Centennial Care
2018 Annual Technical Report
Report Issued: April 14, 2020
State of New Mexico Human Services Department
Medical Assistance Division
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# ACRONYMS USED IN THIS REPORT

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADV</td>
<td>Annual Dental Visit, HEDIS</td>
</tr>
<tr>
<td>AMM</td>
<td>Antidepressant Medication Management, HEDIS</td>
</tr>
<tr>
<td>BBA</td>
<td>Balanced Budget Act</td>
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<td>BCBS</td>
<td>Blue Cross Blue Shield of New Mexico</td>
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<tr>
<td>CBP</td>
<td>Controlling High Blood Pressure, HEDIS</td>
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<tr>
<td>CCP</td>
<td>Comprehensive Care Plan</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care, HEDIS</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CNA</td>
<td>Comprehensive Needs Assessment</td>
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<td>Calendar Year</td>
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<tr>
<td>EQR</td>
<td>External Quality Review</td>
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<td>EQRO</td>
<td>External Quality Review Organization</td>
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<td>FPC</td>
<td>Frequency of Ongoing Prenatal Care, HEDIS</td>
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<td>Follow-Up after Hospitalization for Mental Illness</td>
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<td>Hemoglobin A1c</td>
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<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set</td>
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<td>HHS</td>
<td>Health &amp; Human Services</td>
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<td>Health Risk Assessment</td>
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<td>Human Services Department</td>
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<td>IAP</td>
<td>Internal Action Plan</td>
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<tr>
<td>IPRO</td>
<td>Island Peer Review Organization</td>
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<tr>
<td>LDL</td>
<td>Low-Density Lipoprotein</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-Term Care</td>
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<td>LTSS</td>
<td>Long-Term Services and Supports</td>
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<td>MAD</td>
<td>Medical Assistance Division</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MHC</td>
<td>Molina Healthcare of New Mexico, Inc.</td>
</tr>
<tr>
<td>MMA</td>
<td>Medication Management for People with Asthma, HEDIS</td>
</tr>
<tr>
<td>MMC</td>
<td>Medicaid Managed Care</td>
</tr>
</tbody>
</table>
NCQA: National Committee for Quality Assurance
NF: Nursing Facility
NMAC: New Mexico Administrative Code
OB/GYN: Obstetrician/Gynecologist
PAHP: Prepaid Ambulatory Health Plans
PCCM: Primary Care Case Management
PCP: Primary Care Practitioner/Provider
PHP: Presbyterian Health Plan, Inc.
PIHP: Prepaid Inpatient Health Plans
PIP: Performance Improvement Project
PHQ: Patient Health Questionnaire
PM: Performance Measure
PPC: Timeliness for Prenatal and Postpartum Care, HEDIS
PQIP: Provider Quality Incentive Program
TOC: Transition of Care
UHC: United Healthcare Community Plan, Inc. of New Mexico
EXECUTIVE SUMMARY

PURPOSE OF REPORT

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations \(^1\) (CFR) 438.350 sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in 42 CFR 438.320 as “the degree to which an MCO, PIHP (Prepaid Inpatient Health Plan), PAHP (Prepaid Ambulatory Health Plan), or PCCM (Primary Care Case Management) entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; through the provision of health services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.”

CFR 438.364 requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness and access, as well as make recommendations for improvement.

To meet CFR 438.364 and CFR 438.358, the New Mexico Human Services Department (HSD) has contracted with Island Peer Review Organization (IPRO), an EQRO, to conduct the annual EQR of the MCOs for calendar year (CY) 2018.

SCOPE OF EXTERNAL QUALITY REVIEW ACTIVITIES CONDUCTED

This EQR technical report focuses on the four (4) federally mandated EQR activities that were conducted. It should be noted that validation of provider network adequacy, though currently mandated, was not part of the federal CMS Protocols \(^2\) for 2018. As set forth in 42 CFR 438.358(b)(1)(i)(ii)(iii)(iv), these activities were:

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\(^1\) Electronic Code of Federal Regulations Title 42-Chapter IV-Subchapter C-Part 438 Managed Care Subpart E - Quality Measurement and Improvement; External Quality Review

\(^2\) Medicaid.gov Quality of Care External Quality Review Activities and Protocols
Compliance Monitoring – This activity determined MCO compliance with its contract and with state and federal regulations.

Validation of Performance Improvement Projects – This activity validated that MCO performance improvement projects (PIPs) were designed, conducted and reported in a methodologically sound manner, allowing for real improvements in care and services.

Validation of Performance Measures – This activity assessed the accuracy of performance measures (PMs) reported by each MCO and determined the extent to which the performance measures calculated by the MCO follow state specifications and reporting requirements.

Validation of Network Adequacy – This activity assessed MCO adherence to state standards for distance for specific provider types, as well as the MCO’s ability to provide an adequate provider network to its Medicaid population.

CMS defines validation in the Final Rule at 42 CFR 438.320 as “the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.”

The results of the EQR activities presented in this report are considered preliminary. At the time of production of the 2018 Annual Technical Report the results of these activities were under review by HSD and not yet presented to the MCOs for rebuttal. The preliminary results of these EQR activities are detailed in the MCO Findings, Strengths and Recommendations section of this report.

Preliminary Conclusions and Recommendations

A high-level summary of the conclusions drawn from the EQR activities regarding New Mexico’s Medicaid MCOs’ strengths and opportunities and IPRO’s recommendations for improvement is displayed in Table 1. Please note that some of these findings are considered preliminary at this time. Findings, strengths and recommendations are described in detail in the section titled MCO Findings, Strengths and Recommendations of this report.

Table 1: Summary of MCOs’ Strengths, Opportunities and Recommendations

<table>
<thead>
<tr>
<th>Blue Cross Blue Shield of New Mexico (BCBS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>▪ BCBS achieved National Committee for Quality Assurance (NCQA) “accredited” status (as of June 30, 2018).</td>
</tr>
<tr>
<td>▪ Preliminary finding: BCBS achieved full compliance for the following areas of the 2018 Compliance Review:</td>
</tr>
<tr>
<td>▪ Adverse Benefit Determinations, document review</td>
</tr>
<tr>
<td>▪ Delegation of Dental Services and Transportation Services, document review</td>
</tr>
<tr>
<td>▪ Grievances and Appeals System, document review</td>
</tr>
<tr>
<td>▪ Maintenance of Medical Records, document review</td>
</tr>
</tbody>
</table>
Preliminary finding: BCBS achieved full compliance for all four (4) PIPs conducted in 2018. Further, BCBS demonstrated continuous improvement in pediatric dental care for four (4) consecutive years. BCBS demonstrated improvement in eye care for diabetic members residing in long-term care (LTC) facilities from baseline to the final measurement period. BCBS demonstrated improvement in the reduction of hospital admissions for diabetes related short-term complications for adult members. BCBS demonstrated improvement in antidepressant medication management in the acute and continuous phases among members aged 65 years and older.

BCBS met or exceeded the PM targets for the following measures:
- PM 1 Annual Dental Visit
- PM 2 Medication Management for People with Asthma
- PM 3 Controlling High Blood Pressure
- PM 4 Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Poor Control
- PM 4 Comprehensive Diabetes Care – Retinal Eye Exam
- PM 4 Comprehensive Diabetes Care – Nephropathy Screening
- PM 5 Timeliness of Prenatal Care
- PM 5 Postpartum Care

Preliminary finding: The CY 2018 Validation of Network Adequacy determined that BCBS met New Mexico Administrative Code (NMAC) distance standards in the urban, frontier and rural regions of the state for the following areas: PCPs, obstetrics/gynecology (OB/GYN), pharmacies, personal care service agencies, nursing facilities, hospitals and transportation providers. BCBS also met distance standards for assisted living facilities in the urban region of the state.

Opportunities

Preliminary finding: BCBS did not achieve full compliance for the following areas reviewed for the 2018 Compliance Review:
- Care Coordination, document review
- Enrollment and Disenrollment, document review
- Provider Network, document review
- Care Coordination, Continuing Members, file review
- Care Coordination, New Members, file review
- Credentialing and Recredentialing, file review
BCBS did not meet the PM targets for the following measures:
- PM 4 Comprehensive Diabetes Care – HbA1c Testing
- PM 7 Antidepressant Medication Management – Acute Phase
- PM 7 Antidepressant Medication Management – Continuous Phase

Preliminary finding: The CY 2018 Validation of Network Adequacy determined that BCBS did not meet NMAC distance standards for assisted living facilities in the rural and frontier regions of the state.

Recommendations
- BCBS should review areas from the previous reporting period for which a “met” or “exceeded” determination was validated, and for which they did not meet or exceed for this period. These areas, as well as successful interventions, should be analyzed to achieve sustained success.
- BCBS should address the findings from the 2018 Compliance Review and develop an internal action plan to improve deficient areas. Specific recommendations are reported in the CY 2018 Compliance Review Report.
- Despite not meeting contractual targets for PM 4 and PM 7, rates for these PMs have increased between CY 2017 and CY 2018. As such, it is recommended that BCBS continue its quality strategy to improve these areas of care.
- BCBS should continue its efforts to contract with more assisted living facilities in rural and frontier regions of the state. As other Centennial Care MCOs met the assisted living facilities standard in the frontier region of the state, BCBS should compare networks to identify the assisted living facilities that are contracted with other MCOs but not contracted with BCBS. Executing agreements with these facilities may address the network gap in the frontier region of the state.

Molina Healthcare of New Mexico, Inc. (MHC)

Strengths
- MHC achieved NCQA “accredited” status (as of June 30, 2018).
- Preliminary finding: MHC achieved full compliance for three (3) of the four (4) PIPs conducted in 2018. MHC demonstrated improvement in the documentation of BMI percentile and counseling for physical activity among members aged 3 to 17 years of age from baseline to the final measurement period. MHC demonstrated improvement in the reduction of LTSS members who reported a fall or problems with balance or walking from baseline to the final measurement period. MHC demonstrated improvement in the reduction of hospital admissions due to diabetes-related short-term complications and demonstrated an increase in HbA1c testing from baseline to the final measurement period.
- MHC met or exceeded the PM targets for the following measures:
  - PM 1 Annual Dental Visit
  - PM 2 Medication Management for People with Asthma
  - PM 3 Controlling High Blood Pressure
  - PM 4 Comprehensive Diabetes Care – HbA1c Testing
  - PM 4 Comprehensive Diabetes Care – HbA1c Poor Control
  - PM 4 Comprehensive Diabetes Care – Retinal Eye Exam
  - PM 4 Comprehensive Diabetes Care – Nephropathy Screening
  - PM 5 Timeliness of Prenatal Care
  - PM 5 Postpartum Care
PM 7 Antidepressant Medication Management – Acute Phase

Preliminary finding: The CY 2018 Validation of Network Adequacy determined that MHC met NMAC distance standards in the urban, frontier and rural regions of the state for the following areas: PCPs, OB/GYNs, pharmacies, personal care service agencies, nursing facilities, hospitals and transportation providers. MHC also met distance standards for assisted living facilities in the frontier region of the state.

Opportunities

Preliminary finding: In regard to PIPs, MHC demonstrates an opportunity for improvement as it did not achieve full compliance for the “Clinical Depression Screening and Follow-Up” PIP. MHC did not report CY 2018 data for one indicator “screening for clinical depression and follow-up plan”. IPRO was unable to assess improvement due to the absence of this data. Further, MHC demonstrated a decline in performance as final measurement rates fell below baseline for the Antidepressant Medication Management measure for the acute and continuous phases.

MHC did not meet the PM target for the following measure:

- PM 7 Antidepressant Medication Management – Continuous Phase

Preliminary finding: The CY 2018 Validation of Network Adequacy determined that MHC did not meet NMAC distance standards for assisted living facilities in the urban and rural regions of the state.

Note: The recommendations presented below are based on CY 2018 performance. During 2018, MHC exited the Centennial Care program. As such, these recommendations do not require follow-up.

Recommendations

Although MHC is not currently contracted as a Centennial Care MCO, IPRO recommends the following:

- To comply with state requirements, MHC should ensure that sufficient PIP data is collected and reported to HSD.

- Despite not meeting the contractual target for PM 7 Continuous Phase, the rate did increase between CY 2017 and CY 2018. As such, it is recommended that MHC continue with its strategy to improve this area of care.

Strengths

- PHP achieved NCQA “accredited” status (as of June 30, 2018).

Preliminary finding: PHP achieved full compliance for the following areas of the 2018 Compliance Review:

- Adverse Benefit Determinations, document review
- Delegation of Dental Services and Transportation Services, document review
- Grievances and Appeals System, document review
- Maintenance of Medical Records, document review
- Member Materials, document review
- Member Services, document review
- PCP and Pharmacy Lock-ins, document review
- Program Integrity, document review
- Provider Agreements, document review
PHP met or exceeded the PM targets for the following measures:
- PM 1 Annual Dental Visit
- PM 2 Medication Management for People with Asthma
- PM 3 Controlling High Blood Pressure
- PM 4 Comprehensive Diabetes Care – HbA1c Testing
- PM 4 Comprehensive Diabetes Care – HbA1c Poor Control
- PM 4 Comprehensive Diabetes Care – Retinal Eye Exam
- PM 5 Timeliness of Prenatal Care
- PM 5 Postpartum Care
- PM 7 Antidepressant Medication Management – Acute Phase
- PM 7 Antidepressant Medication Management – Continuation Phase

Preliminary finding: The CY 2018 Validation of Network Adequacy determined that PHP met NMAC distance standards in the urban, frontier and rural regions of the state for the following areas: PCPs, OB/GYNs, pharmacies, personal care service agencies, nursing facilities, hospitals and transportation providers. PHP also met distance standards for assisted living facilities in the frontier region of the state.

Opportunities
- Preliminary finding: PHP did not achieve full compliance for the following areas reviewed for the 2018 Compliance Review:
  - Care Coordination, document review
  - Enrollment and Disenrollment, document review
  - Provider Network, document review
  - Care Coordination, Continuing Members, file review
  - Care Coordination, New Members, file review
  - Credentialing and Recredentialing, file review
  - PCP and Pharmacy Lock-ins, file review
  - Transition of Care, file review

- Preliminary finding: In regard to PIPs, PHP demonstrates an opportunity for improvement as it did not achieve full compliance for the “Inter-Rater Reliability for Personal Care Services Allocation” PIP. PHP did not report CY 2018 data for this PIP. IPRO was unable to assess improvement due to the absence of this data. The main activity identified by PHP as an intervention was a training assessment tool for PHP care coordination staff. Improved inter-rater reliability is not a valid indicator of member outcomes.

- PHP did not meet the PM target for the following measure:
  - PM 4 Comprehensive Diabetes Care – Nephropathy Screening

- Preliminary finding: The CY 2018 Validation of Network Adequacy determined that PHP did not
meet NMAC distance standards for assisted living facilities in the urban and rural regions of the state.

**Recommendations**

- PHP should review areas from the previous reporting period for which a “met” or “exceeded” determination was validated, and for which they did not meet or exceed for this period. These areas, as well as successful interventions, should be analyzed to achieve sustained success.
- PHP should address the findings from the 2018 Compliance Review and develop an internal action plan to improve deficient areas. Specific recommendations are reported in the 2018 Compliance Review Report.
- When designing PIPs, PHP should ensure the inclusion of at least one measured indicator that tracks performance and improvement over time. All indicators should be based on current clinical knowledge or health services research and enrollee outcomes. Further, to comply with state requirements, PHP should ensure that sufficient PIP data is collected and reported to HSD.
- As PHP’s PM 4 Nephropathy Screening rate declined between CY 2017 and CY 2018, PHP should reevaluate its quality improvement strategy for this area of care and update interventions based on root cause analysis.
- PHP should continue its efforts to contract with more assisted living facilities in the urban and rural regions of the state. As another Centennial Care MCO met the assisted living facilities standard in the urban region of the state, PHP should compare networks to identify the assisted living facilities that are contracted with the other MCO but not contracted with PHP. Executing agreements with these facilities may address the network gap in the urban region of the state.

**BACKGROUND**

**NEW MEXICO MEDICAID MANAGED CARE PROGRAM: CENTENNIAL CARE**

The State of New Mexico’s Centennial Care program is administered through HSD’s Medical Assistance Division (MAD). According to the *HSD Monthly Statistical Reports*, in December 2018 MAD provided Medicaid services to 832,316 individuals, which is a 2.5% decrease from the December 2017 enrollment of 853,861 individuals. These services include physical health, behavioral health, long-term care and community benefits.

Managed care was implemented to improve the quality of care and access to care for New Mexico’s Medicaid clients by providing comprehensive medical and social services in a cost-effective manner. This program has steadily evolved since 1997, from an initial program that provided physical health benefits, to the current one that provides a full array of services in an integrated model of care.

The New Mexico Medicaid Managed Care (MMC) program, formerly referred to as Salud!, was initiated on July 1, 1997. In July 2013, CMS approved the Centennial Care program, a new Medicaid Section 1115

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3 HSD Monthly Statistical Report December 2018
4 HSD Monthly Statistical Report December 2017
New Mexico Quality Goals and Guiding Principles

The goals of the Centennial Care program at implementation included:

- Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting;
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
- Slowing the growth of rate of cost, or “bending the cost curve,” over time without cutting benefits or services, changing eligibility, or reducing provider rates; and
- Streamlining and modernizing the Medicaid program in the state.

In the development of a modernized Medicaid program, New Mexico articulated four (4) guiding principles:

- Developing a comprehensive service delivery system that provides a full array of benefits and services offered through the state’s Medicaid program;
- Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the health care system;
- Increasing the emphasis on payment reforms that pay for performance rather than payment for quantity of services delivered; and
- Simplifying administration of the program for the state, for providers and for recipients where possible.

These guiding principles continue to steer New Mexico’s Medicaid modernization efforts and serve as the foundation for the Section 1115 waiver.

External Quality Review Activities

For CY 2018, IPRO conducted a compliance monitoring site visit, validation of PMs, validation of PIPs and validation of network adequacy. Each activity was conducted in accordance with CMS’s protocols for determining compliance with MMC regulations. Appendices A–D provide details of how these activities were conducted including objectives for conducting the activity, technical methods of data collection, descriptions of data obtained and data aggregation and analysis.

This annual EQR technical report provides summaries of the EQR activities that were conducted. Findings are reported for all MCOs that participated in the Centennial Care program during 2018. (Note: During 2018 two (2) MCOs exited the Centennial Care program. United Healthcare Community Plan, Inc. of New Mexico (UHC) exited the program on August 31, 2018 and transferred its membership to
Presbyterian Health Plan, Inc. on September 1, 2018. For CY 2018, UHC was included in the validation of performance improvement projects. Molina Healthcare of New Mexico, Inc. ended coverage on December 31, 2018. For CY 2018, Molina Healthcare of New Mexico, Inc. was included in all EQR activities except the annual compliance review.)

MCO CORPORATE PROFILES

Three (4) MCOs comprised New Mexico’s Centennial Care program during 2018:

- Blue Cross Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico, Inc. (MHC)
- Presbyterian Health Plan, Inc. (PHP)
- UnitedHealthcare Community Plan, Inc. of New Mexico (UHC)

Table 2: MCO Corporate Profiles

<table>
<thead>
<tr>
<th>Profile Information</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>UHC</th>
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<tr>
<td>NCQA Medicaid Accreditation Status as of June 30, 2018</td>
<td>Accredited</td>
<td>Accredited</td>
<td>Accredited</td>
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<td>NCQA National Medicaid Rating as of June 30, 2018</td>
<td>3.0</td>
<td>3.0</td>
<td>2.5</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Note: NCQA National Medicaid Rating is out of 3.0.

MCO FINDINGS, STRENGTHS AND OPPORTUNITIES

INTRODUCTION

This section of the report addresses the preliminary findings from mandatory EQR activities that were conducted by IPRO. The preliminary findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Validation of Performance Improvement Projects, Validation of Performance Measures and Validation of Network Adequacy).

COMPLIANCE MONITORING

This subpart of the report presents the preliminary results of the review by IPRO of the MCOs’ compliance with regulatory standards and contract requirements for January 1, 2018–December 31, 2018. The review is based on information derived from IPRO’s conduct of the annual regulatory compliance review, which took place in September 2018. IPRO’s assessment methodology is consistent with the protocols established by CMS and is described in detail in Appendix A.

A description of the content evaluated under each compliance domain follows:

- Adverse Benefit Determinations
There was a policy review and a review of thirty (30) files for this area.
Policies and procedures that govern adverse benefit determinations were reviewed.
Member files were also reviewed to ensure that policies and procedures were followed.

- **Care Coordination**
  - There was a policy review and a review of thirty (30) files for this area.
  - Policies and procedures that govern the use of health risk assessments (HRAs) and comprehensive needs assessments (CNAs) and the development of the comprehensive care plans (CCPs) were reviewed.
  - The file review portion included a random sample of care coordination files for members who qualify for a higher level of care with a focus on the timely completion of HRAs, CNAs and the development and authorization of the CCPs.

- **Delegation of Dental and Transportation Services**
  - Policies and procedures for delegation were reviewed for evidence of MCO oversight of dental and transportation vendors.
  - A file review was not conducted for this review subject.

- **Enrollment and Disenrollment**
  - Policies and procedures for enrollment and disenrollment were reviewed for evidence that each MCO had reliable systems in place to provide continuous tracking of member enrollment status.
  - A file review was not conducted for this review subject.

- **Grievances and Appeals**
  - There was a policy review and a review of thirty (30) files for this area.
  - Policies and procedures were reviewed for compliance with contractual and regulatory requirements. This included verifying that the MCOs followed the mandated timeframes, had the appropriate staff assigned to review the grievance or appeal and disseminated the required information to members and providers.
  - The file review for this subject area included a random sample of grievances, appeals and expedited appeals with particular focus on adherence to timeliness, policies and procedures.

- **Maintenance of Medical Records**
  - Policies governing medical record documentation requirements for contract providers.
  - Tools used to abstract the information from the medical health records and the qualification and training provided to the medical record abstractors.
  - Methodology employed to choose which providers were reviewed for compliance with these standards.
  - Documentation that the MCO communicated the audit results back to the medical provider with recommendations for performance improvement.
  - Evidence of follow-up by the MCO and corrective action when a provider’s performance is below a certain threshold that is determined in advance by the MCO.

- **Member Materials**
  - Policies, procedures and other material evidence were reviewed to determine if the MCO had the proper systems in place to generate and distribute materials that are
designed in a manner and format that may be easily understood and is readily accessible by enrollees and potential enrollees.

- A file review was not conducted for this subject area.

**Member Services**

- Policies and procedures were reviewed to determine if the MCO had the systems in place to properly manage a call center, provide vital services to members such as, electronic access to their health records, and report required metrics to HSD.

- A file review was not conducted for this subject area.

**PCP and Pharmacy Lock-ins**

- There was a policy review and a review of thirty (30) files for this area.

- Policies and procedures were reviewed to determine that the MCO had the proper systems in place to manage PCP and pharmacy lock-in enrollment and disenrollment when conditions warranted such an action.

- This area included a random sample file review of PCP and pharmacy lock-ins with particular focus on communication with the member.

**Program Integrity**

- Provider enrollment forms showing evidence that all the required databases had been checked by the MCO for excluded providers.

- Completed corrective action plans for providers.

- Work plans for announced and unannounced site visits to providers at higher risk for fraud and abuse.

- Reports from contracted providers and quarterly and annual reports that were sent to HSD by the MCOs.

- A file review was not conducted for this subject area.

**Provider Network**

- Policies and procedures governing the MCO’s provider network were reviewed. The review included an evaluation of the provider manual, provider training programs, geographic access report, network update report and the provider satisfaction survey.

- A file review was not conducted for this subject area.

**Provider Services**

- A review was conducted of the policies and procedures that govern the development and distribution of a provider handbook, the operation of a provider services call center and the development and implementation of provider training and outreach.

- A file review was not conducted for this subject area.

**Quality Assurance**

- Policies and procedures governing quality assurance oversight, monitoring and evaluation were reviewed. The review included results of member and provider surveys, minutes from member advisory board meetings, evidence of the adoption and dissemination of clinical guidelines, and the quality assurance program description.

- A file review was not conducted for this subject area.

**Reporting Requirements**
Policies and procedures were reviewed to determine that the MCO had the proper systems in place to generate, analyze and submit required reports to HSD.

A file review was not conducted for this subject area.

- **Self-Directed Community Benefit**
  - Policies and procedures were reviewed to determine that the MCO had the proper systems in place to monitor and guide member use of this benefit including budget management, critical incidence reporting, and fiscal management agency contracting.
  - A file review was not conducted for this subject area.

- **Transition of Care (TOC)**
  - There was a policy review and a review of thirty (30) files for this area.
  - Policies and procedures were reviewed to determine that the MCO had the proper systems in place to facilitate smooth transitions for members leaving a nursing facility for a community-based setting.
  - This area included a random sample file review of TOC with particular focus on the development of a formal transition plan to help members successfully transition from a nursing facility (NF) to a home or community-based setting.

During this review period, there were four (4) compliance levels: full, moderate, minimal and non-compliance. Table 3 displays the compliance levels, score ranges and definitions.

<table>
<thead>
<tr>
<th>Compliance Levels</th>
<th>Score Range</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90%–100%</td>
<td>MCO met or exceeded the standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80%–89%</td>
<td>MCO met requirements of the standard but had deficiencies in certain areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50%–79%</td>
<td>MCO met some requirements of the standard but had significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>&lt;50%</td>
<td>MCO did not meet the standard and requires corrective action</td>
</tr>
</tbody>
</table>

Table 4 displays the preliminary 2018 compliance review designations for each MCO.

<table>
<thead>
<tr>
<th>Compliance Domain</th>
<th>BCBS5</th>
<th>PHP6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

5 HSD initiated internal action plans (IAP) for Care Coordination and Transition of Care in October 2017 for BCBS. The IAPs were active in CY 2018.

6 HSD initiated IAPs for Care Coordination and Transition of Care in October 2017 for PHP. The IAPs were inactivated on December 15, 2018.
<table>
<thead>
<tr>
<th>Compliance Domain</th>
<th>BCBS⁵</th>
<th>PHP⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>Document Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Benefit Determinations</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Delegation – Dental and Transportation</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Enrollment and Disenrollment</td>
<td>Moderate</td>
<td>Minimal</td>
</tr>
<tr>
<td>Grievances and Appeals System</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Maintenance of Medical Records</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Materials</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Services</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>PCP and Pharmacy Lock-ins</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Program Integrity</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Provider Agreements</td>
<td>-</td>
<td>Full</td>
</tr>
<tr>
<td>Provider Network</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Provider Services</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Self-Directed Community Benefit</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>Moderate</td>
<td>Full</td>
</tr>
<tr>
<td>File Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Benefit Determinations, Standard</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Adverse Benefit Determinations, Expedited</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Care Coordination, Continuing Members</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Care Coordination, New Members</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Credentialing and Recredentialing</td>
<td>-</td>
<td>Minimal</td>
</tr>
<tr>
<td>Member Appeals, Standard</td>
<td>Minimal</td>
<td>Full</td>
</tr>
<tr>
<td>Member Appeals, Expedited</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Grievances</td>
<td>Moderate</td>
<td>Full</td>
</tr>
<tr>
<td>PCP and Pharmacy Lock-ins</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>Non-Compliance</td>
<td>Minimal</td>
</tr>
</tbody>
</table>

The MCOs demonstrated full compliance in 2018 with standards related to the following areas:

- Adverse Benefit Determination, document review
- Delegation of Dental Services and Transportation Services, document review
- Grievances and Appeals System, document review
- Maintenance of Medical Records, document review
- Member Materials, document review
High level summaries for areas determined to be less than moderately compliant are provided in Table 5.

Table 5: Preliminary Findings for Less Than Moderately Compliant Elements

<table>
<thead>
<tr>
<th>BCBS</th>
</tr>
</thead>
</table>
| **Enrollment and Disenrollment, document review**
  | o BCBS did not submit evidence that addressed newborn enrollment. |
  | o BCBS did not meet non-discrimination requirements for enrollment. |
  | o BCBS did not submit evidence that addressed MCO-initiated member disenrollment. |
  | o BCBS did not submit evidence that addressed member-initiated disenrollment due to automatic re-enrollment. |
| **Credentialing and Recredentialing, file review**
  | o Eight (8) of thirty (30) files exceeded the 45 day timeframe. |
  | o Twenty (25) of thirty (30) files did not include ownership and control disclosures. Eleven (11) of twelve (12) files did not include evidence that primary admitting privileges were verified by BCBS. (Only thirteen (13) providers indicated on the application that they had admitting privileges.) |
  | o Five (5) of thirty (30) files did not include evidence that the applicant’s education and training were verified by BCBS. |
  | o One (1) of thirty (30) files did not include evidence of malpractice insurance. |
  | o Thirty (30) of thirty (30) files did not include evidence of an initial site visit. |
| **Transition of Care, file review**
  | 7 BCBS scored 76.00% and achieved a “minimal” designation for Enrollment and Disenrollment. |
  | 8 BCBS scored 72.51% and achieved a “minimal” designation for Credentialing and Recredentialing. |
  | 9 BCBS scored 57.66% and achieved a “minimal” designation for Transition of Care. BCBS had an active IAP for Transition of Care in CY 2018. |
o Four (4) of twenty-five (25) files did not include evidence that BCBS identified and facilitated coordination of care for all members during various transition scenarios or evidence of a CNA. Three (3) of these four (4) files did not include evidence of community reintegration allocation.

o Thirteen (13) of twenty-five (25) files did not include evidence of a transition plan.

o Six (6) of the twelve (12) files that included a transition plan did not include evidence that the selection of providers in the community was addressed.

o Two (2) of the twelve (12) files that included a transition plan did not include evidence that financial needs were addressed.

o Two (2) of the twelve (12) files that included a transition plan did not include evidence that interpersonal skills were addressed.

o Four (4) of twenty-four (24) files did not include evidence that an additional in-home assessment was conducted within seventy-five (75) days of the transition to determine if the transition was successful and identify any remaining needs.

PHP

- **Care Coordination, document review**: 10

  o PHP did not submit evidence of the requirement to conduct the standardized HRA on all members who are newly enrolled in Centennial Care and who are not in care coordination level 2 or level 3 and who have a change in health condition that requires a higher level of care coordination.

  o PHP did not submit evidence of the requirements to obtain HRA information from the member or representative, to document this information in the member’s file and to ensure PHP staff, or vendors conducting the HRA are adequately trained.

  o PHP did not submit evidence of the requirement to include in the following elements in the HRA: indication of a 1915 (c) waiver level of care assessment or client individual assessment; assistance with two (2) or more activities of daily living and type of need; interest in and need for LTC services; advance directives preference and interest in receiving information; and interest in receiving care coordination.

  o PHP did not submit evidence of the requirement to make reasonable efforts to contact new members to conduct HRA and provide information by engaging in community supports such as community health workers, CSAs and centers for independent living.

  o PHP did not submit evidence of the requirements to notify members identified as needing a comprehensive needs assessment within seven (7) calendar days of completion of the HRA and to ensure that the same standards are met for members enrolled in Health Home.

  o PHP did not submit evidence of the requirement to conduct a comprehensive needs assessment for members who have “other” indicators. Such indicators would require HSD approval for a CNA to be conducted. 11

  o PHP did not submit evidence of the requirement to ensure, for members residing in nursing homes, that an MDS is completed and supplemental information is collected related to behavioral health needs and the member’s interest in receiving home community benefit services (HCBS).

  o PHP did not submit evidence of the requirement to include in the comprehensive needs

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10 PHP scored 79.76% and achieved a “minimal” designation for Care Coordination. PHP’s IAP for Care Coordination was inactivated on December 15, 2018.

11 See Amendment 8 to the Medicaid Managed Care Agreement among New Mexico Human Services Department and Presbyterian Health Plan Contract citations 4.4.3.5 and 4.4.3.5.12.
assessment a risk assessment using a tool and protocol approved by HSD.

- PHP did not submit evidence of the requirement to include in the comprehensive needs assessment a disease management needs assessment.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement for care coordinators to provide copies of completed CCPs to other providers authorized to deliver care to the member and to ensure that such providers who do not receive a copy of the CCP are informed in writing of all relevant information needed.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement to conduct an annual comprehensive needs assessment to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed.
- PHP did not submit evidence of the requirement to initiate services in the updated CCP within five (5) business days of the reassessment.
- PHP did not submit evidence of the requirement to inform each member of his or her eligibility end date; or the requirement to educate members on the importance of maintaining eligibility, that eligibility must be redetermined at least once a year and that members will be contacted when redetermination is needed.
- PHP did not submit evidence of the requirement to document the member’s decision on having an advance directive in the member’s file.
- PHP did not submit evidence of the requirement for the care coordination team to begin monitoring that services noted in the CCP have been initiated and continue to be provided as authorized and that services continue to meet the member’s needs.
- PHP did not submit evidence of the requirement to monitor the member's community benefit to ensure that the benefit sufficiently meets the member's needs.
- PHP did not submit evidence of the requirement to monitor the member's community benefit to ensure that the benefit sufficiently meets the member's needs.
- PHP did not submit evidence of the requirement to monitor the member's community benefit to ensure that the benefit sufficiently meets the member's needs.
- PHP did not submit evidence of the requirement to monitor the member's community benefit to ensure that the benefit sufficiently meets the member's needs.
- PHP did not submit evidence of the requirement to document the date of when the level of care assessment was completed in the member’s file in the event of no change in level of care.
- PHP did not submit evidence of the requirement to interact with both the member and the provider through modern technologies to facilitate better care coordination and promote health behaviors.
- PHP did not submit sufficient evidence of the requirement to monitor and evaluate emergency room and behavioral health crisis service utilization to determine the reasons for these visits.
- PHP did not submit evidence of the requirement to include the most recent HRA, CNA, level of care assessment and documentation of care coordination level in member case files. (Citation: PHP did not submit evidence of the requirement to include a list of emergency contacts approved by the member in member case files.
- PHP did not submit evidence of the requirement to maintain a policy for care coordination staff requirements.
- PHP did not submit evidence of the requirement to not exceed the maximum caseload per care coordinator ratio of 1:40 for members under the age of twenty-one (21) who participate in the SDCB.
- PHP submitted the “Care Coordination New Hire and Ongoing Training Schedules” as evidence of the requirement to provide training, initial and ongoing, to all care coordinators on the required training topics; however, the evidence was insufficient as it did not include training content.
- PHP did not submit evidence of the requirement to allow HSD to have remote access to case files.
- **Enrollment and Disenrollment, document review**:  
  - PHP did not submit evidence that addressed newborn enrollment requirements.
  - PHP submitted evidence that did not address the effective date of enrollment requirement.
  - PHP did not submit evidence that addressed the ninety (90) day change period. The document referred to by PHP was not received by IPRO.
  - PHP did not submit sufficient evidence of the requirement to accept all members transferring from any MCO.
  - PHP did not submit evidence that PHP’s internal policy and procedure on mass transfers was approved by HSD.
  - PHP did not submit sufficient evidence that addressed member-initiated disenrollment.
  - PHP did not submit evidence that addressed HSD initiated disenrollment.
  - PHP submitted evidence that did not address the effective date of disenrollment requirement.

- **PCP and Pharmacy Lock-ins, file review**:  
  - Twenty-two (22) of twenty-eight (28) files did not include evidence of the requirement to inform the member of the intent to lock-in, including the reasons for imposing the lock-in.
  - Twenty-three (23) of twenty-eight (28) files did not include evidence of the requirement to provide grievance procedures to the member.
  - Twenty-four (24) of twenty-four (24) files did not include evidence of the requirement to review lock-ins every quarter. (Only twenty-four (24) of the twenty-eight (28) files qualified for a subsequent quarterly review.)
  - Twenty-two (22) of twenty-four (24) files did not include evidence of the requirement to remove the member from a lock-in when it was determined that the utilization problems had been resolved.

- **Transition of Care, file review**:  
  - Twenty-six (26) of the twenty-eight (28) files submitted by PHP for this area did not meet the requirements for TOC and were therefore excluded from the sample. Only two (2) files qualified for this area of review.
  - Two (2) of two (2) files did not include evidence that PHP identified and facilitated coordination of care for all members during various transition scenarios.
  - One (1) of two (2) files did not include evidence of a CNA. The single file with the CNA did not include evidence of community reintegration allocation.
  - One (1) of two (2) files did not include evidence of a transition plan.
  - One (1) of two (2) files did not include evidence that an additional in-home assessment was conducted within seventy-five (75) days of the transition to determine if the transition was successful and to identify any remaining needs.

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12 PHP scored 8.00% and achieved a “non-compliance” designation for Enrollment and Disenrollment.
13 PHP scored 12.50% and achieved a “non-compliance” designation for PCP and Pharmacy Lock-ins.
14 PHP scored 33.33% and achieved a “non-compliance” designation for Transition of Care. Due to PHP sampling errors, compliance findings for Transition of Care are based on a sample of two (2) files. PHP’s IAP for Transition of Care was inactivated on December 15, 2018.
VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Note: United Healthcare Community Plan, Inc. of New Mexico exited the Centennial Care program on August 31, 2018. However, United Healthcare Community Plan, Inc. of New Mexico was included in the CY 2018 validation of performance improvement projects.

This subpart of the report presents the preliminary results of the evaluation of the Centennial Care PIPs conducted in CY 2018.

In 2018 Centennial Care MCOs were required to implement one (1) PIP in each of the following areas:
- Services to Children
- LTC Services
- Diabetes Prevention and Management
- Screening and Management for Clinical Depression

The PIP assessments were conducted using tools developed by IPRO and consistent with CMS EQR Protocol 3 for PIP validation. IPRO’s assessment and scoring framework are described in Attachment B. Table 6 displays a summary of the MCOs’ PIP assessments. Table 7–Table 9 summarizes the PIPs conducted for CY 2018.

Table 6: Summary of MCO PIP Assessments

<table>
<thead>
<tr>
<th></th>
<th>PIP 1</th>
<th>PIP 2</th>
<th>PIP 3</th>
<th>PIP 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children’s Services</td>
<td>LTC Services and Support</td>
<td>Diabetes Prevention and Management</td>
<td>Clinical Depression Screening and Follow-Up</td>
</tr>
<tr>
<td>BCBS MHC</td>
<td>Compliance Level</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>PHP</td>
<td>Compliance Level</td>
<td>Full</td>
<td>Minimal</td>
<td>Full</td>
</tr>
<tr>
<td>UHC</td>
<td>Compliance Level</td>
<td>Full</td>
<td>Minimal</td>
<td>Full</td>
</tr>
</tbody>
</table>

Table 7: BCBS PIP Summaries

**PIP 1: Attention to Dental Health for Children**
BCBS conducted this PIP to increase annual dental visits received by their members. BCBS organized dental health events across the state for members to receive on-the-spot care. BCBS also conducted member outreach by telephone and mail. BCBS demonstrated continuous improvement in pediatric dental care for four (4) consecutive years.

**PIP 2: Long-Term Care and Diabetic Eye Exams**
BCBS conducted this PIP to increase the proportion of diabetic, low nursing facility level of care, LTC facility resident members who completed a yearly diabetic retinal eye exam. BCBS outreached to
facility staff with educational materials on recommended diabetic services and with gaps in care lists. BCBS demonstrated overall improvement in eye care for diabetic members residing in LTC facilities.

**PIP 3: Diabetes Management and Short-Term Complications Admission Rate**

BCBS conducted this PIP to increase HbA1c testing and to decrease diabetes-related short-term complications admissions for adult members. Member and provider education outreach was conducted by telephone and mail. BCBS demonstrated overall improvement in the reduction of hospital admissions but did not demonstrate overall improvement in HbA1c testing.

**PIP 4: Screening and Management for Clinical Depression**

BCBS conducted this PIP to increase the proportion of adult members who have an annual screening for depression with appropriate follow-up if positive for depression; and aimed to increase adult member adherence to antidepressant medication. BCBS enlisted community health workers and pharmacists to engage with members on medication adherence. BCBS implemented a financial incentive program to increase provider documentation of depression screenings outcomes and follow-up plan when the member screened positive for depression. BCBS demonstrated overall improvement in depression screening and follow-up for members 18 to 64 years of age but not for members 65 years of age and older. BCBS demonstrated improvement in member adherence to antidepressant medication management for members 65 years of age and older but not for members 18 to 64 years of age. Results for the 65 years and older population should be further evaluated as the denominator in CY 2017 was equal to fifteen (15) members.

**Table 8: MHC PIP Summaries**

**PIP 1: Services to Children: BMI Percentile, Nutrition, Physical Activity Ages 3-17**

MHC conducted this PIP to improve its HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity Counseling for Children and Adolescents (WCC) rates. MHC distributed toolkits to providers to increase knowledge and to improve billing. MHC demonstrated overall improvement in weight assessment and counseling for physical activity but did not demonstrate overall improvement in counseling for nutrition.

**PIP 2: Fall Risk Factors and Service Referrals for Long-Term Services and Support**

MHC conducted this PIP to increase risk fall assessments and fall-related preventive services, and to decrease the rate of falls among long-term services and support (LTSS) members. MHC implemented an online course to educate care coordinators on fall prevention and the availability of member resources. MHC did not demonstrate overall improvement in the reduction of falls and issues with walking for LTSS members.

**PIP 3: Diabetes Prevention and Management**

MHC conducted this PIP to increase HbA1c testing and to decrease the rate of diabetes short-term complications admissions for adult members. MHC held events for members to receive on-the-spot diabetes screenings. MHC educated providers on diabetic clinical guidelines, proper bill coding and electronic transfer of labs results. MHC demonstrated an overall reduction in hospital admissions for diabetes-related short-term complications and demonstrated overall improvement in HbA1c testing.

**PIP 4: Clinical Depression Screening and Follow-Up**
MHC conducted this PIP to increase medication compliance for members who were diagnosed with major depression and newly treated with antidepressant medication. MHC conducted member outreach by telephone to promote medication compliance. MHC modified an internal policy to allow members to refill antidepressant prescriptions for 90 days. MHC demonstrated continuous improvement in depression screening and follow-up for adult members between CY 2014 to CY 2017. However, these outcomes could not be validated as IPRO was not provided with the data used to calculate the rates reported by MHC. Further, CY 2018 data for this project indicator was not provided to IPRO. MHC did not demonstrate improvement in member adherence to antidepressant medication management for members 18 years of age and older.

Table 9: PHP PIP Summaries

<table>
<thead>
<tr>
<th>PIP 1: Service for Children - Adolescent Well-Child Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHP conducted this PIP to increase the rate of adolescent well-care visits. PHP included the adolescent well-care visit measure into PHP’s Provider Quality Incentive Program (PQIP). PHP performance demonstrated improvement in adolescent well-care visits between CY 2017 and CY 2018.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 2: Inter-Rater Reliability for Personal Care Services Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHP conducted this PIP to assure that PHP care coordinators evaluate member needs with consistency and agree within a five (5) hour difference for personal care services. PHP implemented a training assessment for PHP care coordinators. Without the inclusion of at least one (1) robust member intervention with a corresponding intervention tracking measure, the result of this PIP is not a valid indicator of member outcomes. Improved inter-rater reliability is not a valid indicator of member outcomes. Additionally, CY 2018 data was not provided to IPRO to be validated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 3: Diabetes Prevention and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHP conducted this PIP to increase the rate of HbA1c tests and to decrease the rate of hospital admissions due to diabetes-related short-term complications. PHP trained Albuquerque Ambulance staff and Presbyterian Medical Group providers on the process for Albuquerque Ambulance staff to complete home visits, specifically for HbA1c testing. PHP attempted to increase the number of providers participating in the PQIP, rewarding providers who actively participate in having their membership complete HbA1c screenings. PHP incorporated the use of community health workers in outreach efforts to members who have diabetes. PHP interventions also included screening events, on-the-spot testing rewards, Healthy Solutions health coaching with rewards, disease management outreach, and member newsletter articles. PHP did not demonstrate overall improvement in HbA1c testing or an overall reduction in hospital admissions for diabetes-related short-term complications for members 18 to 64 years of age. PHP demonstrated an overall reduction in hospital admissions for diabetes-related short-term complications for members 65 years of age and older.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 4: Screening and Management of Clinical Depression</th>
</tr>
</thead>
</table>
| PHP conducted this PIP to increase member adherence to antidepressant medications by conducting outreach calls to members. PHP posted clinical practice guidelines for depression screening and follow-up recommendations for positive screening results on provider portal websites and outreach to members by telephone. PHP demonstrated improvement in the screening for and management of
clinical depression and in member adherence to antidepressant medication management.

Table 10: UHC PIP Summaries

<table>
<thead>
<tr>
<th>PIP 1: Annual Pediatric Dental Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC conducted this PIP to increase annual dental visits among members ages 2 to 20 years. UHC implemented interventions for members and providers, as well as UHC staff. UHC established an incentive program for adult and pediatric members. UHC Care Coordinators worked with members to schedule appointments and transportation. UHC published articles in the member and provider newsletters regarding dental care and best practices. UHC worked with in-network providers to carve out office hours specifically for UHC members. UHC’s Quality Dental Clinical Practice Consultants held outreach events with contracted providers in rural areas of the state to provide on-the-spot care to members. UHC demonstrated overall improvement in oral care for members 2 to 20 years of age.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 2: Influenza Vaccination for Long Term Care Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC conducted this PIP to increase influenza vaccinations among its adult LTC population. To achieve this aim, UHC trained care coordination staff on the importance of promoting the influenza vaccine to high risk members, published member newsletter articles and conducted member outreach by e-mail. UHC demonstrated declines in performance in influenza vaccines for LTC members ages 18 to 64 years and members ages 65 years and older between the baseline measurement and interim measurement periods. However, final performance could not be assessed as CY 2018 data was not reported to IPRO.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 3: Diabetes Prevention and Enhanced Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC conducted this PIP to increase the rate of HbA1c testing and to decrease the admission rate for short-term diabetes complications. UHC coordinated clinic days for members with gaps in care to include testing for all metrics. Gift cards were given to members who participated in a clinic day. Through the Diabetes Targeted Health Management program, UHC distributed education packets along with a checklist tool that teaches the member to get HbA1c testing, and retinal and foot exams done on a regular basis. Members were educated to take the checklist to their provider and with the provider document individual goals. UHC Care Coordinators monitored individual goals, assisted with scheduling for eye screens, labs and appointments. UHC provided professional development opportunities for providers, staff and diabetes educators on members who have had admissions due to short-term complications of diabetes. UHC initiated value based contracting to include HbA1c testing for eight (8) federally qualified health center (FQHC) providers. UHC demonstrated overall improvement in the reduction of hospital admissions for diabetes-related short-term complications and demonstrated continuous improvement HbA1c testing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIP 4: Antidepressant Medication Management, Screening for Clinical Depression and Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC conducted this PIP to increase the documentation of depression screenings and follow-up and to increase member adherence to antidepressant medication treatment. UHC initiated a depression project around Navajo members, which focused on recognizing, screening, referrals and treatment.</td>
</tr>
</tbody>
</table>

15 United Healthcare Community Plan, Inc. of New Mexico exited the Centennial Care program on September 30, 2018, and therefore did not complete CY 2018 reporting for PIP 2.
UHC trained in-network PCPs on standard depression screening tools, and Patient Health Questionnaires (PHQ) 2 and 9. UHC encouraged providers to utilize proper coding for depression screening and follow-up plans. UHC did not demonstrate improvement in depression screening and follow-up or in member management of antidepressant medication.

**VALIDATION OF PERFORMANCE MEASURES**

This subpart of the report presents the results of the evaluation of MCO PMs calculated for CY 2018.

**New Mexico HSD Requirements for PM Reporting**

HSD required the MCOs to report a total of eight (8) PMs under the Centennial Care Performance Measure project. All PMs, with the exception of PM 8\(^{16}\), follow NCQA Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications. PM 6, Frequency of Ongoing Prenatal Care, was retired as a HEDIS measure at the end of 2017 and has since been removed as a PM. The PMs are defined in Table 11.

**Table 11: HSD Performance Measure Descriptions**

<table>
<thead>
<tr>
<th>PMs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PM 1 HEDIS Annual Dental Visit (ADV)</strong></td>
</tr>
<tr>
<td>The percentage of enrolled members ages two (2) to twenty (20) years, who had at least one (1) dental visit during the measurement year.</td>
</tr>
<tr>
<td><strong>PM 2 HEDIS Medication Management for People with Asthma (MMA)</strong></td>
</tr>
<tr>
<td>The percentage of members ages five (5) through sixty-four (64) years who are identified as having persistent asthma and who were appropriately prescribed medication that they remained on during half (50%) of the treatment period.</td>
</tr>
<tr>
<td><strong>PM 3 HEDIS Controlling High Blood Pressure (CBP)</strong></td>
</tr>
<tr>
<td>The number of members, ages eighteen (18) to eighty-five (85) years, who had a diagnosis of hypertension with blood pressure control (&lt;140/90) in the most recent blood pressure reading in a medical chart in the measurement year.</td>
</tr>
<tr>
<td><strong>PM 4 HEDIS Comprehensive Diabetes Care (CDC)</strong></td>
</tr>
<tr>
<td>The percentage of members ages eighteen (18) through seventy-five (75) years with diabetes (type 1 or type 2) who had each of the following during the measurement year: an HbA1c test, HbA1c poor control (greater than 9.0%), a retinal eye exam and a nephropathy screening test for kidney disease.</td>
</tr>
<tr>
<td><strong>PM 5 HEDIS Timeliness for Prenatal and Postpartum Care (PPC)</strong></td>
</tr>
<tr>
<td>• The percentage of deliveries that received a prenatal care visit as a member of the contractor’s MCO in the first trimester or within forty-two (42) calendar days of enrollment in the MCO.</td>
</tr>
<tr>
<td>• The percentage of deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) calendar days after delivery.</td>
</tr>
<tr>
<td><strong>PM 6 HEDIS Frequency of Ongoing Prenatal Care (FPC)</strong></td>
</tr>
<tr>
<td>NCQA retired the FPC measure from the HEDIS 2018 Volume 2: Technical Specifications. The FPC measure is discontinued as an HSD PM.</td>
</tr>
</tbody>
</table>

\(^{16}\) Technical specifications from PM 8 were developed by HSD.
PMs

PM 7 HEDIS Antidepressant Medication Management (AMM)
- The percentage of members eighteen (18) years and older who were treated with medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least eighty-four (84) calendar days (12 weeks).
- The percentage of members eighteen (18) years and older who were treated with medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least one-hundred eighty (180) calendar days (6 months).

PM 8 Non-HEDIS Follow-up After Hospitalization for Mental Illness of Four (4) Days or More (FUH)
- The percentage of members six (6) to seventeen (17) years of age who had a follow-up visit within seven (7) days after an inpatient psychiatric hospital stay of four (4) days or more.
- The percentage of members eighteen (18) years of age and older who had a follow-up visit within seven (7) days after an inpatient psychiatric hospital stay of four (4) days or more.

For the PMs presented in Table 11 HSD requires Centennial Care MCOs to achieve specified levels of performance. For CY 2018, each MCO is required to demonstrate a two (2) percentage point improvement above the MCO’s CY 2017 PM rate, or demonstrate achievement of the 2018 Quality Compass Health & Human Services (HHS) Dallas Regional benchmark (for CY 2017), or achieve the HSD determined target. If the MCO's baseline CY 2017 audited rate for a performance measure is within two (2) percent points of the target, the performance measure requirement is only improvement to the HHS Regional Average or HSD determined target. MCO failure to meet an HSD target results in a monetary penalty.

The MCOs' PM rates for CY 2018 are presented in Table 12. The table is also color coded to indicate whether or not the MCO’s rate achieved the target. The Color Key below displays what each color represents.

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Did not meet PM target</td>
</tr>
<tr>
<td>Green</td>
<td>Met or exceeded PM target</td>
</tr>
</tbody>
</table>

23
### Table 12: Performance Measure Results for Calendar Year 2018

<table>
<thead>
<tr>
<th>PM</th>
<th>BCBS CY 2018 Rate</th>
<th>MHC CY 2018 Rate</th>
<th>PHP CY 2018 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM 1 ADV</td>
<td>67.90%</td>
<td>74.61%</td>
<td>71.31%</td>
</tr>
<tr>
<td>PM 2 MMA (50%)</td>
<td>59.42%</td>
<td>58.82%</td>
<td>60.73%</td>
</tr>
<tr>
<td>PM 3 CBP</td>
<td>48.66%</td>
<td>46.47%</td>
<td>56.20%</td>
</tr>
<tr>
<td>PM 4 CDC HbA1c Test</td>
<td>82.97%</td>
<td>86.86%</td>
<td>84.85%</td>
</tr>
<tr>
<td>PM 4 CDC HbA1c Poor Control&lt;sup&gt;1&lt;/sup&gt;</td>
<td>50.61%</td>
<td>48.18%</td>
<td>46.72%</td>
</tr>
<tr>
<td>PM 4 CDC Retinal Eye Exam</td>
<td>53.77%</td>
<td>62.77%</td>
<td>54.01%</td>
</tr>
<tr>
<td>PM 4 CDC Nephropathy</td>
<td>88.56%</td>
<td>89.78%</td>
<td>85.40%</td>
</tr>
<tr>
<td>PM 5 PPC Timeliness</td>
<td>80.78%</td>
<td>75.43%</td>
<td>73.62%</td>
</tr>
<tr>
<td>PM 5 PPC Postpartum Care</td>
<td>63.50%</td>
<td>59.85%</td>
<td>62.81%</td>
</tr>
<tr>
<td>PM 6 FPC</td>
<td>Discontinued</td>
<td>Discontinued</td>
<td>Discontinued</td>
</tr>
<tr>
<td>PM 7 AMM Acute</td>
<td>49.12%</td>
<td>49.62%</td>
<td>53.74%</td>
</tr>
<tr>
<td>PM 7 AMM Continuation</td>
<td>32.79%</td>
<td>32.34%</td>
<td>36.40%</td>
</tr>
<tr>
<td>PM 8 FUH 6-17 Years of Age</td>
<td>Not Validated</td>
<td>Not Validated</td>
<td>Not Validated</td>
</tr>
<tr>
<td>PM 8 FUH 18+ Years of Age</td>
<td>Not Validated</td>
<td>Not Validated</td>
<td>Not Validated</td>
</tr>
</tbody>
</table>

Note: IPRO's validation revealed issues in the production of the PM 8 rates across all MCOs. Initial PM 8 rates reported by the MCOs are unreliable as they are not validated and therefore are not displayed in this report.

<sup>1</sup> Lower rate indicates better performance.
**VALIDATION OF PROVIDER NETWORK ADEQUACY**

This subpart of the report presents the results of the evaluation of the MCOs’ ability to provide Medicaid members with an adequate provider network.

Centennial Care plans are required to meet certain distance standards in achieving network adequacy. The assessment of MCO adherence to the distance standards outlined in 8.308.2.11 NMAC was performed using network data submitted by the MCOs. Data presented in this section are as of December 2017. **Table 13–Table 18** displays the results of the IPRO’s assessment of MCO adherence to the distance standards.

**Table 13: Analysis of MCO Adherence to PCP Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>PCP – Rural (1 provider within 45 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>PCP – Frontier (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 14: Analysis of MCO Adherence to OB/GYN Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>OB/GYN – Rural (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>OB/GYN – Frontier (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 15: Analysis of MCO Adherence to Pharmacy Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy – Urban (1 pharmacy within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Pharmacy – Rural (1 pharmacy within 45 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Pharmacy – Frontier (1 pharmacy within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 16: Analysis of MCO Adherence to Long-Term Care Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living Facility – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Assisted Living Facility – Rural (1 provider within 60 miles)</td>
<td>Not Met</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Assisted Living Facility – Frontier (1 provider within 90 miles)</td>
<td>Not Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Rural (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Frontier (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Frontier</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Specialty and NMAC Standard</td>
<td>BCBS</td>
<td>MHC</td>
<td>PHP</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>(1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Rural (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Nursing Facility – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Nursing Facility – Rural (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Nursing Facility – Frontier (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 17: Analysis of MCO Adherence to Hospital Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital – Rural (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital – Frontier (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 18: Analysis of MCO Adherence to Transportation Provider Distance Standards**

<table>
<thead>
<tr>
<th>Specialty and NMAC Standard</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation Providers – Urban (1 provider within 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Transportation Providers – Rural (1 provider within 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Transportation Providers – Frontier (1 provider within 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>
APPENDIX A: COMPLIANCE MONITORING

OBJECTIVES

Federal regulations at 42 CFR 438.358, delineates that a review of an MCO’s compliance with standards established by HSD to comply with the requirements of 438 Subpart E is a mandatory EQR activity. Further, this review must be conducted within the previous three (3)-year period, by the state, its agent, or the EQRO.

New Mexico HSD annually evaluates the MCO’s performance against contract requirements and state and federal regulatory standards through its EQRO contractor.

The annual compliance review for January 1, 2018–December 31, 2018, conducted in September 2019 addressed contract requirements and regulations within the following categories:

- Adverse Benefit Determinations
- Care Coordination
- Delegation – Dental
- Delegation – Transportation
- Enrollment and Disenrollment
- Grievances and Appeals
- Maintenance of Medical Records
- Member Materials
- Member Services
- PCP and Pharmacy Lock-ins
- Program Integrity
- Provider Network
- Provider Services
- Reporting Requirements
- Self-Directed Community Benefit
- Transition of Care

Data collected from each MCO submitted pre-onsite, during the onsite visit, or in follow-up were considered in determining the extent to which the MCO was in compliance with the standards. Further, descriptive information regarding the specific types of data and documentation reviewed is provided in Description of Data Obtained and Compliance Monitoring in this report.

TECHNICAL METHODS OF DATA COLLECTION

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific review tools with standard-specific elements (i.e., sub-standards). The tools include the following:
- Statement of federal regulation and related federal regulations;
- Statement of state regulations;
- Statement of state and MCO contract requirement(s);
- Suggested evidence;
- Reviewer determination;
- Prior results (based on Readiness Review);
- Descriptive reviewer findings and comments related to findings; and
- MCO response and action plan.

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.

Reviewer findings on the tools formed the basis for assigning preliminary and final determinations. The standard determinations used are listed in Table A.1.

**Table A.1: Standard Compliance Determinations**

<table>
<thead>
<tr>
<th>Compliance Levels</th>
<th>Score Range</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90%-100%</td>
<td>MCO met or exceeded standard</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80%-89%</td>
<td>MCO met requirements of the standard but had deficiencies in certain areas</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50%-79%</td>
<td>MCO met some requirements of the standard but had significant deficiencies requiring corrective action</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>&lt;50%</td>
<td>MCO did not meet standard and requires corrective action</td>
</tr>
</tbody>
</table>

The list of elements due for review and the related review tools were shared with NM HSD and each MCO.

**Pre-onsite Activities** – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports. Additional documents were requested to be available for the onsite visit, such as reports and case files.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing of grievances received by the MCO during the review period is requested. From these listings, IPRO selects a random sample of files for review onsite.
Additionally, IPRO began its “desk review” or offsite review when the pre-onsite documentation was received from the MCOs.17 Prior to the review, a notice was sent to the MCOs including a confirmation of the onsite dates18, an introduction to the review team members, the onsite review agenda, and an overall timeline for the compliance review activities.

**Onsite Activities** – The onsite review commenced with an opening conference, where staff was introduced, and an overview of the purpose and process for the review, including the onsite agenda, was provided. Following the opening conference, IPRO conducted review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed, and the next steps in the review process.

**DESCRIPTION OF DATA OBTAINED**

As noted in the Pre-onsite Activities section, in advance of the review IPRO requested documents relevant to each standard under review, to support each MCO’s compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures, sample contracts, annual QI Program Description, Work Plan, and Annual Evaluation, Member and Provider Handbooks, access reports, committee descriptions and minutes, case files, program monitoring reports, and evidence of monitoring, evaluation, analysis and follow-up. Additionally, as reported above under Onsite Activities, staff interviews and demonstrations were conducted during the onsite visit. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the CY 2018 review is contained in the Compliance Monitoring section of this report.

**DATA AGGREGATION AND ANALYSIS**

Post-onsite Activities – Following the onsite review, the MCOs were provided forty-eight (48) hours to submit additional documentation while IPRO prepared the preliminary review findings. As noted earlier, each standard reviewed was assigned a level of compliance ranging from Full Compliance to Non-Compliance. The review determination was based on IPRO’s assessment and analyses of the evidence presented by the MCO. For standards where an MCO was less than fully compliant, IPRO provided in the review tool a narrative description of the evidence reviewed and reason for non-compliance. Each MCO was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. IPRO reviewed any responses submitted by the MCO and made final review determinations.

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17 IPRO’s desk review began on August 8, 2019.
18 BCBS’s onsite took place on September 20, 2019. PHP’s onsite took place on September 18, 2019.
APPENDIX B: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

OBJECTIVES

Medicaid MCOs implement PIPs to assess and improve processes of care, and as a result improve outcomes of care. The goal of PIPs is to achieve significant and sustainable improvement in clinical and nonclinical areas. A mandatory activity of the EQRO is to review PIPs for methodological soundness of design, and conduct and report to ensure real improvement in care and confidence in the reported improvements.

PIPs were reviewed according to the CMS protocol described in the document “Validating Performance Improvement Projects.” The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following ten (10) elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO’s enrollment
2. Review of the study question(s) for clarity of statement
3. Review of selected study indicator(s), which should be objective, clear, unambiguous and meaningful to the focus of the PIP
4. Review of the identified study population to ensure it is representative of the MCO enrollment and generalizable to the MCO’s total population
5. Review of sampling methods (if sampling used) for validity and proper technique
6. Review of the data collection procedures to ensure complete and accurate data were collected
7. Assessment of the improvement strategies for appropriateness
8. Review of the data analysis and interpretation of study results
9. Assessment of the likelihood that reported improvement is “real” improvement
10. Assessment of whether the MCO achieved sustained improvement

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable. Specific to New Mexico, each PIP is then scored based on the MCO’s compliance with elements 1-8 (listed above). The element is determined to be “met” or “not met”. If the element was met, the MCO achieved one (1) point. The total number of achievable points per PIP was eight (8). Compliance levels are assigned based on the number of points (or percentage score) achieved. Compliance level score ranges are described in Table B.1.

Table B.1: Standard Compliance Determinations

<table>
<thead>
<tr>
<th>Compliance Levels</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Compliance</td>
<td>90%-100%</td>
</tr>
<tr>
<td>Moderate Compliance</td>
<td>80%-89%</td>
</tr>
<tr>
<td>Minimal Compliance</td>
<td>50%-79%</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>&lt;50%</td>
</tr>
</tbody>
</table>
TECHNICAL METHODS OF DATA COLLECTION

The methodology for validation of the PIPs was based on the CMS protocol for “Validating Performance Improvement Projects”. For CY 2018, each PIP was reviewed using this methodology upon final report submission.

DESCRIPTION OF DATA OBTAINED

Each PIP was validated using the MCO’s PIP project reports. Data obtained at the final reporting stage included baseline, interim, final and goal rates.

DATA AGGREGATION AND ANALYSIS

Upon final reporting, a determination was made as to the overall credibility of the results of each PIP, with assignment of one (1) of three (3) categories:

- There were no validation findings to indicate that the credibility of the PIP results is at risk.
- The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution. Processes that put the conclusions at risk will be enumerated.
- There are one (1) or more validation findings to indicate a bias in the PIP results. The concerns that put the conclusion at risk will be enumerated.

APPENDIX C: VALIDATION OF PERFORMANCE MEASURES

OBJECTIVES

Medicaid MCOs calculate PMs to monitor and improve processes of care. As per the CMS regulations, validation of PMs is one of the mandatory EQR activities.

The primary objectives of the PM validation process are to assess the:

- MCO’s process for calculating PMs and to determine whether the process adhered to the specifications outlined for each measure; and
- Accuracy of the PM rates, as calculated and reported by the MCO.

TECHNICAL METHODS OF DATA COLLECTION

The methodology for validation of PMs is based on the CMS protocol “Validating Performance Measures.” As an NCQA-accredited health plan, the MCO reports HEDIS rates to NCQA that are audited by an independent NCQA-licensed HEDIS compliance audit firm. IPRO requested copies of the auditor-submitted final HEDIS compliance audit report, as well as the final rates for validation. Using the findings
of the audit report, IPRO evaluated the MCO’s information systems capabilities, audit designation findings and any issues that precluded accurate reporting.

For the single state-developed measure, IPRO reviewed the MCOs’ source codes, process flow charts, date values and date ranges, value sets, and conducted virtual walk-through of their information systems.

**DESCRIPTION OF DATA OBTAINED**

PMs were validated using the MCO’s final HEDIS compliance audit report, final HEDIS rates, and MCO-reported numerators, denominators and rates.

**DATA AGGREGATION AND ANALYSIS**

NCQA-certified HEDIS compliance auditors validated each MCO’s reported HEDIS PMs. IPRO used the final audit reports as a basis for its evaluation. Measure validation included the following steps:

- IPRO reviewed the final audit report of the HEDIS results reported by the MCO that was prepared by an NCQA-licensed organization to ensure that appropriate audit standards were followed. The NCQA HEDIS Compliance Audit: Standards, Policies and Procedures document outlines the requirements for HEDIS compliance audits and was the basis for determining the accuracy of the findings stated in the final audit report.
- IPRO used available regional HEDIS benchmarks and trended data to assess the accuracy of the reported rates.

Subsequent to the validation process, a report of the findings and our recommendations was prepared and included in the technical report.

**APPENDIX D: VALIDATION OF NETWORK ADEQUACY**

**OBJECTIVES**

The Centers for Medicare and Medicaid Services (CMS) Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Final Rule establishes network adequacy standards in Medicaid managed care for certain providers and provides flexibility to states to set state specific standards. New Mexico currently has network adequacy standards in place that address these requirements. The validation of network adequacy assesses MCO adherence to these standards, specifically the distance standards outlined in 8.308.2.11 NMAC.
**TECHNICAL METHODS OF DATA COLLECTION**

MCOs collect and submit network data to HSD on a quarterly basis. IPRO utilized these data to conduct the validation of each MCO network.

**DESCRIPTION OF DATA OBTAINED**

The data obtained from the MCOs included provider counts, GeoAccess reports, provider panel status, PCP-to-member ratios, distance analysis and MCO narrative on improvement activities. These data were reported by region (rural, urban and frontier).

**DATA AGGREGATION AND ANALYSIS**

IPRO compared each MCO’s calculated distance analysis by specialty and by region to the NMAC standards. A determination of whether or not the standard was met or not met was made.

IPRO’s analysis also included a review of MCO network-related documentation to assess MCO consideration and implementation of the network adequacy elements described in Title 42 CFR 438.68(c). IPRO’s findings related to these network adequacy elements are found in each MCO’s subsection of this report.