Centennial Care
2017 Annual Technical Report
Report Issued: April 12, 2019
State of New Mexico Human Services Department
Medical Assistance Division
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ACRONYMS USED IN THIS REPORT

ADV: Annual Dental Visit, HEDIS
AMM: Antidepressant Medication Management, HEDIS
BBA: Balanced Budget Act
BCBS: Blue Cross Blue Shield of New Mexico
CBP: Controlling High Blood Pressure, HEDIS
CCP: Comprehensive Care Plan
CDC: Comprehensive Diabetes Care, HEDIS
CFR: Code of Federal Regulations
CMS: Centers for Medicare and Medicaid Services
CNA: Comprehensive Needs Assessment
CY: Calendar Year
EQR: External Quality Review
EQRO: External Quality Review Organization
FPC: Frequency of Ongoing Prenatal Care, HEDIS
FUH: Follow-Up after Hospitalization for Mental Illness
HbA1c: Hemoglobin A1c
HEDIS: Healthcare Effectiveness Data and Information Set
HHS: Health & Human Services
HRA: Health Risk Assessment
HSD: Human Services Department
IAP: Internal Action Plan
IPRO: Island Peer Review Organization
LDL: Low-Density Lipoprotein
LTC: Long-Term Care
LTSS: Long-Term Services and Supports
MAD: Medical Assistance Division
MCO: Managed Care Organization
MHC: Molina Healthcare of New Mexico, Inc.
MMA: Medication Management for People with Asthma, HEDIS
MMC: Medicaid Managed Care
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NF</td>
<td>Nursing Facility</td>
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<tr>
<td>NMAC</td>
<td>New Mexico Administrative Code</td>
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<tr>
<td>OB/GYN</td>
<td>Obstetrician/Gynecologist</td>
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<tr>
<td>PAHP</td>
<td>Prepaid Ambulatory Health Plans</td>
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<tr>
<td>PCCM</td>
<td>Primary Care Case Management</td>
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<tr>
<td>PCP</td>
<td>Primary Care Practitioner/Provider</td>
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<td>PHP</td>
<td>Presbyterian Health Plan, Inc.</td>
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<td>PIHP</td>
<td>Prepaid Inpatient Health Plans</td>
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<td>PIP</td>
<td>Performance Improvement Project</td>
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<td>PM</td>
<td>Performance Measure</td>
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<tr>
<td>PPC</td>
<td>Timeliness for Prenatal and Postpartum Care, HEDIS</td>
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<td>PQIP</td>
<td>Provider Quality Incentive Program</td>
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<td>TOC</td>
<td>Transition of Care</td>
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<td>UHC</td>
<td>United Healthcare Community Plan, Inc. of New Mexico</td>
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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 (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 and through the provision of health services that are consistent with current professional, evidence-based knowledge.”

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) 2017.

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 Protocols for 2017. As set forth in 42 CFR 438.358(b)(1)(i)(ii)(iii)(iv), these activities were:

**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 2017 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>
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<tbody>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>▪ BCBS achieved National Committee for Quality Assurance (NCQA) “accredited” status (as of June 30, 2017).</td>
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<tr>
<td>▪ <em>Preliminary finding</em>: BCBS achieved full compliance for the following areas of the 2017 Compliance Review:</td>
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▪ Preliminary finding: BCBS PIPs related to pediatric dental care and diabetic eye exams demonstrated improvement from the baseline measurement year to the final measurement year.

▪ BCBS met or exceeded the PM targets for the following measures:
  - Annual Dental Visit
  - Comprehensive Diabetes Care – HbA1c Testing
  - Comprehensive Diabetes Care – HbA1c Poor Control
  - Comprehensive Diabetes Care – Retinal Eye Exam
  - Timeliness of Prenatal Care
  - Postpartum Care

▪ Preliminary finding: BCBS met New Mexico Administrative Code (NMAC) distance standards in the urban, frontier and rural regions of the state for the following areas: primary care providers (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 2017 Compliance Review:
  - Enrollment and Disenrollment, document review
  - Transition of Care, document review
  - Care Coordination, New Members, file review
  - Member Appeals, file review
  - Member Grievances, file review
  - Transition of Care, file review

▪ Preliminary finding: BCBS demonstrates an opportunity for improvement related to the development and conduct of PIPs, especially as it relates to determining targets for improvement and implementing a robust intervention strategy.

▪ BCBS did not meet the PM targets for the following measures:
  - Medication Management for People with Asthma
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care – Nephropathy Screening
  - Antidepressant Medication Management – Acute Phase
  - Antidepressant Medication Management – Continuous Phase

▪ Preliminary finding: BCBS did not meet NMAC distance standards for assisted living facilities in the rural and frontier regions of the state.

Recommendations
▪ BCBS should address the findings from the 2017 Compliance Review and develop a corrective action plan to improve deficient areas. Specific recommendations are reported in the 2017 Compliance Review Report.

▪ BCBS should use the two percent (2%) improvement goal for indicators as a starting point but not necessarily the ultimate target for improvement. PIP targets should be based on an evaluation of current status, feasibility of change, the strength of the intervention strategy and the time allotted to complete the project. BCBS should ensure that each PIP includes a barrier analysis, robust interventions geared to members and providers, and well-defined tracking and outcome measures to monitor their progress. BCBS should also rely on the EQRO for technical assistance when challenges are encountered during the conduct of PIPs.

▪ BCBS should include in its quality improvement strategy the PMs that did not meet the contractual targets. Interventions for improvement should be developed based on root cause analyses and routinely monitored for effectiveness.

▪ BCBS should continue its efforts to contract with more assisted living facilities in rural and frontier regions of the state.

Molina Healthcare of New Mexico, Inc. (MHC)

Strengths
▪ MHC achieved NCQA “accredited” status (as of June 30, 2017).

▪ Preliminary finding: MHC achieved full compliance for the following areas of the 2017 Compliance Review:
  o Adverse Benefit Determinations, document review
  o Care Coordination, document review
  o Delegation of Dental Services, document review
  o Delegation of Transportation Services, document review
  o Grievances and Appeals System, document review
  o Maintenance of Medical Records, document review
  o Member Materials, document review
  o Member Services, document review
  o Provider Services, document review
  o Reporting Requirements, document review
  o Self-Directed Community Benefit, document review
  o Transition of Care, document review
  o Adverse Benefit Determinations, Expedited, file review
  o Care Coordination, New Members, file review
  o Member Appeals, file review
  o Member Appeals, Expedited, file review
  o Member Grievances, file review
  o PCP and Pharmacy Lock-ins, file review
  o Transition of Care, file review

▪ Preliminary finding: MHC PIPs related to weight assessment and counseling for nutrition and physical activity for children and adolescents, fall reduction, and HbA1c testing demonstrated improvement from the baseline measurement year to the final measurement year.

▪ MHC met or exceeded the PM targets for the following measures:
  o Annual Dental Visit
Medication Management for People with Asthma
Controlling High Blood Pressure
Comprehensive Diabetes Care – HbA1c Testing
Comprehensive Diabetes Care – HbA1c Poor Control
Comprehensive Diabetes Care – Retinal Eye Exam
Comprehensive Diabetes Care – Nephropathy Screening

Preliminary finding: MHC met NMAC distance standards in the urban, frontier and rural regions of the state for the following areas: PCPs, OB/GYNs, pharmacies, assisted living facilities, personal care service agencies, nursing facilities, hospitals and transportation providers.

Opportunities

Preliminary finding: MHC did not achieve full compliance for the following areas reviewed for the 2017 Compliance Review:

- Enrollment and Disenrollment, document review
- PCP and Pharmacy Lock-ins, document review
- Program Integrity, document review
- Provider Network, document review
- Adverse Benefit Determinations, file review
- Care Coordination, Continuous, file review

Preliminary finding: MHC demonstrates an opportunity for improvement related to the development and conduct of PIPs, especially as it relates to determining targets for improvement and implementing a robust intervention strategy.

MHC did not meet the PM targets for the following measures:

- Timeliness of Prenatal Care
- Postpartum Care
- Antidepressant Medication Management – Acute Phase
- Antidepressant Medication Management – Continuous Phase

Note: The recommendations presented below are based on CY 2017 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:

- MHC should address the findings from the 2017 Compliance Review and develop a corrective action plan to improve deficient areas. Specific recommendations are reported in the 2017 Compliance Review Report.
- MHC should use the two percent (2%) improvement goal for indicators as a starting point but not necessarily the ultimate target for improvement. PIP targets should be based on an evaluation of current status, feasibility of change, the strength of the intervention strategy and the time allotted to complete the project. MHC should ensure that each PIP includes a barrier analysis, robust interventions geared to members and providers, and well-defined tracking and outcome measures to monitor their progress. MHC should also rely on the EQRO for technical assistance when challenges are encountered during the conduct of PIPs.
MHC should include in its quality improvement strategy the PMs that did not meet the contractual targets. Interventions for improvement should be developed based on root cause analyses and routinely monitored for effectiveness.

Presbyterian Health Plan, Inc. (PHP)

**Strengths**
- PHP achieved NCQA “accredited” status (as of June 30, 2017).
- **Preliminary finding:** PHP achieved full compliance for the following areas of the 2017 Compliance Review:
  - Adverse Benefit Determinations, *document review*
  - Care Coordination, *document review*
  - Delegation of Dental Services, *document review*
  - Delegation of Transportation Services, *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 Network, *document review*
  - Provider Services, *document review*
  - Reporting Requirements, *document review*
  - Self-Directed Community Benefit, *document review*
  - Transition of Care, *document review*
  - Adverse Benefit Determinations, *file review*
  - Adverse Benefit Determinations, Expedited, *file review*
  - Care Coordination, New Members, *file review*
  - Member Appeals, *file review*
  - Member Appeals, Expedited, *file review*
  - Member Grievances, *file review*
  - PCP and Pharmacy Lock-ins, *file review*
- PHP met or exceeded the PM targets for the following measures:
  - Annual Dental Visit
  - Medication Management for People with Asthma
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care – HbA1c Testing
  - Comprehensive Diabetes Care – HbA1c Poor Control
  - Comprehensive Diabetes Care – Retinal Eye Exam
- **Preliminary finding:** 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 2017 Compliance Review:
  - Enrollment and Disenrollment, document review
  - Grievances and Appeals System, document review
  - Care Coordination, Continuous, file review
  - Transition of Care, file review

▪ **Preliminary finding:** PHP’s PIP titled, “Inter-Rater Reliability for Personal Care Services Allocation” lacked member focus. The main activity identified by PHP as an intervention was a training assessment tool for PHP care coordination staff. Further, improved inter-rater reliability is not a valid indicator of member outcomes.

▪ **Preliminary finding:** PHP demonstrates an opportunity for improvement related to the development and conduct of PIPs, especially as it relates to determining targets for improvement and implementing a robust intervention strategy.

▪ PHP did not meet the PM targets for the following measures:
  - Comprehensive Diabetes Care – Nephropathy Screening
  - Timeliness of Prenatal Care
  - Postpartum Care
  - Antidepressant Medication Management – Acute Phase
  - Antidepressant Medication Management – Continuous Phase

▪ **Preliminary finding:** PHP did not meet NMAC distance standards for assisted living facilities in the urban and rural regions of the state.

**Recommendations**

▪ PHP should address the findings from the 2017 Compliance Review and develop a corrective action plan to improve deficient areas. Specific recommendations are reported in the 2017 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 measured indicators should be based on current clinical knowledge or health services research and enrollee outcomes. PHP should use the two percent (2%) improvement goal for indicators as a starting point but not necessarily the ultimate target for improvement. PIP targets should be based on an evaluation of current status, feasibility of change, the strength of the intervention strategy and the time allotted to complete the project. PHP should ensure that each PIP includes a barrier analysis, robust interventions geared to members and providers, and well-defined tracking and outcome measures to monitor their progress. PHP should also rely on the EQRO for technical assistance when challenges are encountered during the conduct of PIPs.

▪ PHP should include in its quality improvement strategy the PMs that did not meet the contractual targets. Interventions for improvement should be developed based on root cause analyses and routinely monitored for effectiveness.

▪ Rather than contract with out-of-network providers, PHP should focus its efforts on establishing in-network contracts with assisted living facilities in the urban and rural regions of the state.

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United Healthcare Community Plan, Inc. of New Mexico (UHC)

**Strengths**

▪ UHC achieved NCQA “accredited” status (as of June 30, 2017).
Preliminary finding: UHC achieved full compliance for the following areas of the 2017 Compliance Review:

- Adverse Benefit Determinations, document review
- Delegated Dental Services, document review
- Delegated Transportation Services, document review
- Grievances and Appeals System, document review
- Maintenance of Medical Records, document review
- PCP and Pharmacy Lock-ins, document review
- Program Integrity, document review
- Provider Network, document review
- Provider Services, document review
- Reporting Requirements, document review
- Self-Directed Community Benefit, document review
- Transition of Care, document review
- Member Appeals, file review
- Member Appeals, Expedited, file review
- Member Grievances, file review
- PCP and Pharmacy Lock-ins, file review

Preliminary finding: UHC PIPs related to pediatric dental care and HbA1c testing and short-term complications admissions demonstrated improvement from the baseline measurement year to the final measurement year.

UHC met or exceeded the PM targets for the following measures:

- Annual Dental Visit
- Controlling High Blood Pressure
- Comprehensive Diabetes Care – HbA1c Testing
- Comprehensive Diabetes Care – HbA1c Poor Control
- Comprehensive Diabetes Care – Retinal Eye Exam
- Comprehensive Diabetes Care – Nephropathy Screening
- Antidepressant Medication Management – Acute Phase
- Antidepressant Medication Management – Continuous Phase

Preliminary finding: UHC 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. UHC also met distance standards for assisted living facilities in the urban and frontier regions of the state.

Opportunities

Preliminary finding: UHC did not achieve full compliance for the following areas reviewed for the 2017 Compliance Review:

- Care Coordination, document review
- Enrollment and Disenrollment, document review
- Member Materials, document review
- Member Services, document review
- Adverse Benefit Determinations, file review
- Adverse Benefit Determinations, Expedited, file review
- Care Coordination, Continuous, file review
- Care Coordination, New Members, file review
- Transition of Care, file review
Preliminary finding: UHC demonstrates an opportunity for improvement related to the development and conduct of PIPs, especially as it relates to determining targets for improvement and implementing a robust intervention strategy.

UHC did not meet the PM targets for the following measures:
- Medication Management for People with Asthma
- Timeliness of Prenatal Care
- Postpartum Care

Preliminary finding: UHC did not meet NMAC distance standards for assisted living facilities in the rural region of the state.

Note: The recommendations presented below are based on CY 2017 performance. During 2018, UHC exited the Centennial Care program. As such, these recommendations do not require follow-up.

Recommendations
Although UHC is not currently contracted as a Centennial Care MCO, IPRO recommends the following:
- UHC should address the findings from the 2017 Compliance Review and develop a corrective action plan to improve deficient areas. Specific recommendations are reported in the 2017 Compliance Review Report.
- UHC should use the two percent (2%) improvement goal for indicators as a starting point but not necessarily the ultimate target for improvement. PIP targets should be based on an evaluation of current status, feasibility of change, the strength of the intervention strategy and the time allotted to complete the project. UHC should ensure that each PIP includes a barrier analysis, robust interventions geared to members and providers, and well-defined tracking and outcome measures to monitor their progress. UHC should also rely on the EQRO for technical assistance when challenges are encountered during the conduct of PIPs.
- UHC should include in its quality improvement strategy the PMs that did not meet the contractual targets. Interventions for improvement should be developed based on root cause analyses and routinely monitored for effectiveness.
- UHC should continue its efforts to contract with more assisted living facilities in the rural 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). The Centennial Care program provides health care services for over 600,000 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 demonstration waiver. Centennial Care consolidated nine (9) waiver programs into a single, comprehensive managed care delivery system with four (4) MCOs. CMS approved this waiver for an initial five-year demonstration period from January 1, 2014 through December 31, 2018.

**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 2017, 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 2017. (Note: During 2018 two (2) MCOs exited the Centennial Care program. United Healthcare Community Plan, Inc. of New Mexico transferred its membership to Presbyterian Health Plan, Inc. on September 30, 2018. Molina Healthcare of New Mexico, Inc. ended coverage on December 31, 2018.)

MCO CORPORATE PROFILES

Four (4) MCOs comprised New Mexico’s Centennial Care program during 2017:

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

Table 2: MCO Corporate Profiles

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<thead>
<tr>
<th>Profile Information</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>UHC</th>
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<tr>
<td>Total Medicaid Enrollment as of 12/2017</td>
<td>137,239</td>
<td>221,446</td>
<td>217,599</td>
<td>87,061</td>
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<tr>
<td>NCQA Medicaid Accreditation Status as of June 30, 2017</td>
<td>Accredited</td>
<td>Accredited</td>
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<tr>
<td>NCQA National Medicaid Rating as of June 30, 2017</td>
<td>3.0</td>
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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, 2017–December 31, 2017. 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.

- **Primary Care Provider (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.

- **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 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>

**Table 4** displays the preliminary 2017 compliance review designations for each MCO.
### Table 4: Summary of Preliminary 2017 Compliance Review Findings

<table>
<thead>
<tr>
<th>Compliance Domain</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Benefit Determinations</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Delegation – Dental</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Delegation – Transportation</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Enrollment and Disenrollment</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Minimal</td>
<td>Moderate</td>
</tr>
<tr>
<td>Grievances and Appeals</td>
<td>Full</td>
<td>Full</td>
<td>Moderate</td>
<td>Full</td>
</tr>
<tr>
<td>Maintenance of Medical Records</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Materials</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Member Services</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Minimal</td>
</tr>
<tr>
<td>PCP and Pharmacy Lock-ins</td>
<td>Full</td>
<td>Minimal</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Program Integrity</td>
<td>Full</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Provider Network</td>
<td>Full</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Provider Services</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Self-Directed Community Benefit</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
</tbody>
</table>

#### File Review

<table>
<thead>
<tr>
<th>Compliance Domain</th>
<th>BCBS</th>
<th>MHC</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Benefit Determinations</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Adverse Benefit Determinations, Expedited</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Minimal</td>
</tr>
<tr>
<td>Care Coordination, Continuous</td>
<td>Full</td>
<td>Minimal</td>
<td>Moderate</td>
<td>Minimal</td>
</tr>
<tr>
<td>Care Coordination, New Members</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
<td>Moderate</td>
</tr>
<tr>
<td>Member Appeals</td>
<td>Minimal</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Appeals, Expedited</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Member Grievances</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>PCP and Pharmacy Lock-ins</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>Non-Compliant</td>
<td>Full</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
</tbody>
</table>

Overall, all four (4) MCOs demonstrated full compliance with standards related the following areas:

- Adverse Benefit Determination, *document review*
- Delegation – Dental, *document review*
- Delegation – Transportation, *document review*
- Maintenance of Medical Records, *document review*
- Provider Services, *document review*
- Reporting Requirements, *document review*
- Self-Directed Community Benefit, *document review*
- Member Appeals, Expedited, *file review*
- PCP and Pharmacy Lock-ins, *file 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

| BCBS | Member Appeals, *file review:*  
|      | - Acknowledgement letter issues included timeliness and content.  
|      | - Resolution letter issues included timelessness and content.  
|      | Transition of Care, *file review:*  
|      | - Transition plan issues included lack of a transition plan and lack of a transition assessment as required by the HSD Policy Manual.  

**Note:** HSD recommended an internal action plan (IAP) for Transition of Care in October 2017 for BCBS.

| MHC | PCP and Pharmacy Lock-ins, *document review:*  
|     | - Policies and procedures did not address quarterly reviews of member lock-ins or the evaluation of drug-seeking behavior.  
|     | Care Coordination, Continuous, *file review:*  
|     | - Care plan issues included unsigned care plans and timeliness of verbal consent, or member signature on care plan.  

**Note:** HSD recommended an IAP for Care Coordination in November 2015 and an IAP for Transition of Care in September 2017 for MHC. The IAP for care coordination initiated in September 2015 was due to an internal audit and not as the result of the EQRO review. The Compliance Review Report for CY 2016 indicated that the MCO did not meet the requirements relevant to the development of the CCP, more specifically obtaining the signature from the member or member’s representative. The CCP element was added to the existing care coordination IAP in September 2017.

| PHP | Enrollment and Disenrollment, *document review:*  
|     | - Policies and procedures did not address the acceptance of transferring members or MCO disenrollment of a member.  
|     | Transition of Care, *file review:*  
|     | - Transition plan issues included lack of a transition assessment as required by the HSD Policy Manual.  

**Note:** HSD recommended an IAP for Transition of Care in September 2017 for PHP.

| UHC | Member Services, *document review:*  
|     | - Policies and procedures did not comprehensively address interpreter services or member access to electronic personal health records.  
|     | Adverse Benefit Determinations, Expedited, *file review:*
Issues included lack of oral notification, timeliness of oral notification, lack of notification to the member of the right to present evidence in person, and timeliness of MCO decision for authorization.

- Care Coordination, Continuous, file review:
  - CCP issues included timelines of development and approval of the CCP, evidence of CCP and evidence of verbal consent, or member signature on CCP.
- Transition of Care, file review:
  - Transition plan issue included lack of comprehensive transition assessment.

**Note:** HSD recommended an IAP for Transition of Care in September 2017 for UHC.

**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 2017.

In 2017 Centennial Care MCOs were required to implement one (1) PIP in each of the following areas:
- Long-Term Care (LTC) Services
- Services to Children
- 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. **Tables 6–9** summarize the PIPs conducted for CY 2017.

**Table 6: BCBS PIP Summaries**

| PIP 1: Attention to Dental Health for Children |
| BCBS conducted this PIP to increase annual dental visits received by their members. Interventions included mailing postcard reminders to 7,458 members. In addition, educational scripts about the importance of dental care were shared with 2,517 members who called the plan’s Member Services Department and telephonic outreach was made to 1,601 members about the importance of the annual dental visit and to assist with scheduling appointments with a dentist. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk. |

| PIP 2: Long-Term Care and Diabetic Eye Exams |
| BCBS conducted this PIP to increase diabetic retinal eye exams among low nursing facility level of care and LTC facility members with diabetes. To accomplish this aim, BCBS implemented both letter and telephone interventions. Gaps in care reports were developed and used by BCBS to identify and outreach to a total of 184 members and LTC facilities regarding missing retinal eye exams. One-on-one telephonic outreach with LTC facilities was implemented to encourage the facilities to schedule |
diabetic eye exams for members with a gap in care. In addition, diabetic educational materials, including current guidelines on diabetic retinal exams were sent to LTC facilities. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**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. Key interventions to accomplish these aims included outreach to diabetic members who had one or more gaps in care and short-term complications of diabetes admission notification mailings to eighty-one (81) providers noting admission dates, discharge dates and potential gaps in care, along with a provider toolkit and copies of newsletter articles on caring for patients with diabetes. Preliminary findings indicate that the interventions implemented to improve HbA1c testing were not effective. However, BCBS did have success with the interventions implemented to decrease diabetes-related short-term complications admissions. There were no validation findings to indicate that the credibility of the PIP results is at risk.

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

BCBS conducted this PIP to improve member adherence to antidepressant medication and to increase the proportion of members who have an annual screening for depression with appropriate follow-up. To accomplish these aims, BCBS Community Health Coordinators conducted telephonic outreach to engage members prior to their medication refill date and to offer support for medication compliance to encourage refilling the antidepressant medications and contacting their health care provider for any questions or concerns about the medication. BCBS also implemented a provider incentive program for reporting depression screening outcomes. Preliminary findings indicate that interventions to improve member medication management were effective for the 65 years of age and older population and ineffective for the 18 to 64 years of age population. Conversely, the interventions to increase depression screening and follow-up were effective for the 18 to 64 years of age population and ineffective for the 65 years of age and older population. The denominator for the 65 years of age and older population was equal to fifteen (15) members in CY 2017 and should be considered when interpreting the results of this PIP.

**Table 7: MHC PIP Summaries**

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

MHC conducted this PIP to improve weight assessment and counseling for nutrition and physical activity for children and adolescents. To accomplish this aim, the MHC Provider Engagement Team conducted outreach to train providers on how to use the Molina Provider Portal to review current gaps in care reports. MHC also worked directly with eight (8) high-volume provider groups, offering educational interventions either via telephone or onsite visit. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**PIP 2: Fall Risk Factors and Service Referrals for Long-Term Services and Support**
MHC conducted this PIP to increase fall risk assessments and fall-related preventive services, and to decrease the rate of falls among long-term services and support (LTSS) members. To achieve these aims, MHC implemented an online self-paced training that was designed according to data collected by MHC on its members and validated information from literature regarding falls risk in the LTSS population. The training was initially given to a pilot group of 100 care coordinators within Bernalillo County and then distributed to care coordinators statewide. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**PIP 3: Diabetes Prevention and Management**

MHC conducted this PIP to increase HbA1c testing and to decrease the rate of diabetes short-term complications. To achieve these goals, MHC distributed educational materials to providers, conducted outreach to members who had missing services, implemented monetary incentives for members and providers and organized mobile screening events for members. MHC also worked with provider sites to increase electronic submission of test results. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**PIP 4: Clinical Depression Screening and Follow-Up**

MHC conducted this PIP to improve medication compliance for members who were diagnosed with major depression. To accomplish this aim, MHC distributed a behavioral health toolkit to providers which included information on medication management strategies, depression screening tools and proper claims coding. Members received prescription refill reminders and information on medication management resources. Preliminary findings indicate that these interventions were ineffective. There were no validation findings to indicate that the credibility of the PIP results is at risk as it relates to medication management; however, outcomes related to the measurement of depression screenings and follow-up should be further evaluated as the EQRO was not provided the data used to calculate the rates presented.

### Table 8: 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 adolescent well-care visits among members whose primary care providers participate in PHP’s Provider Quality Incentive Program (PQIP). Eligible providers received telephonic outreach to review gaps in care reports and scorecards that included site performance for the HEDIS Adolescent Well-Care Visit measure. A total of ninety-six (96) provider sites participated in the PQIP. PHP performance on this PIP cannot be assessed as CY 2017 was the baseline year. There were no validation findings to indicate that the credibility of the PIP results is at risk.</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 improve the consistency of care coordinator evaluations for personal care services. To achieve this goal PHP implemented a continuous training schedule, and developed training modules around pediatric chronic care, shared households assessments and functional assessments. One-on-one coaching was conducted for staff who demonstrated inconsistencies during inter-rater</td>
</tr>
</tbody>
</table>
reliability testing. Preliminary findings indicate that this is not a “true” PIP as much as it is 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.

### PIP 3: Diabetes Prevention and Management

PHP conducted this PIP to increase HbA1c testing and to decrease the rate of hospital admissions due to diabetic short-term complications. To accomplish these goals PHP distributed gaps in care reports to providers and implemented several member interventions. Member interventions included monetary incentives, educational materials and screening events. Preliminary findings indicate that these interventions were moderately effective given that PHP’s indicator rates fluctuated and yielded slight improvement. There were no validation findings to indicate that the credibility of the PIP results is at risk.

### PIP 4: Screening and Management of Clinical Depression

PHP conducted this PIP to improve member adherence to prescribed antidepressant medications. To achieve this goal PHP coordinated with a nurse advice line, pharmacies and care coordinators to conduct member outreach. Members received prescription refill reminders and educational materials. Providers received notification of members identified as high-risk. Preliminary findings indicate that these interventions were ineffective at improving member management of antidepressant medications. The second aim of improving the screening of depression with appropriate follow-up cannot be assessed as the CY 2017 rate is the baseline year for this indicator.

### Table 9: UHC PIP Summaries

#### PIP 1: Annual Pediatric Dental Visits

UHC conducted this PIP to increase annual dental visits among members two (2) to twenty (20) years of age. To accomplish this goal UHC offered monetary and gift card incentives to members and hosted a series of events to promote oral health and to close gaps in care. A total of 399 gaps in care were closed during these UHC events. Outreach was conducted by UHC’s dental clinical practice consultants to support providers in closing gaps in care. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

#### PIP 2: Influenza Vaccination for Long Term Care Population

UHC conducted this PIP to increase influenza vaccinations among its LTC population. To achieve this goal UHC enhanced member contact to include education on the importance of vaccines, offered its members free transportation to appointments, trained staff on the importance of flu vaccinations and provided them with talking points to utilize when discussing vaccinations with members. UHC provided clinical practice guidelines on its website. UHC performance on this PIP cannot be assessed as data reported is for the baseline period.

#### PIP 3: Diabetes Prevention and Enhanced Disease Management

UHC conducted this PIP to increase the rate of HbA1c testing and to decrease the admission rate for short-term diabetes complications. To accomplish these goals UHC collaborated with other MCOs to
develop a one-page practice guideline handout for providers, promoted clinical practice guidelines on its website, distributed gaps in care reports to providers and utilized a mobile unit to perform HbA1c tests for UHC members. Preliminary findings indicate that these interventions were effective. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**PIP 4: Antidepressant Medication Management, Screening for Clinical Depression and Compliance**

UHC conducted this PIP to improve the documentation of depression screenings and follow-up and to improve member adherence to antidepressant medication. To achieve these goals UHC’s clinical practice consultants met with providers to promote proper coding for depression screening and follow-up plans and to review monthly gaps in care reports. Providers also received education on the appropriate use of screening tools, clinical practice guidelines and how to access the behavioral health system. UHC conducted postpartum outreach calls to members at-risk for depression and offered assistance to members with scheduling labs and appointments. Preliminary findings indicate that these interventions were ineffective as demonstrated by a continuous decline in performance across all three (3) project indicators. There were no validation findings to indicate that the credibility of the PIP results is at risk.

**VALIDATION OF PERFORMANCE MEASURES**

This subpart of the report presents the results of the evaluation of MCO PMs calculated for CY 2017.

**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, 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 10.

**Table 10: 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>
</tbody>
</table>
PM 4: HEDIS Comprehensive Diabetes Care (CDC)
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 (less than 9.0%), a retinal eye exam and a nephropathy screening test for kidney disease.

PM 5: HEDIS Timeliness for Prenatal and Postpartum Care (PPC)
- 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.
- The percentage of deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) calendar days after delivery.

PM 6: HEDIS Frequency of Ongoing Prenatal Care (FPC)
Retired.

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: 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 days.
- 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 days.

For the PMs presented in Table 10 HSD requires Centennial Care MCOs to achieve specified levels of performance. For CY 2017, each MCO is required to demonstrate a two (2) percentage point improvement above the MCO’s CY 2016 PM rate, or demonstrate achievement of the 2017 Quality Compass Health & Human Services (HHS) Dallas region benchmark (for CY 2016), or achieve the HSD determined target. If the MCO’s baseline CY 2016 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 penalty.

The MCOs’ PM rates for CY 2017 are presented in Table 11. 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 Key</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>
Table 11: Performance Measure Results for Calendar Year 2017

<table>
<thead>
<tr>
<th>PM</th>
<th>BCBS CY 2017</th>
<th>MHC CY 2017</th>
<th>PHP CY 2017</th>
<th>UHC CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADV</td>
<td>64.38%</td>
<td>73.65%</td>
<td>70.86%</td>
<td>61.02%</td>
</tr>
<tr>
<td>MMA</td>
<td>51.52%</td>
<td>55.10%</td>
<td>57.47%</td>
<td>64.82%</td>
</tr>
<tr>
<td>CBP</td>
<td>45.50%</td>
<td>50.73%</td>
<td>48.66%</td>
<td>54.99%</td>
</tr>
<tr>
<td>CDC HbA1c Test</td>
<td>82.00%</td>
<td>87.10%</td>
<td>84.85%</td>
<td>89.29%</td>
</tr>
<tr>
<td>CDC HbA1c Poor Control</td>
<td>50.36%</td>
<td>47.93%</td>
<td>49.45%</td>
<td>45.50%</td>
</tr>
<tr>
<td>CDC Retinal Eye Exam</td>
<td>51.09%</td>
<td>60.34%</td>
<td>52.01%</td>
<td>56.20%</td>
</tr>
<tr>
<td>CDC Nephropathy</td>
<td>86.37%</td>
<td>88.56%</td>
<td>86.13%</td>
<td>89.78%</td>
</tr>
<tr>
<td>PPC Timeliness</td>
<td>78.59%</td>
<td>73.35%</td>
<td>71.36%</td>
<td>68.86%</td>
</tr>
<tr>
<td>PPC Postpartum Care</td>
<td>61.07%</td>
<td>52.32%</td>
<td>59.30%</td>
<td>56.20%</td>
</tr>
<tr>
<td>AMM Acute</td>
<td>47.81%</td>
<td>45.77%</td>
<td>50.59%</td>
<td>52.32%</td>
</tr>
<tr>
<td>AMM Continuation</td>
<td>32.59%</td>
<td>30.54%</td>
<td>34.31%</td>
<td>37.48%</td>
</tr>
<tr>
<td>FUH (6-17 years of age)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>FUH (18+ years of age)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA: Not available. At the time of publication of this report, the validation of the FUH rates was still in progress.
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 12–Table 17 display the results of the IPRO’s assessment of MCO adherence to the distance standards.

Table 12: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>PCP – Rural (1 provider in 45 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>PCP – Frontier (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

Table 13: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>OB/GYN – Rural (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>OB/GYN – Frontier (1 provider in 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

Table 14: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy – Urban (1 pharmacy in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Pharmacy – Rural (1 pharmacy in 45 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Pharmacy – Frontier (1 pharmacy in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

Table 15: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living Facility – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Not Met</td>
<td>Met</td>
</tr>
<tr>
<td>Assisted Living Facility – Rural (1 provider in 60 miles)</td>
<td>Not Met</td>
<td>Met</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Assisted Living Facility – Frontier (1 provider in 90 miles)</td>
<td>Not Met</td>
<td>Met</td>
<td>Not Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Rural (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Delegated - Frontier (1 provider in 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Urban</td>
<td>Met</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>
<td>UHC</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>(1 provider in 30 miles)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Frontier</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>(1 provider in 60 miles)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Service Agency – Directed - Rural</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>(1 provider in 90 miles)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facility – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Nursing Facility – Rural (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Nursing Facility – Frontier (1 provider in 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 16: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital – Rural (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital – Frontier (1 provider in 90 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Table 17: 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>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation Providers – Urban (1 provider in 30 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Transportation Providers – Rural (1 provider in 60 miles)</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>Transportation Providers – Frontier (1 provider in 90 miles)</td>
<td>Met</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, 2017–December 31, 2017, conducted in September 2018 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 for a selected time period; or, for care coordination, a listing of members enrolled in care management during a selected time period. From these listings, IPRO selected 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. Prior to the review, a notice was sent to the MCOs including a confirmation of the onsite dates, 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 2017 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 with a limited time period 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.
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.

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 2017, 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 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

For each MCO, IPRO compared the 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. For distance standards not met, IPRO made recommendations to the MCO.