surgeons

UHC monitored and reported on the accessibility of seven provider groups/services:
- Cardiology
- Obstetricians/Gynecologists
- Orthopedic Surgeons
- Otolaryngologists
- PCPs
- Dental
• Pharmacy

The distance-to-providers access requirement was evaluated by reviewing geoaccess for both the overall program and the MCOs.

Figure 2 looks at the overall CoLTS program for member access by geoaccess category. It compares the total percentage of members residing in each category (urban, rural, and frontier) to the percentage of members in the categories who have access to the provider groups or services being monitored by the MCOs.

![Members by Category & Percent of Access](chart)

<table>
<thead>
<tr>
<th></th>
<th>AMG</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontier</td>
<td>13.4%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Rural</td>
<td>45.7%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Urban</td>
<td>40.8%</td>
<td>40.9%</td>
</tr>
</tbody>
</table>

Figure 2: Comparison of Total Members to Members with Access by Category

In each category, there is a close ratio between the total member population compared to the population of members with access. This indicates a good distribution of CoLTS service providers on a statewide level to meet the needs of the members.

Specific provider groups/services for the MCOs were also examined. Except for two specialist groups, AMG and UHC did not track access to the same provider groups/services. Additionally, the MCOs set their distance-to-provider standards based on their service utilization and member population distribution, so the standards were not the same for those two groups that were tracked by both MCOs. Therefore, direct comparison of MCO-to-MCO in the CoLTS program was not possible for the measurement of compliance with access standards. As an alternative, each MCO was evaluated for compliance with its own established standards.

Performance percentages for meeting the distance standards of access are shown in Table 4. Red font indicates performance was below 90 percent of the standard established by the MCO.
Table 4: Select Provider Groups Access Standards Performance

<table>
<thead>
<tr>
<th>Provider Groups</th>
<th>Urban</th>
<th>Rural</th>
<th>Frontier</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMG Labs</td>
<td>94.3%</td>
<td>81.0%</td>
<td>99.8%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>98.6%</td>
<td>96.0%</td>
<td>99.1%</td>
</tr>
<tr>
<td>Orthopedic Surgeons</td>
<td>98.6%</td>
<td>94.6%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Overall Geoaccess Average</td>
<td>97.2%</td>
<td>90.5%</td>
<td>95.2%</td>
</tr>
</tbody>
</table>

| UHC Cardiology            | 90.6% | 87.0% | 64.4%    |
| OB/GYN                    | 90.6% | 94.2% | 74.3%    |
| Orthopedic Surgeons       | 90.6% | 94.2% | 70.3%    |
| Otolaryngologist          | 90.6% | 83.7% | 50.6%    |
| Primary Care Physicians   | 99.1% | 96.8% | 99.4%    |
| Dental                    | 100.0%| 85.3% | 82.8%    |
| Pharmacy                  | 100.0%| 95.5% | 98.9%    |
| Overall Geoaccess Average | 94.5% | 91.0% | 77.2%    |

For the provider groups/services monitored by AMG, the 90 percent access standard was met in all geoaccess categories except rural laboratories (81.0 percent) and frontier Orthopedic Surgeons (86.6 percent). UHC met the requirement for urban providers in all categories measured. However, it only met the requirement for half of the rural categories, and only two of the frontier categories. UHC PCPs and pharmacies were readily accessible in all areas of the state (97 percent or better). But access to UHC Otolaryngologists and Cardiology services was only 50.6 and 64.4 percent, respectively, meaning that about half the members had to travel further than the set distance standard to obtain service from these specialists. It is unknown what the percentage of access to these services was for AMG members because these service groups were not reported by AMG.

D. Availability of Providers

Provider-to-Member Ratios

To meet the access requirements, MCOs are required to monitor the ratio of PCPs to members to assure there are enough providers to meet the needs of the population within the health plan. As the amount of members receiving care from a PCP approaches the maximum allowed per NMAC standard, the MCO will reassign members to a different PCP to even out the caseload. HSD may allow for a single provider to exceed the maximum amount of members (1,500), if necessary, but exceeding the maximum is not a common occurrence, especially for the CoLTS program.

The dual-eligible segment of the CoLTS member population is not required to have an assigned PCP. However, the 17 percent of members who have Medicaid-only coverage must select one specific provider as their PCP. Table 5 shows the PCP-to-member ratios for the Medicaid-only population.
Table 5: Overall PCP-to-Member Ratios by MCO

<table>
<thead>
<tr>
<th>PCP to Member Ratios</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Members</td>
<td>3,524</td>
<td>1,590</td>
<td>5,114</td>
</tr>
<tr>
<td>Total Providers</td>
<td>2,900</td>
<td>463</td>
<td>3,363</td>
</tr>
<tr>
<td>Ratio</td>
<td>1.2</td>
<td>3.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Met Standard for # Members/PCP</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The PCP-to-member ratio was very low, averaging 1.5 members assigned to each PCP. This indicates that CoLTS Medicaid members should have had a good selection of providers from which to choose their PCPs in FY 2012.

E. Timely Access to Care

Members expect timely access to care, and monitoring their satisfaction levels can help give important feedback to allow the managed care health plans an opportunity to improve their services. Two measures for timely access focus on level of care needed/desired and the speed of service rendered when contacting the MCO. Both of these measures were examined for AMG and UHC.

Satisfaction with Appointment Scheduling Timeliness

CoLTS MCOs are obliged to survey their members on an annual basis to measure customer satisfaction in several quality-related areas. The survey is conducted by an independent research organization using the CAHPS® 4.0H Adult Medicaid Survey. For PH Salud! and BH SE, two surveys are conducted, one for adults and one for children. With CoLTS, there are too few members under the age of 21 to allow for a sample large enough from which to obtain meaningful data, therefore, only the adult survey was conducted for the CoLTS program.

Two composite question sections on the survey relate to access:

- Getting Needed Care
- Getting Care Quickly

Table 6 shows a comparison of the satisfaction level results received by each of the MCOs. Benchmarks were provided by the research organizations conducting the surveys and varied slightly between surveys, but both organizations identified the primary benchmark as the 2011 National Mean obtained from the NCQA Quality Compass®.

---

4 Only the questions relating to access are discussed in this section. See Quality of Care Assessment (section V.H.) for details about the entire survey results and analysis.

5 Quality Compass® is the registered trademark of the National Committee for Quality Assurance (NCQA).
Table 6: Adult CAHPS® Survey Responses for Access-related Questions

<table>
<thead>
<tr>
<th>Questions Related to Access</th>
<th>AMG</th>
<th>UHC</th>
<th>2011 Quality Compass® National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ease of getting appointment with a specialist</td>
<td>75.9%</td>
<td>76.9%</td>
<td>73.9%</td>
</tr>
<tr>
<td>Getting care, tests, or treatment necessary</td>
<td>78.2%</td>
<td>84.7%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Percentile for Overall Category</td>
<td>63rd</td>
<td>90th</td>
<td></td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtaining needed care right away</td>
<td>83.3%</td>
<td>84.4%</td>
<td>82.1%</td>
</tr>
<tr>
<td>Obtaining appointment when needed (non-emergent situation)</td>
<td>79.6%</td>
<td>82.7%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Percentile for Overall Category</td>
<td>50th</td>
<td>90th</td>
<td></td>
</tr>
</tbody>
</table>

Both MCOs scored at or above the national mean and ranked in the 50th percentile or higher, ranging from 76 to 85 percent satisfaction with access.

Customer Service Response Time
Telephone calls are received from members on a daily basis. Each MCO tracks the number of calls received and how quickly they are answered. If callers do not make contact with a customer service representative in a timely manner, many will hang up. Two measures of member satisfaction are the timeliness of answering and the call abandonment rate. The standards are: 90.0 percent of all calls are to be answered within 30 seconds and no more than 5.0 percent of calls are abandoned.

Table 7 shows the percentage of calls answered within 30 seconds and the rate of abandonment for each MCO. Red font indicates performance was below the standard.

Table 7: Telephone Statistics by MCO

<table>
<thead>
<tr>
<th>Telephone Call Tracking</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Answer Timeliness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Calls answered within 30 sec.</td>
<td>77,687</td>
<td>23,805</td>
<td>101,492</td>
</tr>
<tr>
<td># of Calls received</td>
<td>89,185</td>
<td>29,958</td>
<td>119,143</td>
</tr>
<tr>
<td>% of Calls answered within 30 sec.</td>
<td>87.1%</td>
<td>79.5%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Call Abandonment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Calls abandoned</td>
<td>1,272</td>
<td>1,037</td>
<td>2,309</td>
</tr>
<tr>
<td># of Calls received</td>
<td>89,185</td>
<td>29,958</td>
<td>119,143</td>
</tr>
<tr>
<td>% of Calls abandoned within 30 sec.</td>
<td>1.4%</td>
<td>3.5%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Neither MCO met the standard for Call Answer Timeliness, but both were well within the allowable Call Abandonment rate.
F. Access to Information
The MCOs offer a variety of avenues for members to obtain information that is sensitive to the cultural, linguistic, and special physical and behavioral needs of the members. Information can be obtained through oral, written, and electronic formats, and each of the following avenues can be accessed by the member or a caregiver.

Website
Websites are considered the preferred method for members, providers, and other interested stakeholders to obtain the latest information since the site can be updated more quickly than published materials can be reprinted and redistributed.

The website for each plan is:
- AMG – https://www.myamerigroup.com/English/Medicaid/nm/Pages/newmexico.aspx

AMG’s website has all the information needed by members and their families or caregivers. But some sections are lengthy due to the amount of narrative provided on each topic. AMG has postings for community events and offers outside links designed for family involvement, such as “Health A to Z” and “Nourish Interactive.” Members can use the “Find a Provider” section to access the network for provider and pharmacy selections. The member handbook, a list of benefits, and AMG’s annual New Mexico Quality Report also can be accessed through the site.

UHC’s site has been updated recently and is designed to be user-friendly. It gives program details in a short, simple, and easily understood format—usually question-and-answer or short bullets. But there is a multitude of information available, covering everything from general information regarding Medicaid and the CoLTS program, to how to enroll and whom to contact, to benefits available and choosing providers, pharmacies, and prescription drug information. There are also links provided to associated sites, such as HSD, ALTSD, CMS, and Social Security, if additional or more detailed information is desired. An electronic copy of the member handbook, plus a copy of the Cultural Competency Plan can also be accessed through the site.

Member Handbook
Both MCOs provide a hard copy member handbook upon enrollment in the program, and subsequently upon request. Electronic copies are available on the websites. Both hard copy and electronic handbooks are updated annually and are available in English and Spanish.

The NMAC regulation for Member Education outlines 22 elements that must be included in the member handbook. Each MCO’s handbook was examined and found to contain all the required elements for:
- MCO address/phone
- After hours/emergency contacts
- Member bill of rights/responsibilities
- Information regarding language accessibility
• Coordination of care by/with PCP and transition of care
• Care during emergency/urgent conditions (with a notice that prior authorization is not needed)
• Benefits description
• Self-referral process for access to BH services, women’s specialist, family planning, etc.
• Out-of-network limitations to services
• Prior authorization/referrals requirements
• Specialist referral
• Grievance/fair hearing system
• Enrollment termination/disenrollment instructions
• Advanced directives
• Second opinions
• Cost sharing
• Obtainment of MCO information upon request (e.g. MCO’s structure, operation, physician/senior staff incentive plans)
• Identification of populations with mandatory enrollment, freedom to enroll, or excluded from enrollment
• Guidelines for what is not a covered benefit and where to obtain needed services
• Policy on referrals for specialty services, long-term services, and support and other benefits
• Native American self-referral to IHS, Traditional Healer Care, etc.
• Birthing options

Provider Network
A hard copy provider directory is given to the member at the time of enrollment along with the member handbook. This directory is inclusive of all providers contracted with the MCO. Providers under contract change periodically, so members are advised to check the on-line directory or call the MCO customer service telephone line for assistance with choosing a PCP or specialist from the most current listing. MCOs update their provider lists quarterly.

Service Support Lines
Each MCO has a 24/7 customer service line. The telephone numbers are published in the hard copy materials provided to the members and also on the MCO websites. A TTY/TDD line is available for the hearing-impaired. English and Spanish are commonly spoken by representatives answering the phones, but translation/interpreter services are also available for those with other linguistic needs. Each MCO contracts with a service provider, such as Language Line which is used by UHC. This company employs over 2,000 interpreters with proficiency in 196 languages, and has medically-certified interpreters in the top 22 languages. This service is available to all members 24/7.

In addition to a general member service line, there are other important phone numbers provided by the MCOs, such as:
• 24-hour Nurse Helpline
• Behavioral health information
• Care coordinator listing
• Transportation service
• Dental health benefits
• Vision benefits

G. Summary of Access Findings
After reviewing and analyzing the relevant MCO reports and data, it appears the CoLTS program met the access requirements, as evidenced through the following:

• **Geographical access (Geoaccess) of members:** CoLTS member population was evenly split between the two MCOs during the assessment period, with AMG having 52 percent and UHC having 48 percent. Overall breakdown: Urban 40.9 percent, Rural 46.0 percent, Frontier 13.1 percent. (See pages 11-13, Figure 1, Tables 1-2.)

• **Proximity of providers and services to members:** Geoaccess for CoLTS members living in urban areas ranged from 91 to 100 percent for all provider groups/services measured. Access for rural members ranged from 81 to 97 percent. Frontier access to PCPs and pharmacies was excellent (99 percent for both categories). Access to dentists was 83 percent, but access to specialists was much lower (51 to 64 percent). (See pages 13-15, Figure 2, Tables 3-4.)

• **Provider-to-member ratios:** PCP-to-member ratio was very low, averaging 1.5 Medicaid members assigned to each PCP (a maximum of 1,500 is allowed), indicating that there is a high potential for Medicaid members to have a good selection and to be able to obtain the provider of choice. (See pages 15-16, Table 5.)

• **Customer satisfaction with access:** Both MCOs scored at or above the national mean and ranked in the 50th percentile or higher on the CAHPS® 4.0H Adult Medicaid Survey access composite questions. Scores ranged from 76 to 85 percent satisfaction with access. (See pages 16-17, Table 6.)

• **Timeliness of obtaining information:** 82.5 percent of member telephone calls were answered within 30 seconds, which is below the standard of 90.0 percent. The maximum allowable rate for Call Abandonment is 5.0 percent, and both MCOs scored below that (1.4 percent for AMG and 3.5 percent for UHC). (See page 17, Table 7.)

• **Avenues of informational access:** Members and/or caregivers can obtain information through: MCO websites, member handbooks, provider network listings, and service support telephone lines. Formats are oral, written, and electronic. Cultural and linguistic needs have been taken into account. (See pages 18-20.)

V. Quality of Care Assessment

A. Introduction
While the assessment of access to care examines what kind and how much service is being provided to members, quality of care is assessed to determine the level of excellence of those services and the strength of the foundation upon which the services are built.

Both MCOs, along with the CoLTS program as a whole, were assessed for quality of care through the following topics:
• QM/QI program
• PMs
• PIPs
• Utilization management
• Grievances and appeals
• Provider and member satisfaction surveys
• External quality reviews/audits

B. NMAC Regulations and Contract Requirements
The requirements for quality of care are found in NMAC 8.307.8.12 (Standards of Quality Management) and in the HSD/MCO contracts in various parts of Article 3, especially in Section 3.5, Quality Assurance. The contract is very detailed and many of the HSD-required reports identified therein are measurements of the quality of care and services provided by the CoLTS MCOs.

While the contractual obligations and requirements are specific, how it is accomplished is at the discretion of the MCO. Whatever program is established, though, is to be based on the Continuous Quality Improvement/Total Quality Management (CQI/TQM) model, and there must be an annual QM/QI work plan created outlining specific interventions to be utilized to improve quality targets and timelines for evaluation.

Contract requirements can be broken down into three main categories:

Establishment of a Quality Program
• Institute QM/QI plan to address NMAC requirements
• Establish a committee to oversee and implement QM/QI activities
• Create transparency in the system through communication and exchanges of non-confidential information with stakeholders
• Devise a Cultural Competency Plan to demonstrate an understanding of cultural issues and proficiency to address the needs of diverse populations
• Apply the QM/QI program to the entire range of covered services and all major demographic population groups; conduct internal surveys for customer satisfaction levels to obtain feedback regarding these services

Continuous Improvement
• Conduct an annual evaluation of overall effectiveness to demonstrate improvements in quality of clinical care and non-clinical services to members
• Include activities that provide continuous monitoring and regular evaluation; show evidence that corrective action is implemented, as necessary
• Identify opportunities for improvement, initiate targeted quality interventions, and monitor the interventions’ effectiveness
• Conduct MCO-selected quality studies (PIPs)
• Develop and implement a statewide critical incident management system that identifies and tracks critical incidents, corrects case-specific issues, and identifies systems issues that place members at risk
• Submit to external audits and use the findings as a basis for continuous improvement activities
Quality Measurement
- Conduct data-driven evaluations of clinical practices to improve quality of care
- Establish, measure, and track PMs
- Survey members and providers annually for overall MCO satisfaction levels and feedback
- Monitor and evaluate providers; provide training and technical assistance to providers to improve their performance, as needed
- Collect, track, and analyze grievances and appeals filed by members and providers

C. Quality Management/Quality Improvement (QM/QI) Program
A QM/QI program starts by looking at the organization and the internal quality programs and/or structures in place within the MCO. This is followed by collecting data on organizational performance measures, customer satisfaction surveys, and outreach interactions. All that information is combined into a plan of action to address quality issues and implement improvement projects.

An examination of applicable reports revealed that each MCO created a comprehensive QM/QI Program Description and a QM/QI Plan, and that each evaluated itself annually on its quality performance using these tools.

QM/QI Plan
The QM/QI Plans for the CoLTS MCOs are structured as on-going work plans, focusing on studying their PM results and using the data to start quality or performance projects to improve the quality of healthcare provided to the members. These plans are an integral part of each health plan’s delivery of service to its members and are continuously evolving to meet the changing needs of the MCO members.

The emphasis of the plans is related to improving:
- Medical care and service
- Communication
- Education
- Patient safety
- Continuity and coordination of care
- Health promotion, wellness, and preventive care

Communication and Transparency
Program changes and quality improvement project results need to be communicated to all involved parties. This includes members, providers, and other stakeholders, as well as the MCO’s internal organizational membership.

Various methods were used by the MCOs to maintain communication and transparency:
- Committee meetings with representation from all affected groups
- Education and training sessions
- Newsletters
- News and updates on MCO websites
Cultural Competency Plan
Being aware and responsive to member culture is a key element in providing quality service. If the MCO cannot communicate effectively with its members, there is a risk of misunderstanding taking place. This can negatively impact the member's ability to use information obtained and to receive needed healthcare. Not only is it important to communicate pertinent information regarding the health plan, but also to make available providers who can understand a member’s healthcare needs and prescribe an appropriate course of treatment acceptable to the member.

The MCOs conducted an annual evaluation of their plans to assure the cultural and linguistic needs of the population were being met. Each was found to have a comprehensive plan that involved:
- Staff education
- Provider education
- Member education and outreach programs
- Providers who specialize in non-traditional medical services (e.g. Traditional Healer Care or Eastern Medicine)
- Translation/interpretation services

Using the demographics obtained from the CAHPS® 4.0H Adult Medicaid Survey’s sample population, Table 8 shows the distribution of race and ethnicity within the CoLTS program.

Table 8: Race and Ethnicity Distribution

<table>
<thead>
<tr>
<th>Race</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>2.0%</td>
<td>3.2%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Black (African American)</td>
<td>5.0%</td>
<td>2.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>8.0%</td>
<td>18.0%</td>
<td>13.0%</td>
</tr>
<tr>
<td>White (Caucasian)</td>
<td>54.0%</td>
<td>55.6%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>35.0%</td>
<td>26.9%</td>
<td>30.9%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>62.0%</td>
<td>54.1%</td>
<td>58.1%</td>
</tr>
</tbody>
</table>

D. Performance Measures
At the outset of the contract, HSD identified a set of PMs to be tracked and monitored on a monthly basis. No targets or benchmarks were established for these measures, so assessment for compliance was not possible, but comparison of MCO-to-MCO was possible.

Figure 3 provides a visual comparison between the two MCOs for their PM results.
Figure 3: Performance Measure Comparison of CoLTS MCOs

A study of these results indicates that both MCOs had areas of higher or lower performance (i.e., both had strengths and areas for improvement). For strengths, AMG had an excellent rate for call answering timeliness and call abandonment. UHC performed follow up with 100 percent of its home safety visits. Conversely, AMG had a lower percentage of flu and pneumonia shots given to its members, and UHC had a higher readmission rate, which represent opportunities for improvement for the MCOs.

E. Performance Improvement Projects
Each MCO selected two clinically-related projects designed to improve the MCO’s overall CQI systems of tracking, intervention, and reevaluation processes. Once selected, a PIP is measured and evaluated until it has produced the desired level of improvement within the organization. At that point, a new PIP is selected.

The criteria for deciding when to select a new PIP are:
- The existing PIP has sustained a high level of compliance (i.e., at or near 100 percent) over time and no other improvement is possible
- Other internal quality indicators/monitors reveal a more pressing situation requiring a new PIP
- The MCO is new and has not had the opportunity to determine the best PIP to monitor
- HSD or EQRO recommends a new corrective action plan for deficiencies noted in the most recent audit
In FY 2012, both MCOs monitored the following:
- PIP #1: Diabetes Testing for HbA1c and LDL-C
- PIP #2: Transitions from Nursing Facilities (NF) to Home or Community Based Services (HCBS)

Table 9 shows the FY 2012 results for the MCOs’ PIPs. The MCOs compare their results to both the New Mexico HSD baseline goals and to national benchmarks (when available). The NCQA benchmarks included in the table provide the MCOs with a widely accepted industry benchmark that allows them to see how their performances compare with other programs nationally. Red font indicates performance was below the HSD baseline goal.

**Table 9: FY 2012 CoLTS Performance Improvement Project Results**

<table>
<thead>
<tr>
<th>Performance Improvement Projects</th>
<th>HSD Baseline Goal</th>
<th>2010 NCQA HEDIS Benchmarks and Thresholds, 90th Percentile for Medicaid</th>
<th>AMG</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PIP 1 - Diabetes Testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of non-dual CoLTS members with diabetes that have received one or more HbA1c test during the measurement period.</td>
<td>77.0%</td>
<td>89.0%</td>
<td>86.2%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Percentage of non-dual CoLTS members with diabetes that have received one or more LDL-C screening during the measurement period.</td>
<td>71.0%</td>
<td>81.0%</td>
<td>72.9%</td>
<td>70.2%</td>
</tr>
<tr>
<td><strong>PIP 2 - Transitions from NF to Home or Community Based Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of members ages 21 years and older that at any time during the measurement year transitioned from Nursing Facility placement into the community care setting.</td>
<td>60 members will be reintegrated into the community setting</td>
<td>None</td>
<td>N/A</td>
<td>5.3% (108 members)</td>
</tr>
<tr>
<td>Percentage of members ages 21 years and older who remained in the community care setting for 6 months and were not readmitted to a Nursing Facility for greater than 30 days during the measurement year.</td>
<td>75.0%</td>
<td>None</td>
<td>78.4%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>
Both MCOs met or exceeded the HSD goals for all except one PIP. UHC’s LDL-C screenings for members was less than one percentage point below the established goal.

F. Utilization Management

Utilization management (UM) touches on all aspects of the quality of care provided by the health plans. The goal of a UM program is to manage the medical care of its members by effectively utilizing existing resources, while assuring that quality care is delivered in the most cost-effective and the safest manner possible. NMAC 8.307.8.13 states that the UM program shall be based on standard external national criteria and established clinical criteria that are congruent with HSD’s definition of medical necessity. This is to make sure that each decision is as fair, impartial, and consistent as possible.

For its national criteria sources, AMG uses Milliman Care Guidelines®, InterQual® Criteria, and Aetna’s Clinical Policy Bulletins with review guidelines from Apollo Managed Care Consultants. UHC uses the Milliman Care Guidelines®, along with other external guidelines applicable for pharmacy, BH services, and state and federal Medicaid issues.

Medical necessity is determined by the severity of illness, intensity of service, and appropriateness of level of care. Utilization activities are reviewed to determine whether or not the service rendered is medically necessary. Appropriately licensed and experienced healthcare practitioners are contracted with the MCOs to perform the following types of review for both inpatient and outpatient services:

- Prospective
- Pre-determinations
- Concurrent
- Retrospective
- Medical claims

UHC implemented an innovative UM review process in FY 2012, called LifeLens™. LifeLens™ is an iPhone application originally designed to be used by service coordinators for home visit photographic documentation. UHC has upgraded its use to include three-minute videos filmed at the member’s location by the service coordinator and then sent to the Medical Director and other members of the clinical leadership team for use during case reviews.

Service Utilization Rates

The health plans monitor their service utilization rates and compare to national benchmarks to check for over- and under-utilization within the program. Table 10 shows the utilization rates for each MCO and an overall rate for the CoLTS program.
Table 10: Service Utilization for CoLTS FY 2012

<table>
<thead>
<tr>
<th>Service Utilization</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FY 2012 Encounters</td>
<td>182,153</td>
<td>152,985</td>
<td>335,138</td>
</tr>
<tr>
<td>Plan Population</td>
<td>20,676</td>
<td>19,177</td>
<td>39,853</td>
</tr>
<tr>
<td>Utilization Rate (# member visits/year)</td>
<td>8.81</td>
<td>7.98</td>
<td>8.41</td>
</tr>
<tr>
<td>Average Percent of Population using services each month</td>
<td>73.4%</td>
<td>66.5%</td>
<td>70.1%</td>
</tr>
</tbody>
</table>

The service utilization for the CoLTS members was close between the two MCOs, averaging eight (8) or nine (9) visits per member per year. Although this was twice the number of annual visits made by the general population, because of the CoLTS members' state of health, this higher amount of visits was expected and was in line with national averages.

**Denials**

If a member's request does not meet the specified UM criteria, service will be denied. Additionally, benefits may be reduced or eliminated due to changes in criteria. Measuring and monitoring service denials is a common method of examining utilization management. A comparison of the amount of denials to the amount of claims is shown in Table 11.

Table 11: CoLTS Denial of Claims Rate FY 2012

<table>
<thead>
<tr>
<th>Type of Denial</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>0</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Clinical</td>
<td>271</td>
<td>141</td>
<td>412</td>
</tr>
<tr>
<td>Termination of Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reduction of Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Denials</strong></td>
<td>271</td>
<td>186</td>
<td>457</td>
</tr>
<tr>
<td><strong>Total Claims Received</strong></td>
<td>1,391,596</td>
<td>1,214,556</td>
<td>2,606,152</td>
</tr>
<tr>
<td><strong>Percent Denied</strong></td>
<td>0.02%</td>
<td>0.02%</td>
<td>0.02%</td>
</tr>
</tbody>
</table>

The denial rate is very low for the CoLTS program (0.02 percent). The MCOs attributed this to on-going education of providers regarding the established criteria and the overall UM process.

**Critical Incidents**

A critical incident is an occurrence that represents actual harm to the well-being of the member or that could put the member at risk for potentially serious harm. This is especially important to track due to the fragile health of the CoLTS members. Table 12 shows the critical incidents for the CoLTS MCOs and the ratio for occurrences.
Table 12: CoLTS Critical Incidents

<table>
<thead>
<tr>
<th>Critical Incidents</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>110</td>
<td>168</td>
<td>278</td>
</tr>
<tr>
<td>Neglect</td>
<td>87</td>
<td>213</td>
<td>300</td>
</tr>
<tr>
<td>Exploitation</td>
<td>135</td>
<td>141</td>
<td>276</td>
</tr>
<tr>
<td>Natural/Expected Death</td>
<td>254</td>
<td>172</td>
<td>426</td>
</tr>
<tr>
<td>Unexpected Death</td>
<td>61</td>
<td>73</td>
<td>134</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>2205</td>
<td>1362</td>
<td>3567</td>
</tr>
<tr>
<td>Law Enforcement Involvement</td>
<td>154</td>
<td>62</td>
<td>216</td>
</tr>
<tr>
<td>Environmental Hazard</td>
<td>49</td>
<td>42</td>
<td>91</td>
</tr>
<tr>
<td>Total # Incidents</td>
<td>3055</td>
<td>2233</td>
<td>5288</td>
</tr>
<tr>
<td>Incident Ratio</td>
<td>1 : 7</td>
<td>1 : 9</td>
<td>1 : 8</td>
</tr>
<tr>
<td>Unexpected Hospitalizations</td>
<td>897</td>
<td>1017</td>
<td>1914</td>
</tr>
<tr>
<td>Other</td>
<td>262</td>
<td>0</td>
<td>262</td>
</tr>
</tbody>
</table>

The largest percentage of incidents (67.5 percent) occurred around Emergency Services. The ratio of incidents is consistent between the two MCOs, but the rate of occurrence for the CoLTS program is high, averaging one (1) incident for every eight (8) members.

G. Grievances and Appeals
The Member Grievance Resolution system provides a way for members to formally voice their concerns to the MCO. These concerns are taken seriously since any grievance (complaint) may indicate a problem that the MCO needs to address across its system. Each MCO has established procedures in accordance with NMAC regulation 8.307.12 and the HSD/MCO contracts to ensure thorough and consistent investigation and responses to these concerns.

A grievance is any expression of dissatisfaction, either oral or written, and can be either:
- Member grievance – dissatisfaction with the MCO or its operation
- Provider grievance – dissatisfaction with the MCO and/or to the MCO regarding UM decisions, any provider payment issues, or other provider-related issues

An appeal is a request from a member or a provider to change a previous decision made by the MCO, usually in response to denial of service or claim payment. This could include an expedited appeal (where an immediate response is needed) and/or a fair hearing process (which is a request made to HSD for reconsideration of the original appeal resolution made by the MCO).

Grievances
Each MCO tracked the amount and the type of grievances (complaints), as shown in Table 13 and Table 14. Because there is variation in the number of members per health plan, a ratio is provided to allow for direct comparison.
Table 13: FY 2012 Grievances by CoLTS MCO

<table>
<thead>
<tr>
<th>FY 2012 Grievances</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Grievances</td>
<td>179</td>
<td>552</td>
<td>731</td>
</tr>
<tr>
<td>Plan Population</td>
<td>20,676</td>
<td>19,177</td>
<td>39,853</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 116</td>
<td>1 : 35</td>
<td>1 : 55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Grievances</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Population</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Ratio</td>
<td>N/A</td>
<td>1 : 2,397</td>
<td>1 : 4,982</td>
</tr>
</tbody>
</table>

One (1) member out of every 116 members filed a member grievance at AMG. The rate of member grievances filed for UHC was one (1) out of every 35 members.

Provider grievances filed were very low in the CoLTS program: zero (0) for AMG and only eight (8) for UHC.

There are 102 codes identified to categorize the types of grievances and appeals. Those receiving the highest amount of grievances are listed in Table 14.

Table 14: Top Four Reasons for Grievances in CoLTS Program in FY 2012

<table>
<thead>
<tr>
<th>Reasons for Grievances</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Grievances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-32C, Transportation Ground Non-emergency</td>
<td>40</td>
<td>162</td>
<td>202</td>
</tr>
<tr>
<td>P-12B, Outpatient</td>
<td>4</td>
<td>87</td>
<td>91</td>
</tr>
<tr>
<td>P-10A, Personal Care Options Adults</td>
<td>11</td>
<td>71</td>
<td>82</td>
</tr>
<tr>
<td>P-23B, General/Family Practitioner</td>
<td>22</td>
<td>23</td>
<td>45</td>
</tr>
<tr>
<td>Provider Grievances*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-32A, Transportation Ground Emergency</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*There were only eight (8) provider grievances filed in FY 2012 and all fell in the P-32A category.

The number one reason for both types of grievances concerned ground transportation, with members having difficulty getting to and from routine/urgent appointments or to the hospital in an emergency.

**Appeals**

Members and providers voice their concerns regarding denials of service and/or claims payments by filing appeals to the MCO to reconsider its decisions. The amounts and ratios are shown in Table 15.
Table 15: FY 2012 Appeals by CoLTS MCO

<table>
<thead>
<tr>
<th>FY 2012 Appeals</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Appeals</td>
<td>982</td>
<td>608</td>
<td>1590</td>
</tr>
<tr>
<td>Plan Population</td>
<td>27,079</td>
<td>79,965</td>
<td>336,115</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 21</td>
<td>1 : 32</td>
<td>1 : 25</td>
</tr>
<tr>
<td>Provider Appeals</td>
<td>5</td>
<td>240</td>
<td>245</td>
</tr>
<tr>
<td>Plan Population</td>
<td>27,079</td>
<td>79,965</td>
<td>336,115</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 4,135</td>
<td>1 : 80</td>
<td>1 : 163</td>
</tr>
</tbody>
</table>

The ratio for member appeals was fairly close between the two MCOs, but the two provider appeals ratios were very different. Only one (1) out of 4,135 filed a provider appeal with AMG, but one (1) out of 80 filed an appeal with UHC. AMG attributed its very low provider appeal rate to provider education and comprehensive denial letter content, which increased understanding of the denial criteria and satisfaction with the overall UM process.

The top four reasons for appeals filed in FY 2012 are shown in Table 16.

Table 16: Top Four Reasons for Appeals by MCO in CoLTS Program in FY 2012

<table>
<thead>
<tr>
<th>MCO Appeals FY 2012</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Appeals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-10A, Personal Care Options Adults (PCO)</td>
<td>877</td>
<td>543</td>
<td>1420</td>
</tr>
<tr>
<td>P-22, Pharmacy</td>
<td>57</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>P-04, Dental</td>
<td>33</td>
<td>15</td>
<td>48</td>
</tr>
<tr>
<td>P-12A, Inpatient</td>
<td>1</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td><strong>Provider Appeals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-12A, Inpatient</td>
<td>4</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td>P-10, Home Health</td>
<td>0</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>P-14A, LTC (Nursing Homes)</td>
<td>0</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>P-23B, General/Family Practitioner*</td>
<td>0</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>P-23G, Other Specialties*</td>
<td>0</td>
<td>28</td>
<td>28</td>
</tr>
</tbody>
</table>

* Tied for 4th

The reasons for both member and provider appeals were varied, but the largest percentage of those filed (89.3 percent) were for Personal Care Options for Adults. Primarily these appeals were filed due to members’ PCO hours being reduced as members were reassessed with the stricter CoLTS MCO criteria. The criteria were implemented in August 2009 with the intention of bringing the New Mexico program in closer alignment with national industry standards.
H. Provider and Customer Satisfaction
Satisfaction levels are surveyed for both providers and members on an annual basis. Although randomly selected, potential respondents are stratified within the entire plan network prior to sample selection to obtain a representative sample of all provider groups and member demographic populations in the health plan.

Provider Satisfaction
AMG and UHC conducted a provider satisfaction survey through the following independent research agencies:
- AMG – Morpace Market Research and Consulting
- UHC – Market Strategies International

Unfortunately, the information gathered and/or reported to HSD was not standard and the response rates were low, thus making it difficult to obtain meaningful data. In the condensed report it supplied to HSD, AMG reported the results of just four questions, while UHC provided both a summary page and the results with national comparisons for 43 questions. AMG had a response rate of 15.5 percent, but UHC’s rate was only 4.0 percent.

Direct comparison between the two MCOs was possible for only one question: How did the providers rate their health plan/managed care organization against other plans/organizations? Table 17 shows the results.

<table>
<thead>
<tr>
<th>How do you rate your health plan/MCO against other plans?</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly Better/Somewhat Better*</td>
<td>18.0%</td>
<td>27.1%</td>
<td>22.6%</td>
</tr>
<tr>
<td>About the Same</td>
<td>59.0%</td>
<td>54.2%</td>
<td>56.6%</td>
</tr>
<tr>
<td>Significantly Worse/Somewhat Worse*</td>
<td>22.0%</td>
<td>18.8%</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

*Category is an aggregate of two rating choices given to providers on the questionnaire. Both research agencies collapsed the five categories into three for reporting purposes.

A little over half of the providers for both AMG and UHC rated their plan/MCO as “About the Same.” Looking at those giving a more positive response, 27.1 percent of UHC providers felt their plan/MCO was either “Significantly Better” or “Somewhat Better” than the other plans, while only 18.0 percent of AMG providers felt their plan was in one of those two positive response categories.

Customer Satisfaction
The CoLTS MCOs used the CAHPS® 4.0H Adult Medicaid Survey to poll their members annually. In addition to the questions relating to access (previously mentioned in Access Assessment IV.E.), the survey had many questions that related to the quality of care being provided to the members. A standard set of questions designed by NCQA was used by an independent research organization selected by each MCO to administer the survey and report the findings.

The MCOs used the following research organizations:
- AMG – Morpace Market Research and Consulting
- UHC – CSS (Center for the Study of Services)
It should be noted that the two organizations conducting the surveys used slightly different amounts for benchmarks in their reports due to rounding or other formatting differences, but the 2011 NCQA Quality Compass® National Mean was identified as the primary benchmark in both cases.

Data were collected using a combination of mail and telephone surveys. NCQA’s required minimum sample is 1,350 for adults, with oversampling allowed. The desired target is 411 valid surveys collected.

Each MCO had a higher than average response rate compared to the national average, as seen in Table 18.

**Table 18: CAHPS® Adult Medicaid Survey Sample Response Rate**

<table>
<thead>
<tr>
<th>Survey Sample Response Rate</th>
<th>AMG</th>
<th>UHC</th>
<th>2011 NCQA Adult Survey Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in MCO Sample</td>
<td>1,672</td>
<td>1,636</td>
<td></td>
</tr>
<tr>
<td>Valid Responses</td>
<td>581</td>
<td>578</td>
<td></td>
</tr>
<tr>
<td>Response Rate</td>
<td>34.7%</td>
<td>35.3%</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

The Adult Medicaid surveys completed by each MCO had the following results listed in Table 19. The 2011 NCQA Quality Compass® National Mean (also referred to as the 2011 CAHPS® Database Benchmark) is based upon results derived from 129 sample health plans that submitted Adult Medicaid survey results to the CAHPS® Database in 2011. “Effectiveness of Care” measures included in the survey are New Mexico HSD contract-specific and do not have national benchmarks. Red font indicates performance was below the mean.

**Table 19: CoLTS Adult Medicaid Survey Results – All CAHPS® Composite Questions**

(Table continues on next page.)

<table>
<thead>
<tr>
<th>Composite Questions</th>
<th>AMG</th>
<th>UHC</th>
<th>2011 Quality Compass® National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experience of Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>82.1%</td>
<td>79.3%</td>
<td>76.4%</td>
</tr>
<tr>
<td>Rating of Specialist</td>
<td>76.9%</td>
<td>79.0%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Rating of All Healthcare</td>
<td>70.4%</td>
<td>68.0%</td>
<td>68.9%</td>
</tr>
<tr>
<td>Rating of Health Plan</td>
<td>73.3%</td>
<td>71.4%</td>
<td>72.5%</td>
</tr>
<tr>
<td><strong>Composites</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>77.0%</td>
<td>80.8%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>81.4%</td>
<td>83.5%</td>
<td>80.6%</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>72.5%</td>
<td>88.4%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Composite Questions</td>
<td>AMG</td>
<td>UHC</td>
<td>2011 Quality Compass® National Mean</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Customer Service</td>
<td>86.1%</td>
<td>82.5%</td>
<td>79.7%</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td>63.9%</td>
<td>59.4%</td>
<td>59.7%</td>
</tr>
<tr>
<td><strong>Effectiveness of Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advising Smokers &amp; Tobacco Users to Quit</td>
<td>77.1%</td>
<td>81.9%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Discussing Cessation Medications</td>
<td>51.7%</td>
<td>51.9%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Discussing Cessation Strategies</td>
<td>44.5%</td>
<td>41.4%</td>
<td>37.7%</td>
</tr>
<tr>
<td>Health Promotion &amp; Education</td>
<td>62.5%</td>
<td>61.4%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>82.8%</td>
<td>81.4%</td>
<td>77.5%</td>
</tr>
</tbody>
</table>

*These are supplemental questions, not required elements on the NCQA questionnaire, and do not have national benchmarks. CSS provided benchmarking means compiled from an average of all UnitedHealth Group (parent company of UHC) plans using these measures from which it collected and reported survey data.

All composite measures in the “Experience of Care” section scored at or above the national means. The supplemental composites/questions for both CoLTS MCOs regarding “Effectiveness of Care” all scored above the means provided by CSS.

I. External Reviews

External quality review by HSD’s EQRO is a contract requirement. The CoLTS MCOs submit to this annual review to comply with the CMS protocol for independent audit. Another form of external quality review can come from annual NCQA audit and accreditation, which is optional for the CoLTS MCOs.

NCQA

Although there is no requirement that they be nationally accredited, both AMG and UHC have applied for NCQA accreditation. The process is a two-part operation consisting of:
- A quantitative data analysis of the CAHPS® consumer satisfaction results and the HEDIS® performance measure reports related to prevention and treatment
- An on-site visit from NCQA-certified inspectors to evaluate elements in five quality categories

Both MCOs have submitted their CAHPS® and HEDIS® reports for evaluation and been granted temporary accreditation status pending their on-site visit results. These visits have been scheduled, but not completed yet.

EQRO

As HSD’s EQRO, HealthInsight New Mexico performs three CMS-mandated annual audits:
- Compliance to regulations and contracts
- PMs evaluation
- PIPs evaluation

Each of the audits is planned using the CMS protocols for EQRO, 42 CFR 438.352 (for the Compliance audit) and 42 CFR 438.240, Conducting Performance Improvement Projects, (for the PMs and PIPs evaluations). The protocols have been designed to be consistent with industry standards, accommodate evolution of quality assessment, and provide state Medicaid agencies with technical assistance.

Audit tools and the on-site audit plan are created based on the protocols and the NMAC regulations. A numeric score is assigned to each element in the performance criteria in the tools and the maximum total points determined. The individual measurement scores are summed and aggregated. Then an overall percentage score is determined and interpreted as follows:
- Full compliance: 90%-100%
- Moderate compliance: 80%-89%
- Minimal compliance: 50%-79%
- Non-compliance: < 50%

**FY 2012 Audits**

Compliance was evaluated for the CoLTS MCOs by comparing the MCO documentation (policies, procedures, and processes) and case file documents against 15 applicable NMAC 8.307 regulations and subsets and the HSD Letter of Direction (LOD) #32 for Program Integrity requirements. Scores were recorded on the HSD-approved audit tools. Audit approach and methodology consisted of document reviews, file reviews, and interviews with MCO staff. Findings were stated in a combined report for the CoLTS program, plus two appendices of the individualized MCO reports.

The PMs and PIPs were reviewed together and, although they were scored separately, the results were combined into one report because the PMs and PIPs are closely related. HSD identified five (5) out of the 16 CoLTS PMs to be examined for the FY 2012 PMs/PIPs audits. These PMs, plus the two MCO-identified PIPs were evaluated by comparing the MCOs’ documentation to the HSD/MCO contracts and CMS Protocol. The PMs and PIPs audit approach and methodology were designed to align the audit process with the MCOs’ contractual requirements and HSD specifications. This consisted of evaluating the MCOs on the following:
- Rationale (understanding of the regulations and LOD specifications)
- Evidence required (documentation)
- Interpretive guidelines
- Data collection tools
- Scoring criteria

Table 20 shows the overall scores and rating designations for the three audits (compliance, PMs, PIPs).
Table 20: CoLTS EQRO Audit Results for FY 2012

<table>
<thead>
<tr>
<th>Audit Results</th>
<th>AMG</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compliance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>95.9%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td><strong>Performance Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>99.2%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td><strong>Performance Improvement Projects</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Testing (HbA1c &amp; LDL-C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>NF Transition to HCBS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>93.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Full</td>
<td>Full</td>
</tr>
</tbody>
</table>

J. Summary of Quality of Care Findings

The review and analysis of the reports obtained from HSD revealed that the CoLTS program met the quality of care requirements, as evidenced by the following:

- **QM/QI program**: Each MCO had a comprehensive QM/QI program description and a QM/QI plan that was evaluated annually. Each had a Cultural Competency Plan to address the needs of all members. Transparency and communication with stakeholders were built into the program. (See pages 22-23, Table 8.)

- **PMs**: Each MCO tracked the HSD-specified PMs, but no benchmarks or target goals exist to measure against. Both had areas where they excelled and areas for improvement. (See pages 23-24, Figure 3.)

- **PIPs**: Two PIPs were selected in FY 2009 and have been monitored each year since that time. AMG met or exceeded the HSD goals for both PIPs. UHC met/exceeded the one PIP (Transition from NF to HCBS) and was just under the target goal percentage for the other PIP (Diabetes Testing). (See pages 24-26, Table 9.)

- **Utilization management**: Service utilization averaged eight (8) or nine (9) visits per member during FY 2012. The denial rate was very low (0.02 percent). Critical incidents averaged a rate of one (1) out of every eight (8) members, which is high, but expected due to the health status of the CoLTS members. The majority of these incidents were related to emergency services. (See pages 26-28, Tables 10-12.)

- **Grievances and appeals**: One (1) out of every 116 members filed a member grievance at AMG and one (1) out of every 35 members filed at UHC. Provider grievance were very low: zero (0) for AMG and eight (8) for UHC. The top reason cited for both member and provider grievances related to ground transportation for both emergent and non-emergency situations. The ratio for member appeals averaged one (1) out of every 25 members.
Provider appeals filed for AMG averaged one (1) out of 4,135, which was very low (only five [5] filed in FY 2012); UHC had a ratio of one (1) out of 80. (See pages 28-30, Tables 13-16.)

- **Provider satisfaction surveys**: Both MCOs completed a provider survey, but the response rate was low (15.5 percent for AMG and 4.0 percent for UHC). Only one question could be compared between the two MCOs. About 50 percent of both AMG and UHC providers rated their health plan/MCO “About the Same” as other health plans/MCOs; 18.0 percent of AMG providers and 27.1 percent of UHC providers felt their plan was “Significantly/Somewhat Better” than others. (See pages 30-31, Table 17.)

- **Member satisfaction surveys**: Both MCOs surveyed their members via the CAHPS® 4.0H Adult Medicaid Survey. The response rates were significantly higher than the national average at approximately 35 percent for each MCO compared to the national average of 29 percent. Members rated their MCOs at or above the national means or other identified benchmarks for all composite measures relating to “Experience with Care” and “Effectiveness of Care.” (See pages 31-33, Tables 18-19.)

- **External reviews/audits**: AMG and UHC submitted to audit by external quality review for compliance, PMs evaluation, and PIPs evaluation. Both AMG and UHC earned Full Compliance for all three audits. (See pages 33-35, Table 20.)

VI. **Cost-Effectiveness Assessment**

A. **Introduction**

Access and quality of care are assessed to see how well the member’s needs are being met. Cost-effectiveness analysis examines how well the MCOs use the funds provided to meet these needs while still being fiscally responsible with state funds. As a state-funded program, it is essential that it be run as cost-effectively and efficiently as possible.

Several of the MCOs’ financial documents were examined along with publically-available medical cost trending information. The following areas were analyzed to evaluate the cost-effectiveness of the individual MCOs and the overall CoLTS program:

- Contract requirements
- Operational summary statistics
- Average member cost comparison
- Capitation rate ranges and actuarial rate certification
- Capitation rate progression
- Cost comparisons of New Mexico rates to national norms
- Medicaid spending trends

B. **Contract Requirements**

The requirements for cost-effectiveness are found in the HSD/MCO contracts in Article 3, Section 3.11, Fiduciary Responsibilities, and can be broken down into two main categories:
Financial Viability
- Net worth in compliance with New Mexico Insurance Code, NMSA 1978
- Positive working capital balance (current assets minus current liabilities)

Financial Stability
- Compliance with state and federal laws and regulations regarding solvency and risk
- Soundness and stability of the MCO and its subcontractors (with immediate notification to HSD if not able to maintain)
- Insolvency reserve maintained with an independent trustee to ensure members are not at risk
- Independent financial audit performed annually
- Identification of third party coverage of members and coordination of benefits with those third parties
- Timely payments to both the network providers and non-network providers
- Reinsurance protection against financial loss due to catastrophic events

Per the HSD/MCO contracts, evidence in the form of reports and financial statements must be provided at regular intervals (monthly, quarterly, semi-annually, and/or annually) to show financial stability and viability. These documents were examined to determine compliance with the fiduciary requirements of the HSD/MCO contract. The results are shown in Table 21. A check-marked column indicates compliance.

Table 21: CoLTS MCO Contract Fiduciary Requirements Compliance

<table>
<thead>
<tr>
<th>Fiduciary Requirements</th>
<th>AMG</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Worth</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Working Capital</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Financial Stability Plan</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Insolvency Reserve</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Independent Financial Audit</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Inspection and Audit for Solvency</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Third Party Liability*</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Timely Payments</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Although included in the HSD/MCO contracts, this requirement is not a standard report. It is an ad hoc report occasionally requested by HSD and deliverable within 20 days of request. No reports were requested during FY 2012.

C. Operational Summary
Revenue and expense reports were reviewed and the individual MCOs, along with the overall CoLTS program, were found to be in good financial condition. The economic performance for FY 2012 was assessed through three key operational statistics:
- Medical Loss Ratio – medical costs divided by premium revenue
- Administrative Cost Ratio – administrative costs divided by premium revenue
- Operating Margin Gain (or Loss) – derived by subtracting both medical costs and administrative costs from premium revenue
The data for these statistics were obtained from each MCO’s Schedule of Revenue and Expenses report provided annually to HSD. The results are shown in Table 22.

### Table 22: CoLTS MCO Financial Performance

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Loss Ratio</td>
<td>84.8%</td>
<td>80.1%</td>
<td>82.6%</td>
</tr>
<tr>
<td>Administrative Cost Ratio*</td>
<td>14.1%</td>
<td>11.8%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Operating Gain (Loss)</td>
<td>1.1%</td>
<td>8.1%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

*Per HSD/Administrative Services Division (ASD): Administrative expenses include the New Mexico Medical Insurance Pool (NMMIP) Assessment and State Premium Tax, which together account for 5.5 percent of the MCOs' total administrative expense.

The New Mexico medical loss ratio standard was set at 85.0 percent in the HSD/MCO contracts. In FY 2012, AMG closely matched this at 84.8 percent and UHC was slightly below the average at 80.1 percent.

The administrative cost ratio for the CoLTS program was set at 15.0 percent. Both MCOs had a ratio below the maximum amount allowed. AMG was at 14.1 percent and UHC was at 11.8 percent in FY 2012.

The table shows a notable difference between the two MCOs operating gains of 1.1 percent for AMG and 8.1 percent for UHC. This was explained by the HSD/ASD Budget Bureau:

“UHC’s Medical Loss Ratio and Underwriting [Operating] Gain are influenced by prior period reserve releases that occurred in 2011 and 2012 for overstated reserves at December 31, 2010 and December 31, 2011 respectively.”

An overall operating gain for an organization indicates good fiscal management (i.e., fixed costs can be paid without exceeding revenue). Both AMG and UHC met this requirement for financial viability.

### D. Average Cost per Member Comparison

Capitation is a payment arrangement between the state and the contracted healthcare providers to pay a set amount for established services associated with the managed care programs. Payment, in the form of premiums, is made for each enrolled member, whether or not the individual seeks care. An estimated maximum allowable per person capitation payment amount can be derived by dividing the FY 2012 premium revenue (capitation income provided by the state) by the annualized population (member months). When the total expenses incurred in FY 2012 are divided by the member months, the estimated average program cost per person is obtained.

Table 23 shows the average annual cost per person comparisons. Data were obtained from each MCO’s Schedule of Revenue and Expenses report for the financial entries and from the PCP-to-Members Ratio reports for member population.
Table 23: Comparison of FY 2012 Average Cost to Average Allowable Amount per Member

<table>
<thead>
<tr>
<th>Annual Cost Comparisons</th>
<th>AMG</th>
<th>UHC</th>
<th>Overall CoLTS</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Members</td>
<td>20,676</td>
<td>19,177</td>
<td>39,853</td>
</tr>
<tr>
<td>Member Months</td>
<td>248,112</td>
<td>230,124</td>
<td>478,236</td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>$377,079,479.14</td>
<td>$329,155,161.03</td>
<td>$706,234,640.17</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>$62,692,643.89</td>
<td>$48,302,160.29</td>
<td>$110,994,804.18</td>
</tr>
<tr>
<td>Average Cost per Member</td>
<td>$1,772.47</td>
<td>$1,640.23</td>
<td>$1,708.84</td>
</tr>
<tr>
<td>Premium Revenue</td>
<td>$444,605,953.62</td>
<td>$410,690,877.00</td>
<td>$855,296,830.62</td>
</tr>
<tr>
<td>Average Allowable Amount per Member</td>
<td>$1,791.96</td>
<td>$1,784.65</td>
<td>$1,788.44</td>
</tr>
</tbody>
</table>

The expense rates for the two MCOs were close, averaging $1,709 per person in the program. This was only slightly below the average per member amount allowed for services of $1,788, indicating that the CoLTS MCOs were being fiscally responsible with the state funds.

E. Capitation Rate Ranges and Actuarial Rate Certification

The total amount of capitation income allotted to the MCOs in the CoLTS program is divided up into categories designed to cover services for nine member population groups known as cohorts. Some examples of the cohort categories are: Dual-eligible members who reside in a nursing facility or Mi Via Medicaid-only members or Healthy Duals. Each of the nine cohort categories is given a capitation rate range payment amount determined by an external, independent organization.

HSD contracted with Mercer Government Services Consulting (Mercer) to develop the capitation rates and provide actuarial rate certification. Rate ranges were determined by studying the following factors and projecting expenses in order to bring the average expected service utilization and the amount of funds paid as close together as possible:

- Recent claims payment amounts
- Encounters
- Federal and state legislative changes
- Managed care program changes
- Medical trends for utilization and unit costs
- Member demographic mixes
- Past and prospective trends

Mercer certified that the rates were developed in accordance with generally accepted actuarial practices and principles and in accordance with the rate-setting guidelines established by CMS. The methodology of the rate development was detailed, and an overview of the analyses was included in a narrative report, along with a set of rate tables, provided to HSD as evidence of actuarial soundness.
F. CoLTS Capitation Rate Progression

Capitation rates can change over time due to a variety of factors. Rates are revised at least annually, although they are analyzed and updated more frequently if major changes have occurred on a state or federal level. Individual MCO issues and program changes also may affect the rate-setting process. For instance, in 2009 there was one range of rates for the entire CoLTS program. But starting in mid FY 2010, separate rate ranges were developed for AMG and for UHC, based in part upon differences in the member population and service utilization for each group.

To see how the capitation rates have changed over time, an annual weighted average capitation rate needs to be determined. Data for this calculation were obtained from the MCOs’ Expenditures by Category Report provided monthly to HSD for member month service utilization and from the cohort midpoint amount of the capitation rate ranges provided to HSD by Mercer. The rates in the table have been quantified across the MCOs and payment rate categories then weighted by each MCO’s enrollment level and mix to get an average amount for each rate adjustment period. Table 24 shows the weighted average capitation rates and the rate of change for capitation expenditures (as identified by the MCOs) since FY 2010.

Table 24: CoLTS Weighted Average Capitation Rates FY 2010 – FY 2012*

<table>
<thead>
<tr>
<th>Rate Progression</th>
<th>FY10 (1)</th>
<th>FY10 (2)</th>
<th>FY10 (3)</th>
<th>FY11 (1)</th>
<th>FY11 (2)</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average Capitation Rates</td>
<td>$695.28</td>
<td>$702.74</td>
<td>$717.08</td>
<td>$739.54</td>
<td>$715.62</td>
<td>$737.50</td>
</tr>
<tr>
<td>Percent Change Over Time</td>
<td>1.1%</td>
<td>2.0%</td>
<td>3.1%</td>
<td>-3.2%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Average Rate of Increase/(Decrease)</td>
<td></td>
<td></td>
<td></td>
<td>1.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Because FY 2009 was a phase-in year, the weighted average rate for that year was not included in this table.

In FY 2010, the CoLTS program capitation rates were re-evaluated and adjusted three times, and two times in FY 2011. This was done to bring the capitation rates into alignment with base data changes, MCO efficiency adjustments, program changes, and prospective trends that were already taking place or were anticipated. The table shows that over the three years, the capitation rates have been slowly increasing at an average rate of 1.2 percent. There was very little variation over the years, indicating a fiscally stable program.

G. Comparisons of New Mexico Rates to National Norms

Medicaid managed care services are established and monitored by each state, as opposed to having one standard program on a federal level. In New Mexico there is a transportation component, a premium tax component, and a pharmaceutical component which are not included in the medical services component of the Consumer Price Index (CPI). Also, providers must pay a gross receipts tax of approximately seven (7) percent of receipts in New Mexico. As this tax is imposed on most medical services, it is reflected in somewhat higher capitation rates relative to other states which do not tax medical services in this manner.
Because of this, a direct comparison of the capitation rate progression to other states or to the national averages collected by the CPI is not possible. As an alternative, the rate of change over the last three years was compared for the New Mexico capitation rates and the national (United States average) rates.

Table 25: Comparison of Rate of Change for State and National Capitation Rates

<table>
<thead>
<tr>
<th>Program Level</th>
<th>FY10 (2)</th>
<th>FY10 (3)</th>
<th>FY11 (1)</th>
<th>FY11 (2)</th>
<th>FY12</th>
<th>Average Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM CoLTS</td>
<td>1.1%</td>
<td>2.0%</td>
<td>3.1%</td>
<td>-3.2%</td>
<td>3.1%</td>
<td>1.2%</td>
</tr>
<tr>
<td>US National</td>
<td>-</td>
<td>-</td>
<td>3.1%</td>
<td>-</td>
<td>3.9%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

The rate of change for New Mexico and for the United States (US) was very close with an average of just 2.3 percent of difference between the two programs. Although the CoLTS capitation rates are at the high end of the national rate range because of the addition fees and taxes included, the New Mexico rates mirrored the same linear patterns as the US rates. This indicates the CoLTS program was in line with the national capitation rate progression during the measurement period.

H. Medicaid Spending Trends

Since the Medicaid program was introduced in the 1960s, its cost has generally increased each year. Total spending is due to a combination of cost and enrollment growth, so increased growth in spending is normal. Table 26 shows the average annual growth (by percentage) in Medicaid spending from FY 1990 to FY 2012. The information provided in Tables 26 and 27 was obtained from www.statehealthfacts.org.

Table 26: Average Annual Growth in Medicaid Spending, FY1990 - FY2010

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>NM Percent</th>
<th>Rate of Change</th>
<th>US Percent</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1990-2001</td>
<td>15.7%</td>
<td>-</td>
<td>10.9%</td>
<td>-</td>
</tr>
<tr>
<td>FY 2001-2004</td>
<td>14.8%</td>
<td>(5.7%)</td>
<td>9.4%</td>
<td>(13.8%)</td>
</tr>
<tr>
<td>FY 2004-2007</td>
<td>5.9%</td>
<td>(60.1%)</td>
<td>3.6%</td>
<td>(61.7%)</td>
</tr>
<tr>
<td>FY 2007-2010</td>
<td>9.3%</td>
<td>57.6%</td>
<td>6.8%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Overall Rate of Change</td>
<td>(2.7%)</td>
<td>4.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Over the last 20 years, while New Mexico averaged a decrease of -2.7 percent for its Medicaid spending, there was an average increase of 4.5 percent for national (US) Medicaid spending. In the most recent measurement period, the amount of money spent for Medicaid services in New Mexico increased 9.3 percent. During the same period, Medicaid spending for the US grew by 6.8 percent.

Medicaid programs are funded through a combination of federal and state money. Table 27 shows the percentages of the federal and state portions for New Mexico and compares it to the nationwide averages for Medicaid spending.
Table 27: Federal and State Share of Medicaid Spending, FY2010

<table>
<thead>
<tr>
<th>Medicaid Spending</th>
<th>In New Mexico</th>
<th>Nationwide Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Portion</td>
<td>80.4%</td>
<td>$2,768,728,590</td>
</tr>
<tr>
<td></td>
<td>$2,637,367,784,409</td>
<td></td>
</tr>
<tr>
<td>State Portion</td>
<td>19.6%</td>
<td>$674,429,808</td>
</tr>
<tr>
<td></td>
<td>$125,707,549,543</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>$3,443,158,398</td>
</tr>
<tr>
<td></td>
<td>$389,084,333,952</td>
<td></td>
</tr>
</tbody>
</table>

According to the 2011 Actuarial Report on the Financial Outlook for Medicaid, in 2010 the average federal portion for Medicaid spending was 68 percent and the state portion was 32 percent. Looking at New Mexico (in Table 27), the state received a higher than average federal share and paid a lower state portion than the average. Although the rate of spending in New Mexico was 2.5 percent higher than the national average in the latest measurement period, New Mexico paid much less than most states at 19.6 percent.

I. Summary of Cost-effectiveness Findings
After reviewing and analyzing the financial reports and data, it appears the CoLTS program has demonstrated cost-effectiveness through the following:

- **Contract requirements:** All contract requirements for financial viability and stability were met and reports documenting this were submitted to HSD. (See pages 36-37, Table 21.)
- **Operational summary statistics:** The overall program had an operating gain of 4.5 percent; national average is -5.0 percent (an operating loss). This showed sound financial management. (See pages 37-38, Table 22.)
- **Average cost per member comparison:** The annual average cost per person in the CoLTS program was $1,709. With an average of $1,788 allowed, this indicates that the CoLTS MCOs were being fiscally responsible with the state funds. (See pages 38-39, Table 23.)
- **Capitation rate ranges and actuarial rate certification:** Mercer established capitation rate ranges and provided actuarial rate certification. The program showed evidence of being actuarially sound. (See page 39.)
- **Capitation rate progression:** Over the last three years (FY 2010 to FY 2012), the capitation rates have been slowly increasing at an average rate of 1.2 percent. Little variation indicates a fiscally stable program. (See page 40, Table 24.)
- **Comparisons of New Mexico rates to national norms:** New Mexico includes costs for transportation, taxes, and pharmacy that are not included in many other states’ programs, which makes direct comparison unfeasible. As an alternative, an indirect comparison was made for the rate of change for capitation rate progression for New Mexico and for the national program averages. It was very close with an average of just 2.3 percent of difference between the two programs. (See pages 40-41, Table 25.)
- **Medicaid spending trends:** In comparing state and federal Medicaid spending, the rate of spending in New Mexico was 2.5 percent higher than the national average in the latest measurement period, but New Mexico paid much less for its share than most states at 19.6 percent. The program appears to be managed well and is fiscally sound. (See pages 41-42, Tables 26-27.)
VII. Overall Summary of Findings and Conclusions
The CoLTS managed care program has been in existence for four years. Access and quality of care has improved with time and the program has operated cost-effectively.

HSD has shown good management of the state’s Medicaid Managed Care system, and it is anticipated that this will continue with the future changes. As New Mexico moves forward with the new combined (PH, BH, and CoLTS) program, Centennial Care, it will continue to look for ways to maintain or improve the access and quality of care to the members and increase the cost-effectiveness of the overall managed care system by addressing any weaknesses found since program inception and building on the strengths revealed through analysis.