NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

Summary of

External Quality Review Organization

Reports

October 2017

This report is a summarization by HSD of External Quality Review (EQRO) reports. The New Mexico Human Services Department (HSD) created this summary based upon reports supplied by HealthInsight New Mexico, the contracted EQRO for New Mexico.

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How to Use This Report

This report, provided by HSD, contains summarization of the external quality reviews (EQRs) of Centennial Care managed care organizations (MCOs) in New Mexico. To get a complete, detailed understanding of the projects, refer to the original, published reports available on the HSD website. As a summary, the precise wording may vary from the original report.

The reports covered in this summary include:

1. Compliance reports Calendar Year (CY) 2014 and CY 2015
2. Performance Measurements and Performance Improvement Projects for CY 2014 and CY 2015
3. Initial Encounter Reconciliation Report dated April 7, 2017 for the Encounter Data Validation (EDV) Project CY 2014
4. Independent Assessment (IA) performed for CY 2014

The summary includes scores and recommendations. Recommendations indicate the actionable items for the organizations under review.

The MCOs reviewed for all of these projects are the four MCOs contracted for provision of Medicaid Managed Care services under Centennial Care and are:

- Blue Cross and Blue Shield of New Mexico (BCBS)
- Molina Healthcare of New Mexico (MHP)
- Presbyterian Health Plan, Inc. (PHP)
- United Healthcare of New Mexico, Inc. (UHC)

For reference, a glossary is provided at the end of this report that defines acronyms and other terms specific to these reviews.

1.0 Compliance Report CY 2014 and 2015

1.1. Compliance Report Comparison Executive Summary

During the annual compliance review projects, the MCOs were assessed for compliance with federal and state regulations. This report covers data gathered during CY 2014 and CY 2015, which were the first two years of Centennial Care.

Both assessments were conducted according to EQR Protocol 1, published by Centers for Medicare & Medicaid Services (CMS), and included an evaluation of each MCOs' policies, procedures and other documentation; and an examination of medical records and case files. The Human Services Department (HSD) determined the topics for assessment and approved the assessment methodology. The original, approved versions of this report are available on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

Table 1 shows the overall results for each MCO included in this review.

Table 1: Overall Compliance Scores by MCO				
MCO	CY 2014 Scores	CY 2015 Scores	Percentage Point Change from 2014 to 2015	Compliance Levels
BCBS	97.80%	92.15%	-5.65	Full
MHP	98.89%	96.96%	-1.93	Full
PHP	96.91%	95.46%[1]	-1.45	Full
UHC	95.55%	94.47%	-1.08	Full

Compliance Levels By Defined Score Range			
Full Compliance: 90% - 100%	Moderate Compliance: 80% - 89%	Minimal Compliance: 50% - 79%	Non-Compliance: <50%

While MCOs do fall below the threshold for full compliance for individual sections, the EQRO has not identified a MCO that fell below the threshold for overall compliance. The scores above reflect the final scores after all zero scores and timeliness/accuracy penalties have been deducted.

[1] This score was revised due to a rounding function used by the Excel spreadsheet to generate the score and the change in the Care Coordination score. The previous score was 95.89 percent.

1.2. Compliance Scores

Table 2 shows the scores by review subject for each MCO and compares the scores between CY 2014 and CY 2015. These scores are based on weighted averages. For more information on the details of the weighting structure, refer to the full State Fiscal Year (SFY) 15 or SFY 16 Compliance Reports posted to the HSD website at http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

Table 2: MCO Score by Subject Annual Comparison

Review Subject	CY 2014 BCBS Scores	CY 2015 BCBS Scores	CY 2014 MHP Scores	CY 2015 MHP Scores	CY 2014 PHP Scores	CY 2015 PHP Scores	CY 2014 UHC Scores	CY 2015 UHC Scores
Enrollment/Disenrollment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%
Member Handbook	100.00%	N/A	100.00%	N/A	100.00%	N/A	100.00%	N/A
Member Materials	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Member Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Program Integrity	95.80%	95.00%	94.40%	98.40%	100.00%	100.00%	98.60%	95.00%
Provider Network	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Provider Services	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Reporting Requirements	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Self-Directed Community Benefit	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Care Coordination	87.40%	73.10%	96.70%	93.10%	99.00%	80.76%[2]	96.00%	89.70%
Transition of Care	100.00%	62.20%	100.00%	90.80%	100.00%	81.50%	100.00%	84.70%
Grievances and Appeals	99.30%	99.50%	99.60%	99.60%	99.30%	99.60%	99.46%	97.60%
Medical Records	96.78%	97.00%	95.78%	96.56%	96.22%	97.44%	92.00%	96.89%
Primary Care Provider (PCP) and Pharmacy Lock-ins	100.00%	100.00%	100.00%	100.00%	78.75%	94.44%	62.60%	100.00%
Adverse Determinations (Denials)	99.67%	91.00%	97.67%	100.00%	96.00%	100.00%	100.00%	100.00%
Approvals	91.00%	N/A	100.00%	N/A	78.72%	N/A	100.00%	N/A
Scores	97.80%	92.15%	98.89%	96.96%	96.91%	95.46%	95.55%	94.47%

The Member Handbook subject was merged into the Member Materials section for the CY 2015 review, therefore the score for Member Handbook for CY 2015 is reported as "N/A." In the CY 2014 review for Transitions of Care, HSD elected to remove the file review portion from the scores due to the need for

[2] This score was revised based on the clarification responses. The previous score was 77.78 percent.

clarifying language from HSD in the Managed Care Policy Manual. The file review scores were included for the CY 2015 review, therefore accounting for the noticeable drop in scores. The subject 'approvals' was removed for the CY 2015 report so that the EQRO could look more closely at adverse determinations (denials).

1.3. Compliance Recommendations

The section below details MCO specific recommendations in each category of review for the CY 2014 and CY 2015 compliance reports. The CY 2014 recommendations are given first and the CY 2015 recommendations immediately follow for each MCO. Recommendations listed in CY 2014 that are not repeated in CY 2015 indicates the MCO addressed the recommendation from the previous year's review. Recommendations listed in CY 2015 that were not specified in CY 2014 indicates a new finding upon subsequent review. Such a change does not imply a change in requirements, only that the review identified something that had not been previously identified. Parenthetical to the subject names listed below is the Citation of Authority from which that subject is drawn. The Citation of Authority is the official source from which the EQRO developed the list of questions reviewers asked the MCOs. The Citation of Authority is generally one of four items:

1. The contract between the MCOs and HSD
2. The HSD Managed Care Policy Manual
3. The federal language found in the Code of Federal Regulations (CFR)
4. New Mexico Administrative Code (NMAC)

Blue Cross and Blue Shield of New Mexico

BCBS Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that BCBS:

- Update its policies and procedures to establish a 60-day timeframe for self-reporting of overpayments, as required by NMAC 8.308.22.9.
- Update its policies and procedures to include how often the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System will be checked for providers that are excluded from participation in the Medicaid program.
- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

In CY 2015, the EQRO recommended that BCBS:

- Amend its policies and procedures to include checking all the listed databases upon enrollment and re-enrollment for contracted providers and those with an ownership or controlling interest or who are an agent or managing employee. Enrollment for atypical providers appears to be addressed but not reenrollment for the other persons. Additionally, the MCO should amend its policies and procedures to indicate that the Office of the Inspector General's List of Excluded Individuals (LEI) and Excluded Parties List System (EPLS) are checked monthly for all applicable persons, not just atypical providers.
- Conduct a review to identify contract providers and any person with an ownership and controlling interest or who is an agent or managing employee, as identified by the provider enrollment documents, to ensure that all applicable persons have been checked.

BCBS Care Coordination (MCO/HSD Contract Section 4.4)

For CY 2014, the EQRO recommended that BCBS:

- Continue to assess and improve its care coordination processes to meet all federal and state requirements.

- Develop a method of retaining data from employee laptops when the employee leaves the organization so that documentation of care coordination efforts can be efficiently maintained.

For CY 2015, the EQRO recommended that BCBS:

- Complete all health risk assessments (HRAs) and comprehensive needs assessment (CNAs) within required timeframes and document their completion.
- Provide member notifications within required timeframes and document that activity.
- Conduct a root cause analysis to determine why such a high percentage (46.67 percent) of sampled members refused care coordination.

BCBS Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that BCBS:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that BCBS:

- Create, document, and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to community settings.
- Update policies to reflect the need to develop and implement specific, individual transition plans.

BCBS Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that BCBS:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that BCBS:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

BCBS Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that BCBS:

- Adopt the practice of having medical directors write a “plain language” summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.

BCBS Information Systems Capability Assessment (ISCA) (CMS EQR Protocol 5)

In CY 2015, the EQRO recommended that BCBS:

- Formally document its process for handling erroneous or rejected claims.
- Develop and implement a method for calculating defect rates within its systems.

Molina Healthcare of New Mexico

MHP Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that MHP:

- Update its policies and procedures to include regular checks of the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System for providers who are excluded from participation in the Medicaid program.
- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.
- Require primary business addresses and post office boxes on the Disclosure of Ownership and Control Interest form for providers and fiscal agents.
- Update its policies and procedures to specify that the documentation of any significant business transactions between the provider and any subcontractor must cover the most recent five years.

In CY 2015, the EQRO recommended that MHP:

- Add the requisite language from 42 CFR 422.13 regarding not infringing on the legal rights of persons involved and affording due process of law in the course of conducting an investigation.

MHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that MHP:

- Document the timing of the HRAs and CNAs clearly and consistently and monitor them for completion.
- Determine the best method for recording that the member and/or the member's representative participated in care plan development.

MHP Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that MHP:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that MHP:

- Institute corrective action to create, document, and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to home.

MHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that MHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that MHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

MHP Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that MHP:

- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.

Presbyterian Health Plan, Inc.

PHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that PHP:

- Document the timing of the HRAs and CNAs clearly and consistently and monitor them for completion.
- Add text to the phone script or other HRA-related member education material provided at the time of the HRA that informs the member that she or he has the right to request a higher level of care coordination. Additionally, appropriately document that this notification has occurred.
- Update relevant policies and procedures to include a statement clearly defining how PHP will communicate to the member the care coordination unit contact Information and when to expect contact regarding scheduling a CNA.

PHP Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that PHP:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual, Section 5, Transitions of Care.

In CY 2015, the EQRO recommended that PHP:

- Create, document, and implement specific, individual Transition Plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from nursing facilities to community settings.

PHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that PHP:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that PHP:

- Direct providers to develop and implement a process that can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

PHP Approvals (MCO/HSD Contract Section 4.12.10)

In CY 2014, the EQRO recommended that PHP:

- Develop and implement a method of documenting the approved criteria (e.g. Milliman) and the clinical information used to approve provider requests (from providers outside of the PHS provider partners system) in each member's file beyond what is stated in the Member Handbook.

- Improve internal processes to meet the timeliness requirements for making the prior authorization determination and communicating that information to the member and the requesting provider consistently.

PHP Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2014, the EQRO recommended that PHP:

- Document that PHP informed the requester of the qualifications of the staff member at the health plan who made the determination and advised the requester that the staff member is available by phone for consultation.
- Develop and implement a method of documenting the criteria used to make the determination, including a citation of the regulation used beyond what is stated in the Member Handbook.

In CY 2015, the EQRO recommended that PHP:

- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
- Have medical directors review administrative adverse determinations (denials) as required by the contract. If this is being conducted already, discuss ways to provide documentation of this activity for review.

PHP PCP and Pharmacy Lock-Ins (MCO/HSD Contract Section 4.22.2-3)

In CY 2014, the EQRO recommended that PHP:

- Establish and maintain contact with all members who have a Pharmacy Lock-In in place. Members also need to be educated as to what behavior is necessary for release from the lock-in.

United Healthcare of New Mexico, Inc.

UHC Enrollment/Disenrollment (MCO/HSD Contract Section 4.2-4.3)

In CY 2015, the EQRO recommended that UHC:

- Update the related policies to include contract required language:

  > *The [MCO] shall not request disenrollment because of a change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members. (HSD/MCO Contract 4.3.1)*

UHC Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that UHC:

- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

In CY 2015, the EQRO recommended that UHC:

- Update its policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.

UHC Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that UHC:

- Update its policies and procedures for care coordination to reflect how the member will be informed of the timeframe expectations for the CNA completion.

UHC Transitions of Care (MCO/HSD Contract Section 4.4.16)

In CY 2014, the EQRO recommended that UHC:

- Retain documentation of any guidance from HSD provided beyond what is specified in its contract, the federal and state regulations, and the HSD Managed Care Policy Manual. This includes emails, meeting minutes and other forms of communication.
- Identify members who qualify for a nursing facility to home transition and then document and implement a specific transition plan for that member as described in the HSD Managed Care Policy Manual Section 5 Transitions of Care.

In CY 2015, the EQRO recommended that UHC:

- Develop and implement a consistent way of documenting Transition Plans for members that is retained in one place to facilitate care coordinator management of the transition process and follow-up.

UHC Grievances and Appeals (MCO/HSD Contract Section 4.16)

In CY 2015, for member appeals, the EQRO recommended that UHC:

- Provide a process whereby members can present evidence in support of their appeal in person.

In CY 2015, for provider appeals, the EQRO recommended that UHC:

- Provide a letter to the provider of the findings and conclusions in every provider appeal, whether or not it is resolved in the provider's favor.

UHC Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that UHC:

- Develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

In CY 2015, the EQRO recommended that UHC:

- Direct providers to develop and implement a process that can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.

UHC PCP and Pharmacy Lock-In (MCO/HSD Contract Section 4.22.2-3)

In CY 2014, the EQRO recommended that UHC:

- Implement policies and procedures to identify, monitor and communicate with members requiring a PCP or Pharmacy Lock-In.

UHC Adverse Determinations (Denials) (MCO/HSD Contract Section 4.12.10)

In CY 2015, the EQRO recommended that UHC:

- Work with its dental vendors to update the dental service denial letters to more closely mirror those issued by UHC.
- Adopt the practice of having medical directors write a "plain language" summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required in the denial.

UHC ISCA (CMS EQRO Protocol 5)

In CY 2015, an ISCA was conducted and the EQRO recommended that UHC:

- Include the timeliness requirements in its policy regarding adjudication of pended claims.
- Develop a policy or procedure that describes how claims are tracked when they are sent for manual review and that they are processed timely.

- Develop and provide evidence of its processes for oversight and auditing of vendors that submit data used to report performance measures.
- Add material to its training program for federal and state reporting that addresses how coding affects the data management process.

1.4. HSD Monitoring Activities

- HSD evaluated MCO care coordination records to identify and address any areas of concern during the first six months of Centennial Care in July 2014. The universal finding was the need for additional care coordination training to meet contractual obligations. HSD attended all of the care coordination trainings performed by the MCOs and determined accuracy of trainings.
- In December 2014, HSD reviewed the MCO care coordination records to evaluate the efficacy of the MCOs' additional care coordination training. The evaluation identified specific areas for each MCO to address and improve care coordination activities. MCOs were directed to respond to action plans developed by HSD to address the findings. HSD reviewed the interventions and activities performed by the MCOs and provided feedback and/or technical assistance as necessary. The action plans were closed upon completion of activities.
- In November 2015, HSD reviewed the MCO care coordination records from CY 2015 to evaluate the second year of care coordination in Centennial Care. HSD again developed action plans for care coordination documentation and other care coordination activities in need of improvement.
- HSD developed care coordination training specific to documentation requirements and conducted a training for all of the MCOs in June 2016.
- Throughout 2016 and 2017, MCOs continued to provide interventions and actions to improve care coordination activities in their action plans. The MCOs performed internal auditing of their action items and provided qualitative and quantitative data for HSD's review on a quarterly basis.
- HSD continued to meet with MCOs and provide feedback to action plans. In October 2017, HSD began the process to close MCO action plans that had shown positive internal audit results. HSD will perform audits on the MCO care coordination records to ensure the closed action plans continue to show improved care coordination activities.
- HSD monitors care coordination contractual obligations through monthly MCO reporting of care coordination activities, including assessments performed and required member visits.
- In August 2015, HSD researched the top 10 members at each MCO with high emergency room (ER) utilization and met with the MCOs' key care coordination personnel to establish a framework for increasing care coordination efforts with the identified top 10 high ER utilizers. The MCOs reported monthly on their activities with the high ER utilizers, showing their progress with member engagement and reduction in ER utilization.
- In April 2016, HSD added 25 more members with high ER utilization. The MCOs continue to report on proven interventions to provide adequate care coordination with their top 35 high ER utilizers.
- Beginning in 2016, HSD conducted ride-alongs with the care coordinators to monitor accurate and consistent implementation of the CNA. Recommendations were provided to each MCO.
- HSD conducts a qualitative and quantitative analysis of the MCOs' Grievances and Appeals report submitted monthly by the MCOs to observe for trends and the need for corrective action.

2.0 Performance Measurement Program/Performance Improvement Projects CY 2014 and CY 2015

2.1. Performance Measurement Program (PMP) and Performance Improvement Projects (PIPs) Executive Summary

During the annual PMP and PIP review projects, the MCOs were assessed for compliance with federal and state regulations. This report contains data gathered during CY 2014and CY 2015, which were the first and second years of Centennial Care.

Both assessments were conducted according to CMS EQR Protocols 2 and 3; included an evaluation of each MCO's policies, procedures and other documentation; and included an examination of medical records and case files. HSD determined the topics for assessment and approved the assessment methodology. The original, approved versions of these reports are available on the HSD website.

The EQRO rated each MCOs' quality improvement program as fully compliant with Centennial Care contractual and regulatory requirements. The EQRO validated the accuracy and reliability of the PMs and PIPs reported to HSD by each MCO.

In CY 2014, HSD directed the MCOs to submit four (4) PIPs: one (1) on Long-Term Care Services; one (1) on services to children; one (1) on Behavioral Health; and one (1) on Women's Health.

For CY 2014 and CY 2015 HSD directed the EQRO review and score the MCO submitted PIPs for Long-Term Services and Supports (LTSS) and Services to Children.

For the purposes of reporting, PIP #1 is the Services to Children measure and PIP #2 is the LTSS measure. Since the MCOs can select their own PIPs, submissions varied by MCO; therefore, the scores for CY 2014 may differ than those for CY 2015. For example, in CY 2014, MHP submitted a PIP for dental health for children, whereas in CY 2015, MHP submitted a PIP for diabetes prevention in youth. For this reason, the scores are reported separately.

Table 3 shows the overall PMP and PIP results for each MCO for CY 2014.

Table 3: PMP and PIPs Scores and Compliance Levels for CY 2014						
MCO	PMP Score	PMP Compliance	PIP #1 Score	PIP #1 Compliance	PIP #2 Score	PIP # 2 Compliance
BCBS	100.00%	Full	100.00%	Full	100.00%	Full
MHP	100.00%	Full	100.00%	Full	100.00%	Full
PHP	100.00%	Full	100.00%	Full	100.00%	Full
UHC	100.00%	Full	100.00%	Full	96.84%	Full
Compliance Levels By Defined Score Range						
Full Compliance: Score 90% - 100%		Moderate Compliance: 80% - 89%		Minimal Compliance: 50% - 79%		Non-compliance: <50%

Table 4 shows the scores for the PMP and PIP review for CY 2015.

Table 4: PMP and PIPs Scores and Compliance Levels for CY 2015						
MCO	PMP Score	PMP Compliance	PIP# 1 Score	PIP #1 Compliance	PIP #2 Score	PIP #2 Compliance
BCBS	100.00%	Full	100.00%	Full	100.00%	Full
MHP	100.00%	Full	61.25%	Minimal	100.00%	Full
PHP	100.00%	Full	100.00%	Full	100.00%	Full
UHC	100.00%	Full	100.00%	Full	100.00%	Full
Compliance Levels By Defined Score Range						
Full Compliance: 90% - 100%		Moderate Compliance: 80% - 89%		Minimal Compliance: 50% - 79%		Non-compliance: <50%

PM Rates

Table 5 lists BCBS's Healthcare Effectiveness Data and Information Set (HEDIS®[3]) certified PM rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A PM rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best PM rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 5: BCBS PM Rates and Historical Comparisons

BCBS PMs	CY 2014 PM Rate	CY 2015 PM Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	57.46%	59.63%	2.17	60.65%	-1.02
Medication management for people with asthma[4]					
Medication compliance 50%	N/A	51.09%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	51.66%	56.99%	5.33	43.53%	+13.46
Comprehensive diabetes care					
Eye Exam	54.23%	47.76%	-6.47	44.99%	+2.77
HbA1c Testing	83.42%	80.43%	-2.99	83.25%	-2.82
Nephropathy	78.61%	85.07%	6.46	90.26%	-5.19
Poor HbA1c Control *(lower is better)	47.26%	52.90%	5.64	59.90%	-7.00*
Prenatal and postpartum care					
Prenatal care (timeliness)	73.08%	72.61%	-0.47	81.64%	-9.03
Postpartum visit (frequency)	54.52%	57.91%	3.39	59.84%	-1.93
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	55.20%	50.56%	-4.64	60.65%	-10.09
Antidepressant medication management					
Acute treatment	59.97%	54.80%	-5.17	54.58%	+0.22
Continuation treatment	47.77%	39.40%	-8.37	39.58%	-0.18
Follow-up After Hospitalization for Mental Illness					
7-days after discharge	39.00%	34.27%	-4.73	40.79%	-6.52

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

30-days after discharge	58.49%	55.10%	-3.39	61.46%	-6.36

Table 6 lists MHP's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 6: MHP PM Rates and Historical Comparisons

MHP PMs	CY 2014 PM Rate	CY 2015 PM Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	62.75%	70.07%	7.32	60.65%	+9.42
Medication management for people with asthma[5]					
Medication compliance 50%	N/A	49.38%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	49.88%	51.38%	1.50	43.53%	+7.85
Comprehensive diabetes care					
Eye exam	56.51%	54.53%	-1.98	44.99%	+9.54
HbA1c testing	85.65%	88.08%	2.43	83.25%	+4.83
Nephropathy	74.83%	88.08%	13.25	90.26%	-2.18
Poor HbA1c control *(lower is better)	49.89%	45.03%	-4.86	59.9%	-14.87*
Prenatal and postpartum care					
Prenatal care (timeliness)	76.80%	75.97%	-0.83	81.64%	-5.67
Postpartum visit (frequency)	54.50%	51.49%	-3.01	59.84%	-8.35
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	61.04%	55.38%	-5.66	60.65%	-5.27
Antidepressant medication management					
Acute treatment	53.50%	49.55%	-3.95	54.58%	-5.03
Continuation treatment	38.63%	34.67%	-3.96	39.58%	-4.91
Follow-up after hospitalization for mental illness					
7-days after discharge	41.80%	34.64%	-7.16	40.79%	-6.15

[5] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

30-days after discharge	64.80%	59.76%	-5.04	61.46%	-1.70

Table 7 lists PHP's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 7: PHP PM Rates and Historical Comparison

PHP PMs	CY 2014 Performance Measurement Rate	CY 2015 Performance Measurement Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	68.14%	66.43%	-1.71	60.65%	+5.78
Medication management for people with asthma[6]					
Medication Compliance 50%	N/A	54.57%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	55.95%	56.42%	0.47	43.53%	+12.89
Comprehensive diabetes care					
Eye exam	47.75%	46.07%	-1.68	44.99%	+1.08
HbA1c testing	86.52%	84.64%	-1.88	83.25%	+1.39
Nephropathy	79.53%	86.91%	7.38	90.26%	-3.35
Poor HbA1c control *(lower is better)	43.93%	48.34%	4.41	59.9%	-11.56*
Prenatal and postpartum care					
Prenatal care (timeliness)	77.88%	66.36%	-11.52	81.64%	-15.28
Postpartum visit (frequency)	61.88%	53.13%	-8.75	59.84%	-6.71
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	48.71%	42.92%	-5.79	60.65%	-17.73
Antidepressant medication management					
Acute treatment	53.94%	53.36%	-0.58	54.58%	-1.22
Continuation treatment	38.97%	36.24%	-2.73	39.58%	-3.34
Follow-up after hospitalization for mental illness					

[6] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

7-days after discharge	43.14%	32.56%	-10.58	40.79%	-8.23
30-days after discharge	67.88%	59.75%	-8.13	61.46%	-1.71

Table 8 lists UHC's HEDIS certified performance measurement rates reported to HSD for the eight contract-required PMs for CY 2014 and CY 2015. A performance measurement rate represents the percentage of eligible members who received a specific treatment or service during the review period. Note: Bolded text indicates the best performance measurement rates reported in New Mexico among the four contracted MCOs for the respective years.

Table 8: UHC PM Rates and Historical Comparisons					
UHC PMs	CY 2014 Performance Measurement Rate	CY 2015 Performance Measurement Rate	Difference Between CY 2015 and CY 2014 Rates	CY 2015 Region VI Average	Difference Between CY 2015 Rate and Region VI Averages
Annual dental visit					
Ages 2-21	41.52%	49.88%	8.36	60.65%	-10.77
Medication Management for people with asthma[7]					
Medication compliance 50%	N/A	56.28%	N/A	N/A	N/A
Controlling high blood pressure					
Ages 18-85	53.04%	49.88%	-3.16	43.53%	+6.35
Comprehensive diabetes care					
Eye exam	65.21%	62.53%	-2.68	44.99%	+17.54
HbA1c testing	84.43%	84.43%	0.00	83.25%	+1.18
Nephropathy	83.70%	90.27%	6.57	90.26%	+0.01
Poor HbA1c control *(lower is better)	49.15%	52.55%	3.40	59.90%	-7.35*
Prenatal and postpartum care					
Prenatal care (timeliness)	63.75%	67.40%	3.65	81.64%	-14.24
Postpartum visit (frequency)	48.18%	41.36%	-6.82	59.84%	-18.48
Frequency of ongoing prenatal care					
Completed more than 80% of expected visits	42.58%	34.06%	-8.52	60.65%	-26.59
Antidepressant medication management					
Acute treatment	62.50%	56.62%	-5.88	54.58%	+2.04
Continuation treatment	48.34%	42.89%	-5.45	39.58%	+3.31

[7] This rate was not required in 2014. It replaces the NCQA retired measure, "Use of Appropriate Medications for people with asthma."

Follow-up after hospitalization for mental illness					
7-days after discharge	55.16%	54.96%	-0.2	40.79%	+14.17
30-days after discharge	71.00%	73.08%	2.08	61.46%	+11.62

2.2. PMP and PIP Recommendations

Blue Cross and Blue Shield of New Mexico

BCBS PMP Recommendations

In CY 2015, for the PMP, the EQRO recommended that BCBS:

- Implement alternative methods and/or new settings to increase the rates of follow-up for member who are hospitalized for mental illness.

BCBS PIP Recommendations

In CY 2015, for the PIPs, the EQRO recommended that BCBS:

- Implement alternative methods and/or new settings to increase the number of diabetic members in the LTC program who receive screening for retinopathy.

Molina Healthcare of New Mexico

MHP PIP Recommendations

In CY 2015, for PIP #1, the EQRO recommended that MHP:

- Submit evidence that MHP has researched and analyzed its unique population for the following characteristics: 1) the incidence and/or prevalence of the need or issue; 2) the impact to the enrollee target population; 3) the estimate of enrollees eligible for the PIP; and 4) if the study topic reflects high volume or high-risk enrollees.
- Explain why the study topic was prioritized, including consideration given to the high risk of the population and the feasibility of performing the PIP.
- Show how the study topic has the potential to affect enrollee health, functional status or satisfaction significantly.
- Provide supporting documentation of the rationale behind its choice of this PIP, the location for the population and how the PIP could reasonably be expected to improve the processes and outcomes of health care provided by MHP.
- Submit a clear definition of enrollee characteristics that were used to determine that the interventions chosen were appropriate for the population to be studied.
- Identify and describe the sampling methodology prior to implementing the PIP.
- Report the inclusion criteria and the exclusion criteria for the study population along with associated definitions, data sources, calculation methodology and codes.
- Develop a robust plan for collecting and analyzing data in order to answer the study question(s).
- Identify any threats to the internal or external validity of the study results. Plan to measure again after the baseline period has ended and after the intervention has taken place. Additionally, MHP needs to consider and report factors that might compromise internal and/or external validity (e.g., project's history, maturation, sample size, effects of selection bias, statistical regression, study group composition, matriculation, and other educational experiences).
- Provide supporting documentation of the rationale behind its choice of the PIP and the location for the population and how the PIP could reasonably be expected to improve the indicator.

In CY 2015, for PIP #2, the EQRO recommended that MHP:

- Include a fall risk assessment on the CNA for those transferring from nursing facilities to home.

- Complete the fall risk assessment for its long-term services PIP for 100 percent of members who are identified as having a high risk for falls.
- Implement at least one intervention to be undertaken with all members identified as having a high risk for falls.

Presbyterian Health Plan, Inc.

PHP PIP Recommendations

In CY 2015, for PIP #1, the EQRO recommended that PHP:

- Analyze available data further to see how many of the 476 scheduled appointments for annual dental visits were actually completed.

United Healthcare of New Mexico, Inc.

UHC PIP Recommendations

In CY 2015 for PIP #2, the EQRO recommended that UHC:

- Rephrase the study question to be more precisely defined so that it can be more accurately measured according to CMS EQR Protocol requirements.

2.3 HSD PM and PIP Initiatives for CY 2016

HSD considered CY 2014 and CY 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets. For CY 2016, HSD established performance measure targets, which required; 1) a two percentage (2%) point improvement above the MCOs' NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or HSD's determined target.

HSD formed a Quality Workgroup, which meets quarterly to discuss issues related to Quality Assurance. The Workgroup promotes a collaboration between the MCOs and HSD to evaluate quality of care and improve outcomes. During these meetings, HSD provides feedback on Performance outcomes; direction on contractual requirements related to PMs, tracking measures (TMs) and PIPs; and technical assistance to support the MCOs' understanding of HSD's expectations and achievement of improved performance outcomes.

3.0 Encounter Data Validation

3.1. Encounter Data Validation Executive Summary

The New Mexico Human Services Department contracted with HealthInsight New Mexico as the EQRO for this project. Myers and Stauffer, LC (Myers and Stauffer) is subcontracted and under the direction of HealthInsight New Mexico for the encounter data validation (EDV) project. This project covers the review period of January 1, 2014 through April 30, 2016.

HSD requires that each MCO submit encounter data to HSD's fiscal agent (FA), Conduent, Inc., known as Xerox Health Solutions prior to January 2017. As part of the EQR Protocol 4 process, Myers and Stauffer analyzed Medicaid encounter data for CY 2014 that had been submitted by the MCOs to the FA, Conduent, Inc., and completed a comparison of the encounters to the accounting system data (ASD) provided by each MCO.

Validated encounter data have many uses in rate setting analyses by actuaries, as well as fulfilling the federal reporting requirements related to the Medicaid Managed Care Final Rule, in providing program management and oversight and other ad hoc analyses.

This encounter reconciliation will help fulfill part of the work requirements set forth in Activity Number 3 of the CMS EQR Protocol 4, which requires a determination of the completeness, accuracy and quality of the encounter data submitted by each MCO. CMS EQR Protocol 4 is a way to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps and make management decisions. In addition, the Protocol requires an evaluation of both departmental policies, as well as the policies, procedures and systems of the MCOs to identify strengths and opportunities to enhance oversight.

CY 2014 was the implementation year for the Centennial Care program. Based on Myers and Stauffer LC's experience in other states, multiple issues typically arise with the processing, submission and acceptance of encounter data during the implementation year that are generally resolved as the program matures. Recommendations are based on the on-site interviews, documentation and data provided for this validation. Recommendations are specific to the validation period (CY 2014); are based on correct coding standards, Health Insurance Portability and Accountability Act (HIPAA) rules and regulations and industry best practices; and may not reflect the current status of the Centennial Care encounter data if subsequent modifications have been made.

Below are recommendations for Conduent and HSD. MCO-specific sections in the main report present detailed findings and recommendations for each MCO and is available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

HSD and Conduent acknowledge these findings and recommendations and have implemented, or are in the process of implementing, system changes to address the concerns identified during this validation period (CY 2014). HSD and Conduent meet with the MCOs at least monthly to discuss concerns and issues, such as attestations, provider affiliation, Systems Manual updates and encounter completeness.

3.2. Recommendations

HSD encounter submission standards in some instances are generally stated and could potentially be subject to interpretation. Developing more specific encounter data submission standards could assist in improving the quality of the encounter data and generating the accuracy and completeness required for HSD oversight and other analyses performed using the encounter data. Therefore, HealthInsight and Myers and Stauffer LC make the following recommendations related to the State's requirements.

HSD might consider:

1. Reviewing the provider registration process to ensure that it is working efficiently and not causing delays or the inability of the MCOs to submit certain encounters to Conduent. During the on-site visits, the MCOs stated that certain providers' encounters would be rejected by Conduent because the providers had multiple taxonomy codes and the services they submitted on the encounters were not allowed with the submitted taxonomy code. HSD may need to consider exploring aligning provider taxonomy codes used in the State's registration process with the provider-registered taxonomy codes in the National Provider Identifier (NPI) registry.
2. Evaluating the effectiveness of the affiliation process. Providers who submit claims to the MCOs for payment must be registered with the State with the taxonomy code indicated on the claim. In addition, the MCO must be affiliated with the provider in order for the MCO to submit the encounter to Conduent. Based on the experience of Myers and Stauffer LC in other states, the affiliation process and the provider registration is unique and appears to be causing some delays with the submitting of encounters.
3. Increasing the 30-day encounter submission requirement in the MCO contract (Section 4.19.2.2.11) to 95 percent, based on best practice.

4. Accepting MCO denied encounter data submissions. As of the time of the on-site visits, the MCOs were not required to submit denied encounters. The MCO denied claims would provide a more complete picture of the services being provided to the members. Additionally, we recommend that special consideration be given to encounters with both paid and denied lines.
5. Implementing an on-going measurement of the completeness and accuracy of encounters to comply with the Medicaid Managed Care Final Rule (Mega Rule, 42 CFR 438.602(E)), as directed by CMS, such as the encounter reconciliation, which is part of this analysis.

HSD and Conduent might consider:
6. Requiring the MCOs to attest to all encounter data submissions. It is best practice to require an attestation by the MCOs related to the accuracy and completeness of each of the encounter data submissions.
7. A review of the operations of the Self-Directed Community Benefit (SDCB) program to ensure the MCOs have the ability to adequately oversee its members.

Conduent might consider:
8. Updating its data dictionary to include a list of the code set(s) and the descriptions of each code. A code set is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, medical procedure codes, three-digit provider type codes, three-digit provider specialty codes, or two-digit place of service codes.
9. Adding MCO training regarding the resources available for accessing control totals for the enrollment files. Control totals are used to verify the accuracy of transmitted data files, so that the MCOs can ensure that it has the complete file before processing it into its enrollment and claims system and its subcontractor vendor's claims systems.
10. Increasing the amount and frequency of updates to system companion guides and provide advance communication about system changes to ensure the MCOs have adequate time to account for the changes. Keeping these documents up to date and giving advance notification to the MCOs would allow for upfront adjustments to its claims processing systems and help protect the MCOs against spikes in rejected encounters after the implementation of new exception codes and edits.
11. Reviewing the adequacy of the advance notice provided to the MCOs, related to system changes, to ensure the MCOs have ample time to adjust the claims processing system to account for the changes.
12. Implementing additional reviews or edits to ensure the Medicaid management information system (MMIS) is capturing and retaining all encounter data submitted, is reflective of the encounter data submitted by the MCO, remains as submitted by the provider of service and values are in the appropriate field(s).

4.0 Independent Assessment

4.1. Introduction

This report contains details of the tri-annual independent assessment (IA) of HSD's activities and efforts to monitor the performance of New Mexico MCOs. It fulfills federal and state requirements for oversight of the Medicaid MCOs. The information reviewed was collected from HSD for CY 2014 (January 1 through December 31, 2014). This was the first year of implementation of New Mexico's redesigned Medicaid Managed Care program, Centennial Care. HealthInsight New Mexico was chosen by HSD to perform this IA to fulfill the requirements of the Medicaid waiver.

HealthInsight New Mexico conducted the review according to the following:

- The scope of work provided in the EQRO, contract identified as PSC #15-630-8000-0015 A2.
- Guidance to State Medicaid directors published by the Department of Health and Human Services Centers (DHHS) in December 1998, entitled "Section 1915(b) Waiver Program Independent Assessments: Guidance to States."

4.2. Purpose

As HSD's EQRO, HealthInsight New Mexico performed an in-depth analysis of quantitative and qualitative information obtained regarding the MCOs and the Centennial Care waiver program as a whole. The areas of specific focus were Access to Care, Quality of Care and Cost-effectiveness.

The findings of the analysis for each section are summarized below. A full description of the analysis is provided in the full report posted on the HSD website under SFY15 Independent Assessment at: http://www.hsd.state.nm.us/LookingForInformation/external-quality-review-organization.aspx

This IA is designed to identify opportunities for improvement by HSD in oversight activities related to each of the managed care contracts. These improvements would better serve Medicaid members in New Mexico through access to care, quality of care and cost-effectiveness of care.

4.3. Independent Assessment Access Findings Summary

All four MCOs experienced a significant increase in their membership subsequent to the rollout of the Centennial Care program and in response to expansion of Medicaid in 2014 under the Patient Protection and Affordable Care Act of 2010 (ACA). Despite this growth, the analysis of the information provided indicates that overall, the MCOs have met the standards for access. Specifically, all MCOs met the standards for access to PCPs in urban areas. There is continued progress in establishing and maintaining an adequate number of providers, in particular for specialists in the rural and frontier areas; however, it has been a challenge for the MCOs. Some specialist categories in the rural and frontier areas that did not meet standards are dermatology, neurosurgery, rheumatology, endocrinology and some behavioral health (BH) services.

Primary care physicians are allowed a maximum of 2,000 assigned Medicaid members to enable members to receive appropriate care and services. The provider-to-member ratio averaged 64 members per PCP for Centennial Care, thereby meeting the standard.

MCO call center answering timeliness and call abandonment rates were examined as a measure of customer satisfaction and access. The standard is that 90.0 percent of all calls be answered within 30 seconds and no more than 5.0 percent of the calls waiting would be abandoned. The scores ranged from 76.2 percent to 99.1 percent among the MCOs for call answering timeliness and, on average, all four MCOs met the standard. All four MCOs also had less than a 5.0 percent abandonment rate and so met the standard.

There are opportunities to improve the reports that manage and monitor access to healthcare that would in turn be advantageous for monitoring the program. Consistency and standardization in both data quality and report formats would improve the ability to monitor the contract and waiver.
As is stated in Amendment 1 of the MCO contract – the contract version guiding the MCOs during CY 2014 – it is critical that reports be submitted by the MCOs in a timely manner and in proper format (4.21.1.7). If there are revisions requested, then it is imperative that the revised reports also be submitted in a timely fashion and with a title that clearly tracks the revision number and the revised date of the report. Report templates and specifications are important elements in keeping the reports consistent in format and containing the same data quality across all four MCOs. Amendment 1 requires that reports include data summaries and a brief analysis of the report data compared to previous reports (4.21.1.5 and 4.21.1.8). Both of these elements are critical when synthesizing and analyzing data.

Quality Findings

HealthInsight New Mexico examined the following in assessing the quality of care:

- Quality Management/Quality Improvement
- EQRO Audits
- Performance Measures
- Performance Improvement Projects
- Grievances and Appeals
- National Committee for Quality Assurance (NCQA) Ratings
- Call Center Dropped Call Rates
- Accuracy of claims
- Member Satisfaction Surveys

HealthInsight New Mexico noted that each MCO had a comprehensive Quality Management/Quality Improvement (QM/QI) Program Description and a QM/QI Plan that was evaluated annually. In addition, the MCOs have a variety of plans to address the cultural diversity of their members. In support of continuous improvement, the MCOs are tracking the HSD-specified HEDIS®[8] PMs. In support of results from these PMs, the MCOs have all selected PIPs to address gaps in performance per contractual requirements. All MCOs were audited by NCQA in SFY 2014 and each earned an accreditation rating of either accredited or commendable. Further evidence of a functioning system was the completion of an external quality review by the EQRO, as required by CMS. Each MCO earned a rating of Full Compliance for program compliance, PM, PIPs, and ISCA audits.
The MCOs are tracking member satisfaction by reporting of grievances and appeals. Results in the first year of Centennial Care showed an increase in reporting but also showed patterns of responsiveness and improvement by some MCOs. These results are further supported by satisfaction levels using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[9]) 5.0H Medicaid Survey for both adults and children, which indicated acceptable performance. The MCOs submitted CY 2014 provider satisfaction reports to HSD; however, there was no report template and consequently the reports were not consistent in content or usable for evaluation. HSD identified the problem and revised the report instructions in order to provide the MCOs a clear understanding of the report expectations. HSD expects that these will be completed in following years.
All MCOs provided evidence of satisfactory claims accuracy. The EQRO noted areas of variation, specifically, with MHP where consistent high performance was indicated across all claim types.

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Overall, HealthInsight New Mexico found evidence, based on its review of documents provided, that HSD is providing oversight of the Centennial Care quality programs in compliance with the regulations under which it operates.

Cost-effectiveness Findings

The overall financial status was evaluated by considering the following:

- Financial reports
- Bank statements
- Insurance forms
- Independent audit reports
- Medicaid-specific audit reports

After review of available financial reports, and comparing the data to national reports and benchmarks where available, the Centennial Care MCOs appeared to be cost effective for CY 2014. The MCOs demonstrated fiscal responsibility through maintenance of financial viability and stability for CY 2014. The operational summary report discussed in the Cost-effectiveness Section 9.0 showed an overall operating gain of 6.5 percent. Annual costs per consumer in CY 2014 averaged $244.63 per person, while the allowable per person rate was an average of $257.45. This demonstrated that the Centennial Care program was being fiscally responsible with State funds. Please note that calculations were done for MCOs individually, and then aggregated and/or averaged to look at the program as a whole. Examination of short term cost trends by program (BH, LTSS, and PH) by MCO show an overall pattern for three of the MCOs of the lowest cost in the 4th quarter of CY 2014. Comparison of National Medicaid spending trends show that the rate of spending in New Mexico was 0.2 percent lower than the national average (Federal FY 2010 – FY 2014). In addition, New Mexico paid 15 percent less for its share of federal funds than most states for Federal FY 2014.

Overall Findings

The findings of this assessment are that the Centennial Care program met the requirements for access, quality of care, and cost-effectiveness as outlined in the CFR, NMAC regulations and the HSD/MCO contracts, based upon review and analysis of the available data.

Overall Summary of Findings and Conclusions

Despite some challenges in the first year of the Centennial Care program, access and quality of care were provided to its members in a cost efficient manner. HSD standards have been met and plans and processes are in place that aim to improve in all three categories of access, quality and cost effectiveness. HSD has shown good management of HSD's Medicaid Managed Care system on the items assessed in this report. In writing and revision of this report, HSD communicated that there are processes being implemented to cover any identified gaps. Issues have been identified and HSD has provided the MCOs with technical assistance in order to improve processes. It is anticipated that HSD will continue to maintain and improve the access and quality of care to the members and increase the cost-effectiveness of the overall Medicaid Managed Care system by addressing any weaknesses and building on the strengths revealed through further analysis.

4.4. Independent Assessment Recommendations

One possible approach to evaluate performance is adoption of balanced scorecard methodology. Balanced scorecards are performance and quality management tools that support simple evaluation of company or program performance by identifying key measures across four critical areas. Typically, the measures are limited to about 20 at the macro level. In full balanced scorecard deployment, secondary measures that should be correlated to the high level measures support analysis at a cause-and-effect level. For example, if results are not as expected at the scorecard level, then the structure allows for a "drill-down" into the secondary measures to identify causes. With HSD's wealth of detailed reports, these balance scorecards would be the secondary measures that would support higher-level measures on the summary scorecard.

Another approach that HealthInsight New Mexico used extensively in preparing this report is comparisons between the MCOs. While HealthInsight New Mexico did not assess the way in which HSD uses the reports, other than to note that reviewers are assigned by functional areas, it could be that HSD would identify developing performance issues among the MCOs or possible performance improvement opportunities if this comparison approach is performed on a consistent basis.

In addition, common among fully deployed measurement systems is an annual review of the measures themselves. If the measures and the supporting reporting system are meeting the needs of the program. Such a system helps maintain a flexible, agile reporting structure that meets the evolving needs of the program. It also would help identify and remove underutilized reports and identify reporting gaps. It is unclear for this assessment how HSD maintains the currency of their reporting structure. HealthInsight did observe that the Letter of Direction process allows HSD to modify its reporting needs to current requirements.

5.0 Glossary

Term	Definition
ADL	Activities of Daily Living: The things we normally do in daily living including any daily activity we perform for self-care such as feeding, bathing, dressing, grooming, work and homemaking. If a member is identified as needing help with these activities, then care coordination processes may be implemented by an MCO to provide additional care for the member.
ASD	Accounting System data: This is data extracted by the MCOs as evidence of monies paid out for services rendered by providers. This data was required as part of the Encounter Data Validation review.
BCBS	Blue Cross and Blue Shield of New Mexico: One of the four Medicaid Managed Care organizations in New Mexico.
BH	Behavioral Health: The service by which behavioral healthcare services are provided and monitored by HSD, EQR and the managed care organizations. While administered by the same Medicaid Managed Care organizations, behavioral health is considered distinct from physical health and long-term support services.
BHSD	Behavioral Health Services Division: The division within State government tasked with overseeing the provision of behavioral healthcare services for Medicaid members.
CAP	Corrective Action Plan: A plan that is implemented to correct serious issues that were identified either internally by the managed care organization or by an external review. A managed care organization can implement a corrective action plan internally or may be placed on one by HSD if the managed care organization's EQR score falls below a predefined threshold.
CCP	Comprehensive Care Plans: Plans developed by the managed care organizations in collaboration with the member and the member's family to coordinate care for members who have complex medical cases or need additional help managing their healthcare.
Centennial Care	Centennial Care: The name given to the Medicaid Managed Care program administered by HSD effective January 1, 2014. It replaced the previous system, which had Salud!, State Coverage Insurance, coordination of long-term services, and behavioral health all administered as separate programs.
CAHPS	Consumer Assessment of Health Plans: CAHPS surveys ask consumers and patients to report on and evaluate their health care experiences. Each CAHPS survey is designed to assess patient experience in a specific health care setting.
CFR	Code of Federal Regulations: The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government. It is divided into 50 titles. Title 42 deals with public health.

Term	Definition
Citation of Authority	Citation of Authority: The official source from which the EQRO developed a question for the MCOs. The citation of authority is generally one of four items: 1) the contract between the MCOs and HSD; 2) The HSD Managed Care Policy Manual; 3) the federal language found in the CFR; or 4) New Mexico Administrative Code (NMAC).
CMS	Centers for Medicare & Medicaid Services: A department within the United States Department of Health and Human Services that oversees the implementation of the Medicare and Medicaid programs.
CNA	Comprehensive Needs Assessment: This is part of the care coordination process used under Centennial Care. If a member's Health Risk Assessment identifies the need for further assessment for care coordination needs, this is the tool used to conduct that assessment.
CY	Contract Year: The year as defined in a contract. This year may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Measurement Year as defined elsewhere in this document.
EQR	External Quality Review: The analysis and evaluation by an External Quality Review Organization (EQRO) of information on quality, timeliness and access to the healthcare services that an MCO or its contractors furnish to Medicaid members.
EQRO	External Quality Review Organization: An organization contracted with HSD to conduct reviews of the contracted Medicaid Managed Care organizations. The External Quality Review Organization also writes reports of findings and recommendations for improvement to HSD. The contracted External Quality Review Organization that developed this report is HealthInsight New Mexico.
FY	Fiscal Year: The year as defined for accounting purposes. It may or may not be concurrent with the calendar year. As of this writing, HSD Fiscal Year is July 1-June 30. This is not to be confused with Measurement Year or Contract Year, as defined elsewhere in this document.
FA	Fiscal Agent: The organization contracted with HSD to oversee Medicaid data management fiscal agent (FA), Conduent, Inc. (formerly known as Xerox).
FWA	Fraud, Waste and Abuse: The federal government monitors, investigates, and prosecutes cases of fraud, waste, or abuse against the Medicaid program as a function of the Program Integrity program.
HCBS	Home and Community-Based Services: When members transition from a nursing facility, needed medical services can be provided by various agencies in either the member's home or other settings outside of the nursing facility. These are part of the Nursing Facility Level of Care (NF LOC) review.

Term	Definition
HEDIS	Healthcare Effectiveness Data and Information Set: A tool used by the National Committee for Quality Assurance (NCQA) to measure health plan compliance with a wide array of performance measures. The results of annual HEDIS audits are published in the Quality Compass, available for purchase from NCQA.
HSD	State of New Mexico Human Services Department, Medical Assistance Division: The agency of State government responsible for administering a portfolio of programs, including Medicaid.
HRA	Health Risk Assessment: A part of the care coordination process used under Centennial Care. This is a basic assessment to determine if a member requires further assessment for care coordination needs.
IRR	Inter-rater Reliability: A metric used to determine the extent to which two or more reviewers agree on a scored item. It is an indicator of the consistency of the implementation of a rating system. It is also an indicator of the accuracy and quality of a review or review process.
LTSS	Long-term Support Services: Services provided by the contracted managed care organizations for members who need long-term care. What care is needed is determined through a series of assessments. This care may be provided in a variety of settings.
MCO	Managed Care Organizations: Organizations contracted with HSD Human Services Department to provide Medicaid Managed Care services. As of this writing (2017) the four currently contracted Medicaid Managed Care organizations are Blue Cross and Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, Inc. and United Healthcare of New Mexico, Inc.
MDS	Minimum Data Set: is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.
MHP	Molina Healthcare of New Mexico: One of the four Medicaid Managed Care organizations in New Mexico.

MY	Measurement Year: The year defined as criteria for measurement of a quality indicator or other metric. It may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Contract Year as defined elsewhere in this document.
NCQA	National Committee for Quality Assurance: An independent nonprofit organization that works to improve healthcare quality through evidence-based standards, measures, programs and accreditation. One of the assessment tools developed and used by NCQA is the Healthcare Effectiveness Data and Information Set (HEDIS).
NF LOC	Nursing Facility Level of Care: The EQRO was tasked by HSD to ensure NF LOC criteria and instructions, outlined in HSD of New Mexico Medical Assistance Program Manual Supplement Number 13-06, are being applied consistently and equitably across the New Mexico Medicaid program. Level of Care assessments are performed by MCOs to determine if the member qualifies for a specific level of care. This determination is made based on the number of Activities of Daily Living (ADLs) with which the member needs assistance.
NOD	Notice of Direction: Notices issued by HSD to HealthInsight New Mexico, outlining the areas to be reviewed and deliverables to be completed as part of external quality review audits and reviews. A separate Notice of Direction is issued for each review or review conducted.
NMAC	New Mexico Administrative Code: The official compilation of current rules filed by State agencies.
PDF	Portable Document Format File: PDF is a file format used to present and exchange documents reliably, independent of software, hardware, or operating system.
PCP	Primary Care Physician: A member's primary physician, who should serve as the member's primary point of contact with the healthcare system. Typically, a PCP is a general practice or family practice doctor or nurse practitioner.
PH	Physical Health: The process by which physical healthcare services are provided and monitored by HSD, external quality review and the managed care organizations. While administered by the same Medicaid Managed Care organizations, physical health is considered distinct from behavioral health and long-term support services.
PHP	Presbyterian Health Plan, Inc.: One of the four Medicaid Managed Care organizations in New Mexico.
PMP	Performance Measurement Program: This is a way to refer to all seven of the MCO/HSD contract-defined Performance Measures as a discrete unit since they are scored together unlike the PIPs, which are scored individually.
QM/QI	Quality Management and Quality Improvement programs.

SFY	State Fiscal Year: HSD's budget year that runs from July 1 to June 30 of the following.
TAT	Turn Around Time: The amount of time it takes to make changes and get the document returned.
UHC	United Healthcare of New Mexico, Inc.: One of the four Medicaid Managed Care organizations in New Mexico.
UM	Utilization Management: UM is the evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called utilization review.