NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

QUALITY STRATEGY

2018 Annual Evaluation and Assessment

Quality Metrics and Performance Targets

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Section I: Introduction:

CMS requirement CFR §438.340(a)
General rule. Each State contracting with a MCO must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO.

Program History

CMS requirement CFR §438.340
Include a brief history of the state's Medicaid (and CHIP, if applicable) managed care programs.

Prior to 1997, New Mexico Medicaid members received their care through a Fee-For-Service (FFS) model. The New Mexico Legislature mandated that the Human Services Department, Medical Assistance Division (HSD/MAD) implement a managed care program. A proposal was submitted under section 1915(b) of the Social Security Act to provide comprehensive medical and social services to the State's Medicaid population.

On July 1, 1997, New Mexico implemented the Salud! program, a managed care program for physical health services. The program was designed to improve quality of care and access to care while making cost-effective use of state and federal funds. During that period, approximately 65% of Medicaid eligible members were participants in Salud!.
In addition, the Medicaid safety net programs for children, including the Children's Health Insurance Program (CHIP) were combined into one program known as New Mexikids.
In 1999, HSD/MAD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a Nursing Facility.

In August 2002, A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver program utilized unspent CHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer-based buy-in insurance plan.
In 2004, the Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established as a pioneering effort in the behavioral health system transformation. The Collaborative had the authority to contract for behavioral health services and make decisions regarding the administration, direction, and management of state-funded behavioral healthcare services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral healthcare services for Medicaid recipients in Salud!.

On March 18, 2005, Governor Bill Richardson signed the State Coverage Insurance Program (SCI) into law. SCI was an innovative insurance product, combining features of Medicaid and a basic commercial health plan. Support from the federal government provided the flexibility to offer coverage to the adults most in need throughout the state.

In 2008, the Coordination of Long-Term Services (CoLTS) program was implemented as the state's first managed long-term care program for Medicaid members who met a NF LOC. This 1915 (b) (c) concurrent program covered members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, dual eligible

members and members with a qualified brain injury (BI). The program was an interagency collaboration between HSD/MAD and the New Mexico Aging and Long-Term Services Department (ALTSD). All acute, preventative, and long-term care services were provided through contracted MCOs. The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual eligibles.

Centennial Care

In 2013, of the two million citizens in the state of New Mexico, approximately 520,000 people received their healthcare through the Medicaid program. The Medicaid program operated 12 separate waivers as well as a FFS program. Seventy percent of the Medicaid enrollees were in a managed care setting. Seven different health plans administered the various delivery systems. Services were provided under an umbrella of programs for eligible individuals in more than 40 eligibility categories.

In 2014, New Mexico embarked on a new path to deliver integrated care to the Medicaid population through a Section 1115 Demonstration Waiver known as Centennial Care. The 1115 Demonstration Waiver consolidated all previous federal waivers, with the exception of the Medically Fragile Waiver (MFW), the Developmentally Disabled Waiver, and the Mi Via ICF/IID Waiver. Similarly, the MCO contracts were reduced from seven (7) to four (4).

The Section 1115 Demonstration Waiver, Centennial Care, was approved by CMS on July 12, 2013, for a 5-year period, beginning in January 2014 through December 2018. Centennial Care modernizes the Medicaid program by improving the efficiency and effectiveness of healthcare delivery; integrating physical health, behavioral health and long-term services and supports (LTSS); advancing person-centered models of care; and slowing the rate of growth in program costs. Guiding principles for Centennial Care include:

- Developing a comprehensive service delivery system;
- Increasing personal responsibility;
- Encouraging active engagement of members in their health care;
- Emphasizing payment reforms to incentivize quality versus quantity of services; and
- Maximizing opportunities to achieve administrative simplification.

In 2014, New Mexico also became an expansion state under the Affordable Care Act. The total enrollment in the Medicaid program has grown 8.5% per year since 2014 while the per capita costs have decreased by 1.5% between 2014 and 2016. Centennial Care demonstrated improved utilization of health care services and cost-effectiveness despite significant enrollment growth.

As part of the initial Centennial Care structure, HSD contracted with four MCOs to administer the full array of services in an integrated model of care. The care coordination infrastructure was an integral focus of Centennial Care and promotes a person-centered approach to care with more than 800 care coordinators ensuring members receive services in the right setting when they need

them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access Home and Community Based Services (HCBS). As a result, approximately 87% of members who meet a NF LOC are receiving services in the community.

In April 1, 2016, New Mexico launched two Health Home sites targeting individuals with serious mental illness or severe emotional disturbance. In 2018 HSD added an additional seven (7) Health Home providers increasing the number of Health Home providers to nine (9).
In addition, HSD expanded Health Home services in eight (8) counties within the state. The Medicaid program continues to see an increase in members participating in a patient centered medical home (PCMH) with over 400,000 members to date.

In December 6, 2017 New Mexico submitted the final Section 1115 Demonstration Waiver renewal application. The state identified opportunities for continued progress in transforming its Medicaid program into an integrated person-centered, value-based delivery system through the implementation of Centennial Care 2.0; therefore, building on the many successes and accomplishments achieved since the implementation of Centennial Care.

On December 18, 2018 CMS approved the state's request to extend the section 1115 Medicaid demonstration project, new entitled "Centennial Care 2.0. This approval is effective January 1, 2019 through December 31, 2023.

During 2018 two (2) MCOs exited the New Mexico Medicaid program. United Health Care terminated on August 31, 2018 and transferred its membership to Presbyterian Health Plan effective September 1, 2018. Molina Healthcare of New Mexico terminated on December 31st, 2018.

Quality Management Structure
The Quality Bureau (QB) within HSD/MAD currently consists of 14 positions plus a bureau chief. The QB is structured with three units: Care Coordination Unit (CCU); Performance Measure Unit (PMU); and the Critical Incident Unit (CIU). The CCU conducts oversight and monitoring activities related to MCO care coordination requirements. The PMU conducts oversight of MCO quality performance and improvement initiatives and manages both the External Quality Review Organization and the 1115 Demonstration evaluation activities. The CIU conducts oversight of the reporting of critical incidents by MCOs and provider monitoring to ensure the health and welfare of members for 14 categories of eligibility (COE). All units operate in accordance within applicable state and federal regulations as well as MCO contract and policy requirements.
The QB is responsible for directing the Division's Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted MCOs. The bureau oversees all aspects of performance measurement for Centennial Care including quality improvement projects, performance measures and performance evaluation and reporting. The State retains ultimate authority and accountability for ensuring the quality initiatives of Centennial Care are accomplished, although several internal and external collaborations and partnerships are utilized to address specific initiatives and/or issues. Administrative authority for

the Quality Strategy lies within the HSD's Director's Office and is delegated to the QB for development, revision, evaluation, and reporting.

Section II: State Standards:

Quality and Appropriateness of Care Standards
CMS requirement CFR §438.340(b)
Summarize the procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO contracts, and to individuals with special health care needs.

Quality Management and Quality Improvement Standards:
MCOs are required to comply with state and federal standards for quality management and quality improvement (QM/QI). HSD, through the QM/QM standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs in the development of the QM/QI Work Plan and in the Evaluation of the QM/QI program, which is submitted annually by each MCO on or before April 1st.
An integrated team from HSD's, Quality Bureau (QB), Behavioral Health Services Division (BHSD), and Centennial Care Contracts Bureau (CCCB), conduct the annual review of each MCO's QM/QI Work Plan and Evaluation to ensure the MCOs QM/QI program is based on a model of continuous quality improvement the applies clinically sound, nationally developed and accepted criteria, and implements standards that ensure the following:

- Recognize the opportunities for improvement are continual;
- Ensure the QM/QI process is data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements;
- Require re-measurement of effectiveness and continuing development and implementation of improvements as appropriate;
- Reflect member and Contract Provider input;
- Develop a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that result in continuous quality improvement;
- Review outcome data at least quarterly for performance improvement, recommendations and interventions;
- Establish a mechanism to detect under and over utilization of services;
- Have access to, and the ability to collect, manage and report to the State data necessary to support the QM/QI activities;
- Establish a committee to oversee and implement all policies and procedures;

- Ensure that the ultimate responsibility for QM/QI is with the MCO and shall not be delegated to subcontractors;
- Develop an annual QM/QI work plan to be submitted at the beginning of each year and include, at a minimum, immediate objectives for each year and long-term objectives for the entire term of the contract;

- Implement Performance Improvement Projects (PIPs) identified internally by the MCO and as directed by HSD;

- Design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and

- Submit an annual QM/QI written evaluation to HSD that includes, but is not limited
    - A description of ongoing and completed QM/QI activities;
    - Inclusion of measures that are trended to assess performance;
    - Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
    - Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
    - Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
    - Demonstration that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
    - Incorporation of annual HEDIS results in the following year's plan as applicable to HSD specific programs;
    - Communication with appropriate Contract Providers about the results of QM/QI activities and opportunities for provider to review and use this information to improve their performance, including technical assistance, corrective action plans, and follow-up activities as necessary; and
    - Upon request, present about Behavioral Health aspects of the MCOs' annual QM/QI work plan during a quarterly meeting of the Collaborative.

Utilization Management Standards:
HSD requires that the MCOs establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and promotes quality of care, adherence to standards of care, efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

- Ensure members receive services based on their current conditions and effectiveness of previous treatment;
- Ensure services are based on the history of the problem/illness, its context and desired outcomes;
- Assist members and/or their representatives in choosing among providers and available treatments and services;
- Emphasize relapse and crisis prevention, not just crisis intervention;
- Detect over and underutilization of services to assess quality and appropriateness of care furnished to members with special health care needs; and
- Accept the uniform prior authorization form for prescriptions drug benefits and respond to prior authorization request within three (3) business days.

MCO Accreditation Standards:

- The MCO shall be either (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the MCO provided Medicaid services and achieved New Mexico NCQA accreditation by 1/01/16.
- Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with the State. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

CMS requirement CFR §438.340(b)(9)

Describe the mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs. (This must include the state's definition of special health care needs.)

Care Coordination Standards:

A comprehensive care coordination model fosters the goal of ensuring that Medicaid recipients receive the right care, at the right time, and in the right place. MCOs establish levels of care coordination for members based on an assessment to determine the level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to reassess the individual and, as appropriate, make the corresponding changes in their care coordination level of support.

HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination includes:

- Assessing each member's physical, behavioral, functional and psychosocial needs;

- Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs;

- Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the beneficiary to receive services in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting;

- Identifying members with special health care needs. The state defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally;

- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and

- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

Access and Network Adequacy Standards

CMS requirement CFR §438.340(b)(1)

Define the network adequacy and availability of service standards for MCOs required by §438.68 and §438.206. Include examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.

New Mexico must ensure the delivery of all covered benefits to all Medicaid beneficiaries. Services must be delivered in a culturally competent manner and require that the MCO coordinate health care services and maintain a provider network sufficient to provide timely access to covered services for all of its members.
The MCO must have written policies and procedures that align with the Network Adequacy Standards detailed in the MCO contract and the Centennial Care policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.

The MCO must establish a mechanism to monitor adherence with Network Adequacy Standards and submits a quarterly Network Adequacy Report and Geographic Access Report as directed by HSD. HSD staff reviews and assesses the quarterly reports to ensure compliance with the following:

- Access Standards
  - Member caseload of any PCP should not exceed two-thousand (2,000)
  - Members have adequate access to specialty providers

- Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies
  - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles
  - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles
  - Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles
- Distance Requirements for Behavioral Health Providers practitioners and Specialty
  - Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles
  - Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State
  - Ninety Percent (90 %) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved ty the State
- Timeliness requirements
  - No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
  - No more than sixty (60) Calendar Days, for routine, asymptomatic member-initiated dental appointments.
  - No more than fourteen (14) calendar Days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care
  - Within twenty-four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions
  - Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
  - Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments
  - Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing
  - Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing
  - No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes
  - Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
  - Within two (2) hours for face-to-face Behavioral Health crisis services.

Provider Standards:

The MCO must have the appropriate licenses in the State to do risk-based contracting through a managed care network of health care providers. The MCO is required by the state to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.
The MCO must develop written policies and procedures that meet NCQA standards and State and federal regulations for credentialing and re-credentialing of contracted providers. The document should include but not be limited to: defining the scope of providers covered; the criteria and the primary source verification of information used to meet the criteria; the process used to make decisions that shall not be discriminatory; and the extent of delegated credentialing and re-credentialing arrangements.
MCO network providers are obligated to abide by all federal, state and local laws, rules and regulations, including but not limited to those laws, regulation, and rules applicable to providers of services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by the State.
All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.
Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their QM/QI plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers. Typically, measurements (i.e. Healthcare Effectiveness Data and Information Set [HEDIS]) are established and evaluated through MCO Quality Committees, NCQA, and HSD.

Health Disparities

CMS requirement CFR §438.340(b)(6)

Detail the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO at the time of enrollment.

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors.
HSD/MAD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for the State's Medicaid beneficiaries. Resources include, but are not limited to:

- Stratified data tracking and monitoring of targeted populations, illness or chronic conditions to identify at risk Medicaid beneficiaries;

- State directed interventions and oversight and monitoring of MCO directed interventions developed to address specific health care needs unique to Medicaid beneficiaries;

- Requiring that the MCOs maintain an adequate provider network that adheres to the State's provider participation standards;
- Establishment of a Care Coordination infrastructure to assess member needs;
- Member rewards program to encourage member engagement with preventive services and follow up care by incentivizing beneficiaries to pursue healthy behaviors;
- Peer support program to provide formalized support and practical assistance to people who have or are receiving services to help regain control over their lives in their own unique recovery process; and
- Requiring the MCO to develop a Cultural Competence and Sensitivity Plan to ensure that covered services provided to members are culturally competent and include provisions for monitoring and evaluating disparities in membership, especially as related to Native Americans.

Transition of Care Standards:
CMS requirement CFR §438.340(b)(5)
Must include a description of the State's transition of care policy.

New Mexico is committed to providing the necessary supports to assist Medicaid beneficiaries and requires the MCOs to establish policies and procedures that adhere to the standards defined by the State in the Managed Care Policy Manual and MCO contract.
The MCOs shall facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services.
The MCOs must identify and facilitate coordination of care for all members during various transitions including, but not limited to:

- From an institutional facility into the community;
- For members turning twenty-one (21) years of age;
- From higher levels of care to lower levels of care. (e.g. acute inpatient, residential treatment centers social detoxification programs, treatment foster care, etc.);
- For members changing MCOs (e.g. while hospitalized, during major organ and tissue transplantation, or while receiving outpatient treatment for significant medical conditions); and
- For members with special conditions, circumstances, treatment needs or ongoing needs such as (e.g. pregnancy, chronic illness, significant behavioral health conditions, chemotherapy, dialysis or durable medical equipment).

Monitoring and Compliance Standards:
CMS requirement CFR §438.340(b)(2)
Detail the State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program.
Centennial Care is driven by the following goals:

1. Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting;
2. Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity;
3. Slowing the growth of rate of costs, or "bending the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates; and
4. Streamlining and modernizing the Medicaid program in the State.

Centennial Care objectives include:

1. Develop a quality framework consistent with, and pertinent to all Medicaid programs;
2. Continue use of nationally recognized protocols, standards of care and benchmarks;
3. Continue use of a system of rewards for physicians, in collaboration with MCOs, based on clinical best practices and outcomes;
4. Develop collaborative strategies and initiatives with state agencies and other external partners;
5. Build upon prevention efforts and health maintenance/management to improve health status through targeted medical management;
6. Assure the effective medical management of at risk and vulnerable populations; and
7. Build capacity in rural, frontier and underserved areas.

Quality Metrics

CMS requirement CFR §438.340(b)(3)

The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported. The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required. The performance improvement projects to be implemented. Include a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO

New Mexico evaluates achievement through analysis of the quality and appropriateness of care and services delivered to members by the MCOs based on member needs and the level of contract compliance of MCOs by comprehensively monitoring MCO activities on an on-going basis. The State requires monthly, quarterly, and annual reports, including Ad Hoc reports reflective of all MCO service delivery activities. HSD reviews and assesses a variety of reports that evaluate structure, process, and outcomes, always with a focus on access, quality and timeliness of services provided by the MCOs. These reports include but not limited to the following:

- Member Satisfaction Survey
- Provider Satisfaction Survey
- Secret Shopper Survey

- MCO Call Center Reports
- Grievance & Appeals Reports
- Care Coordination Reports
- Network Adequacy Reports
- Geo Access Reports
- Utilization Reports
- Pharmacy Reports
- Ad Hoc Reports
- External Quality Review Organization Reports.
- Primary Care Physician to member ratio reports

Performance Measures
New Mexico will focus on eight (8) Performance Measures (PMs) and associated performance targets under Centennial Care and incorporated into each MCO's QM/QI program. PMs and associated targets follow HEDIS methodology, are reasonable, and based on industry standards. Failure to meet the HSD established targets is associated with a monetary penalty. The Centennial Care PMs include the following:

- PM #1 Annual dental visits;
- PM #2 Use of appropriate medications for people with asthma;
- PM #3 Controlling high blood pressure;
- PM #4 Comprehensive diabetes care;
- PM #5 Prenatal and postpartum care;
- PM #6 Frequency of ongoing prenatal care;
- PM #7 Antidepressant medication management; and
- PM #8 Follow-up after hospitalization for mental illness.

Tracking Measures
New Mexico directed the MCOs to report on Tracking Measures (TMs) focus on specific target populations to monitor and implement interventions for improvement, if needed. The TMs are based on HEDIS, CMS Adult Core Set or HSD defined technical specifications. TMs for Centennial Care are detailed below:

2014
TM #1 Fall Risk Management

2015
TM #1 Fall Risk Management
TM #2 Diabetes Short-Term Complications Admission Rate
TM #3 Screening for Clinical Depression and Follow-Up Plan

2016
TM #1 Fall Risk Management
TM #2 Diabetes Short-Term Complications Admission Rate
TM #3 Screening for Clinical Depression and Follow-Up Plan

TM #4 Well-Child Visits in the First 15 Months of Life
TM #5 Children and Adolescents' Access to Primary Care Practitioner
TM #6 Long Acting Reversible Contraceptive (LARC)
TM #7 Smoking Cessation

2017-2018
TM #1 Fall Risk Management
TM #2 Diabetes Short-Term Complications Admission Rate
TM #3 Screening for Clinical Depression and Follow-Up Plan
TM #4 Well-Child Visits in the First 15 Months of Life
TM #5 Children and Adolescents' Access to Primary Care Practitioner
TM #6 Long Acting Reversible Contraceptive (LARC)
TM #7 Smoking Cessation

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
New Mexico incorporates the CAHPS 5.0H Survey required by NCQA for accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state specific questions and provides information on New Mexico's Medicaid beneficiaries and their experiences with the services provided. HSD included NCQA approved state specific questions in 2014 for both the Child and Adult CAHPS Survey, and continue to incorporate the following questions into the annual CAHPS survey:

Children and Children with Chronic Conditions

- In the last 6 months, did anyone from your child's health plan, Doctor's office, or clinic help coordinate your child's care among these doctors or other health providers?
- In the Las 6 months, who helped to coordinate you child's Care?
    - Someone from your child's health plan
    - Someone from your child's doctor's office or clinic
    - Someone from another organization
    - A friend or family member
    - You
- How Satisfied are you with the help you received to coordinate your child's care in the last 6 months?

Adult

- In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?
- In the last 6 months who helped to coordinate your care.
    - Someone from your health plan
    - Someone from your doctor's office or clinic
    - Someone from another organization
    - A friend or family member
    - You
- How satisfied are you with the help you received to coordinate your care in the last 6 months?

- In the last 6 months, have you received any material form your health plan about care coordination and how to contact the care coordination unit?
- Did your care coordinator sit down with you and create a plan of care?
- Are you satisfied that your care plan talks about the help you need to stay health and remain in your home?
- In the last 6 months did you talk with your doctor or other health provider about falling or problems with balance or walking?
- Did you fall in the past 6 months?
- In the past 6 months, have you had a problem with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

Performance Improvement Projects

New Mexico identifies Performance Improvement Projects (PIPs) by assessing gaps in care with a focus on applying sustainable interventions that will improve the access, quality, or timeliness of care and services provided to the State's Medicaid Beneficiaries. Under Centennial Care HSD required the MCOs to develop PIPs in specified services areas. The following are PIPs incorporated into the MCO contracts by year:

2014
MCOs were directed to implement four (4) one PIP for each service area listed below
Long-Term Care Services
Services to Children
Behavioral Health
Women's health

2014-2018
The MCO contract was amended in October 2014 directing the MCOs to implement four (4) PIPs as listed below:
Long-Term Care Services
Services to children
PIPs as required by the Adult Medicaid Quality Grant,

- Diabetes Prevention and Management
- Screening and Management of Clinical Depression

Sanctions
CMS requirement CFR §438.340(b)(7)
Detail the appropriate use of the intermediate sanctions for MCOs.

New Mexico has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD may impose sanctions.
HSD has the option to apply Corrective Action Plans (CAPs) if determined that the MCO is not in compliance with one or more requirements. HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a CAP or

an HSD Directed Corrective Action Plan (DCAP). A notice from HSD of noncompliance that directs a CAP or DCAP may also serve as a notice of sanction in the event HSD determines that sanctions are also necessary.

HSD may impose any or all of the non-monetary sanctions and monetary penalties to the extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

- Suspension of auto-assignment of members in a MCO;
- Suspension of enrollment in the MCO;
- Notification to members of their right to terminate enrollment with the MCO without cause;
- Disenrollment of members by HSD;
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- Rescission of Marketing consent and suspension of the MCO's marketing efforts;
- Appointment of temporary management on any portion thereof for a MCO and the MCO shall pay for any costs associated with the imposition of temporary management; and
- Additional sanctions permitted under federal or state stature or regulations that address areas of noncompliance.

The State has established monetary penalties that may include:

- Actual damages incurred by HSD and/or members resulting from the MCO's non-performance of obligations;
- Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a member in the event of the MCO's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the capitated rates that would have been paid to the MCO and the rates paid to the replacement health plan. HSD may withhold payment to the MCO for damages until such damages are paid in full;
- Civil monetary penalties;
- Monetary penalties up to five percent (5%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed;
- HSD reserves the right to assess a general monetary penalty of five hundred dollars ($500) per occurrence with any notice of deficiency; and
- Other monetary penalties for failure to perform specific responsibilities or requirements.

PROGRAM ISSUES	**PENALTY**
Failure to comply with Claims processing as described in Section 4.19 of the Managed Care contract	Two percent (2%) of the monthly capitation payment per month, for each month that the HSD determines that the MCO is not in compliance with the requirements of Section 4.19 of the Managed Care contract

Failure to comply with Encounter submission as described in Section 4.19 of the Managed Care contract	Monetary penalties up to two percent (2%) of the MCO's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3	$1,000 per member where the MCO fails to comply with the timeframes for that member.
Failure to complete or comply with CAPs/DCAPs	0.12% of the monthly capitation payment per calendar day for each day the CAP/DCAP is not completed or complied with as required.
Failure to obtain approval of member Materials as required by Section 4.14.1 of the Managed Care contract	$5,000 per day for each calendar day that HSD determines the MCO has provided member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the Managed Care contract	$1,000 per occurrence where the MCO fails to comply with the timeframes.
For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of the Managed Care contract	$5,000 per report, per occurrence With the exception of the cure period: $1,000 per report, per calendar day. The $1,000 per day damage amounts will double every ten (10) calendar days.
Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the Managed Care contract	$1,000 per occurrence.
Failure to have legal counsel appear in accordance with Section 4.16 of the Managed Care contract	$10,000 per occurrence.
Failure to meet targets for the performance measures described in Section 4.12.8 of the Managed Care contract	A monetary penalty based on two percent (2%) of the total capitation paid to the MCO for the contract/agreement year, divided by the number of performance measures specified in the contract/agreement year.

HSD can modify and assess any monetary penalty if the MCO engages in a pattern of behavior that constitutes a violation of this contract/agreement or, involves a significant risk of harm to members or to the integrity of Centennial Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete care coordination activities by the timeframes specified; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the MCO up to three times and the report still meets the definition of "Failure to Report" in accordance with Section 4.21 of the contract; etc.	Monetary penalties up to five percent (5.0%) of the MCO's Medicaid capitation payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.

Below is a total of HSD imposed and collected monetary penalties from 2014 through 2018:

- 2014: $8,552,459.08
- 2015: $15,649,707.00 (Note: $325,000.00 of the reported total was not recouped as the MCO was directed to pay this amount directly to a provider. Also, $1,204,618.00 of the total reported was recouped for a partial Delivery System Improvement Project (DSIP) penalty.)
- 2016: $9,608,519.84
- 2017: $8,739,049.93
- 2018: $10,424,030.70

Section III: Development, Evaluation and Revision of the Quality Strategy:

Development

CMS requirement CFR §438.340(c)

(This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.)

CMS requirement CFR §438.340(c)(1)

Include a description of how the state made (or plans to make) the Quality Strategy available for public comment.

CMS requirement CFR §438.340(c)(1)(i)

Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input from the Medical Advisory Committee, beneficiaries and other stakeholders in the development of the quality strategy.

CMS requirement CFR §438.340(c)(1)(ii)

Include a description of how the state obtained the input of the Native American Advisory Committee in accordance with the State's Tribal consultation policy.

HSD retains the ultimate authority, management, direction and oversight of the Quality Strategy and has organized a Quality Strategy work group within the QB that is responsible for the development, evaluation, and revision of the Quality Strategy.

The work group's focus was to develop the Quality Strategy in alignment with the goals and objectives identified by HSD to provide the right amount of care, delivered at the right time, and in the right setting to all Medicaid beneficiaries. HSD believes that by driving improvements in quality, many of the goals of Centennial Care are accomplished.

New Mexico's Quality Strategy is a coordinated, comprehensive, and pro-active approach to drive quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The Quality Strategy was designed to ensure that services provided to the States Medicaid beneficiaries meet or exceed the established standards for access to care, clinical quality of care and quality of services to achieve the delivery of high-quality and high value healthcare.

The key traits of high-quality, high value healthcare include:

- Effectiveness that concentrates on the appropriateness of care (care that is indicated, given the clinical condition of the member);
- Efficient and coordinated care over time that addresses the underlying variation in resource utilization, overuse, misuse, and duplication in the system and the associated costs. The system should be safe for all members, in all processes, in all programs, at all times;
- Member-Centered to encompass respect for members' values, preferences, and expressed needs; coordination and integration of care; information, communication and involvement of family and friends;
- Timeliness to address access issues with the underlying principle that care be provided in a timely manner;
- Equality of appropriate care that is based on an individual's needs, not on personal characteristics that are unrelated to the member's condition or to the reason for seeking care, such as gender, race, geographical location, disability, or insurance status; and
- Prevention and early detection to provide treatment early in the causal chain of disease, with resulting slower disease progression and to reduce the need for long-term care.

HSD developed the Quality Strategy with input from the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers, including Native American Advisory Boards (NAAB) and the Native American Technical Advisory Committee (NATAC). The MAC serves as an advisory body to the Secretary of the Human Services Department and the Medical Assistance Division Director on policy development and program administration for the Medicaid services provided to New Mexicans. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, and public health entities concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

HSD/MAD solicited input and recommendations regarding content and direction of the Quality Strategy from a variety of sources including;

- Medicaid beneficiaries
- The public
- Stakeholders
- Managed Care Organizations
- EQRO
- Behavioral Health Collaborative

The Quality Strategy was published on the New Mexico Human Services Department website for approximately 5 weeks prior to finalizing the document to allow all interested parties to provide feedback and public comment. The comments and feedback provided were considered and/or incorporated into the Quality Strategy as deemed applicable to the goals and objectives established by HSD.

Evaluation

CMS requirement CFR §438.340(c)(2)

Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).

CMS requirement CFR §438.340(c)(2)(i)

Review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.

HSD will continue to utilize a CQI model to evaluate and assess the effectiveness of the Quality Strategy. HSD will review the Quality Strategy annually to ensure alignment with reported outcomes from EQR technical reporting, MCO audited HEDIS reports, CAHPS survey, 1115 waiver evaluation design plan and CMS Special Terms and Conditions (STCs), reported findings from HSD internal audits and State required MCO reports, including QM/QI programs. The outcomes will be utilized to gauge effectiveness of the Quality Strategy and to determine if any necessary changes or updates to the Quality Strategy are warranted.

CMS requirement CFR §438.340(c)(2)(iii)

Updates to the quality strategy must take into consideration the recommendations for improving the quality of health care service furnished by the MCO including how the State can target goals and objectives in the quality strategy to better support improvement in the quality timeliness and access to health care services furnished to Medicaid beneficiaries. Include a timeline for modifying or updating the Quality Strategy. (If this is based on an assessment of “significant changes”).

CMS requirement CFR §438.340(c)(3)(ii)

Submit to CMS a copy of the revised quality strategy whenever significant changes are made to the document, or whenever significant changes occur within the State’s Medicaid Program.

CMS requirement CFR §438.340(c)(2)(ii)

The State must make the results of the review available on the Website.

HSD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed in September 2017 and revised to address the program outcomes through

calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modifications to the Quality Strategy. With the approval from CMS of the 1115 Demonstration Waiver renewal, HSD will revise the Quality Strategy to include additional goals, objectives, and outcome measures for Centennial Care 2.0.

All aspects of the Quality Strategy will be assessed for effectiveness to determine areas of needed improvement. The review will include an evaluation of improvements implemented from the previous year's assessment and address any significant changes made to the Quality Strategy as a result of the assessment. The State defines significant change as changes that materially affect the actual quality of information collected or analyzed. Minor changes in timeframes, reporting dates, or format are not considered significant changes. With Centennial Care 2.0 the performance measures will focus on areas that show improved member outcome with the right care at the right time and the right place as well as the integration of physical, behavioral, and long-term services and supports. The State will submit a final draft of the Quality Strategy to (CMS) for comment and feedback.

Any updates to the Quality Strategy based on "significant changes" shall be developed, reviewed, and submitted to CMS for review and feedback and will be posted on the HSD website once approved.

Section IV: Assessment

CMS requirement CFR §438.340(b)(8)

Describe how the State will assess the performance and quality outcomes achieved by each MCO.

Quality Metrics

CMS requirement CFR §438.340(b)(3)

The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported. The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required. The performance improvement projects to be implemented. Include a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO

HSD defined specific Performance Measures (PMs) and targets, Performance Improvement Projects (PIPs), quality metrics for Tracking Measures (TMs), and performance targets to ensure access, quality, or timeliness of care for all Medicaid beneficiaries. The QB monitors, analyzes, trends and provides feedback and technical assistance to the MCOs to improve access, quality, and timeliness of care to all Medicaid beneficiaries.

HSD QB and the contracted MCOs have formed a Quality Workgroup which meets quarterly to discuss quality outcomes and performance. The group was established to promote a collaboration of those responsible for ensuring quality of care and improved outcomes. The Workgroup provides an arena for discussion on gaps in care, interventions, barriers, and best practices. QB is also able to provide feedback on performance, direction and technical assistance in a group setting which encourages the collaborative effort. The group focuses on the key quality metrics defined by the State to assess performance and encourage positive outcomes.

HSD selects PMs and PIPS utilizing data that identifies the strengths and opportunities for improvement specific to the Medicaid population. PMs, PIPs and performance targets are

reasonable and based on industry standards and consistent with CMS EQR Protocols. An annual review of PMs and PIPs is conducted by the EQRO and the final technical report with findings and recommendations are posted on the HSD website.

2018 Quality Metric and Performance Measure Assessment:

Performance Measures

HSD directed the MCOs to focus on eight (8) clinical initiatives to drive improved quality outcomes from 2014 through 2018. In 2017 HSD removed PM #6, Frequency of ongoing prenatal care due to NCQA retiring the HEDIS measure and was not reported in 2018.

HSD reviewed and analyzed the MCO annual HEDIS report to assess and report performance measure outcomes. The MCO aggregated rates are reported to internal and external stakeholders to assess the effectiveness of the annual PMs in improving member outcomes. The information below provides a summary of PM rates for 2018 as compared to previous years.

PM #1 Annual Dental Visits-In CY18 there was a 1.63 percentage point improvement from CY17. This is consistent with the year over year average of +1.98 percentage point increase.

PM #2 Use of Appropriate Medication for People with Asthma. In CY18 there was a .57 percentage point increase from CY17. This is below the year over year average since CY14 of +3.20 percentage point increase but is still trending upwards.

PM #3 Controlling High Blood Pressure-In CY18 there was an increase of .57 percentage point increase from CY17. This is on trend with year over year average since CY14 of +.95 percentage point increase.

PM #4 Comprehensive Diabetes Care-

- HbA1C testing-In CY18 there was a .85 percentage point decrease from CY17. This is slightly below the year over year average since CY14 of –.05 percentage point decrease.
- HbA1C >9percentage-In CY there was a slight decrease of -.08 percentage point from CY17. This is on trend with year over year average since CY14 of +.27 percentage point increase.
- Retinal Eye Exam-In CY18 there was a 1.88 percentage point increase from CY17. This is an increase from year over year average of +0.39 percentage point increase.
- Nephropathy Screening-In CY18 there was a slight increase of +.07 percentage point from CY17. This is below the year over year since CY14 of +2.15 percentage point increase.

PM #5 Prenatal/Postpartum Visits-

- Prenatal visits within first trimester or within 42 days of enrollment-In CY18 there was a rate increase of +3.59 percentage point increase from CY17. This is an improvement from year over year average since CY14 of +0.91 percentage point increase.
- Postpartum visit on or before 21 & 56 days after delivery-In CY18 there was a 4.84 percentage point increase from CY17. This is an improvement from year over year average since CY14 of +1.80 percentage point increase.

PM #6 Frequency of on-going prenatal care-*This measure was retired by NCQA in CY17*
PM #7 Antidepressant Medication Management

- Acute Phase 84 days-In CY18 there was a 2.25 percentage point increase from CY17. This is an improvement from the year over year average since CY14 of -1.17 percentage point decrease.
- Continuous Phase 180 days-In CY18 there was a .69 percentage point increase from CY17. This is an improvement from year over year average since CY14 of -1.80 percentage point decrease.

PM #8 Follow up after hospitalization for Mental illness

- 7 days-In CY18 there was a 9.40 percentage point decrease from CY17. This is below the year over year average since CY14 of -3.79 percentage point decrease.
- 30 days- In CY18 there was a 14.98 percentage decrease from CY17. This is well below the year over year average of 4.68 percentage point decrease.
- decrease.

Table 1: Performance Measures 2014-2018

Performance Measures	**2014**	**2015**	**2016**	**2017**	**2018**
PM #1 Annual Dental Visits	64.00%	66.01%	67.60%	70.27%	71.90%
PM #2 Use of Appropriate Medication for People with Asthma	46.29%	52.22%	53.50%	56.01%	59.79%
PM #3 Controlling High Blood Pressure	52.56%	53.68%	54.25%	49.88%	50.45%
PM #4 Comprehensive Diabetes Care					
HbA1C testing	85.01%	84.12%	83.54%	85.74%	84.89%
HbA1C >9%	47.24%	49.80%	47.65%	48.40%	48.32%
Retinal Eye Exam	55.03%	51.76%	55.43%	54.69%	56.57%
Nephropathy Screening	79.06%	87.30%	88.71%	87.59%	87.66%
PM #5 Prenatal/Postpartum Visits					
Prenatal visits within first trimester or within 42 days of enrollment	73.00%	70.66%	76.75%	73.05%	76.64%
Postpartum visit on or before 21 & 56 days after delivery	54.82%	51.16%	57.83%	57.21%	62.05%
PM #6 Frequency of on-going prenatal care	52.09%	45.95%	55.81%	*	*
PM #7 Antidepressant Medication Management					
Acute Phase 84 days	55.61%	53.14%	50.37%	48.67%	50.92%

Continuous Phase 180 days	41.12%	37.77%	34.87%	33.21%	33.90%
PM #8 Follow-Up After Hospitalization for Mental illness					
7 days	43.81%	37.58%	41.15%	38.04%	28.64%
30 days	65.35%	60.86%	63.81%	61.60%	46.62%

*NCQA retired Measure

Tracking Measures Assessment

HSD/MAD directed the MCOs to report on tracking measures (TMs) that focus on a specific target population or service area. TMs are areas for the MCOs to evaluate and make improvements, if necessary. The MCOs are required to submit quarterly reports to HSD using the QB developed reporting template which applies HEDIS, CMS Adult Core Set, or HSD defined technical specifications.
The QB team reviews and analyzes the report to identify performance trends, best practices, gaps in care and MCO interventions and strategies applied to improve member outcomes. HSD reports MCO aggregated TM results to internal and external stakeholders.

From 2014 through 2017 the MCO were required to report on three 3 (three) TMs:

- TM #1 Fall-Risk Management
- TM #2 Diabetes Short-Term Complications Admission Rate
- TM #3 Screening for Clinical Depression and Follow up Plan.

In 2016 HSD added four (4) TMs to the list above the MCOs were required to report on a total of seven (7) TM from 2016 through 2018:

- TM #4 Well Child Visits in the First 15 months of life
- TM #5 Children and Adolescents' Access to Primary Care Practitioners
- TM #6 Long Acting Reversible Contraceptive (LARC)
- TM #7 Smoking Cessation.

The information below provides a summary of TM outcomes for 2018 as compared to previous years.

TM#1: Fall Risk Management- 2018 reports the same percentage (13%) as 2017 and a higher percentage compared to the years prior to 2017, which is an improvement. MCOs attribute the improvement to member education and fall risk assessment of members' homes.

TM#2: Diabetes, Short-Term Complications Admission Rate

- (18 to 64 years of age) – 2018 reports the lowest rate per 100,000 member months compared to the previous four years, which is an improvement. MCOs attribute the improvement in member health education events and mailings to members with a gap in care.

- (64+ years of age) – 2018 reports a higher rate per 100,000 member months compared to 2017, which is not an improvement, but a lower rate than the years prior to 2017, which is an improvement form 2014, 2015, and 2016. MCOs attribute the improvement to the alignment of members' disease management goals with evidence-based practices of the American Association of Clinical Endocrinologists and improving medication management adherence.

TM#3: Screening for Clinical Depression and Follow-up Plan

- (18 to 64 years of age) – 2018 reports the highest percentage (0.39%) compared to the four previous years, which is an improvement. MCOs attribute the improvements to member outreach and provider education, including provider adoption of CPT reporting codes.
- (65+ years of age) – 2018 reports the highest percentage (0.63%) compared to the four previous years, which is an improvement. MCOs attribute the improvement to providing education regarding use of depression screening and appropriate treatment and diagnosis.

TM#4: Well-Child Visits in the first 15 Months of Life -2018 reports the lowest rate compared to the two previous years, which not an improvement. Interventions to improve this measure, MCOs are providing post-deliver outreach to mothers and assisting those with barriers to accessing care via member advocate teams.

TM#5: Children and Adolescents' Access to Primary Care Practitioners – 2018 reports a 2 percent increase from 2017, which is an improvement. MCOs attribute the improvement to educating members on the importance of well-child visits and assisting members when barriers to receiving care are identified.

TM#6: Long Acting Reversible Contraceptive (LARC) – 2017 and 2018 numbers have remained consistent.

TM #7: Smoking Cessation –2018 reports increases for the number of unduplicated members utilizing products/services, the number of products and counseling services (units) utilized, and the dollar amount for smoking and tobacco cessation products/services, which indicates more members are utilizing tobacco cessation products and services. The MCOs attribute the increase to removal of prior authorization requirements as well as member education and referrals.

Table 2: Tracking Measures 2014-2018

Tracking Measure	Description of Target Population or Topic	2014	2015	2016	2017	2018

Fall Risk Management	The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months and who received fall risk intervention from their current practitioner.	12%	8%	12%	13%	13%
Diabetes, Short-Term Complications Admission Rate (per 100,000 member months)	The number of inpatient admissions with a principal diagnosis code for diabetes short-term complications.					
	18 to 64 years of age	22	17	19\	14	12
	65 + years of age	88	95	66	17	48
Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.					
	18 to 64 years of age	0.2%	0.09%	0.12%	0.23%	0.39%
	65 + years of age	0.04%	0.24%	0.26%	0.32%	0.63%
Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP	*NR		58%	61%	57%

	during their first 15 months of life.				
Children and Adolescents' Access to Primary Care Practitioners (PCP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP.	*NR	59%	57%	59%
Immunizations for Adolescents 13 years of age	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life.	*NR	*NR	*NR	*NR
Long Acting Reversible Contraceptive (LARC)	The use of LARC among members 15 to 19 years of age.	*NR	3,110 (# of members)	2,831 (# of members)	2,854 (# of members)
Smoking Cessation	The monitoring of unduplicated members utilizing products/services	*NR	7,616	8,199	9,440
	The monitoring of the number of products and counseling services (units) utilized		302,332	359,607	431,189
	The monitoring of smoking cessations products: Cost utilization		$1,146,227	$1,394,130	$1,837,305

*NR - Measure was not required by contract to be reported as a TM for that timeframe.

Child and Adult Core Set Quality Measures

HSD reports on CMS determined Child Core Set and Adult Core Set Quality Measures through the Medicaid and CHIP Program (MACPro) systems data entry portal. The CMS defined Core Set of Quality Measures provides New Mexico with a nationally recognized set of core quality measures to track performance and identify areas needing improvement. Reporting on these performance measures will assist HSD to further enhance the quality of health care for both Children and Adults within the state's Medicaid program.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSD incorporates the CAHPS 5.0H survey required by NCQA for MCO accreditations a part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state-specific questions, which currently focus on the members satisfaction with Fall Risk assessment and management for the Adult population and satisfaction with the care coordination services received from the MCOs for both Child and Adult populations. The CAHPS survey provides information on New Mexico's Medicaid members and their experiences with the services provided.

The data below provides a MCO specific summary of state supplemental questions and results for 2018 Children/Children with Chronic Conditions and Adult survey responses as compared to previous years.

1. Child's care coordination among doctors or other health providers has increased from 2017 to 2018 for both BCBS and PHP, while CCC's care coordination among doctors or other health remained the same from 2017 to 2018.
2. Help to coordinate care for children and CCC has most often been provided by the member and someone from the member's child's doctor's office or clinic from 2014 to 2018.
3. Satisfaction with help received to coordinate child's care has decreased for PHP but stayed the same for BCBS from 2017 to 2018. For the CCC population, satisfaction with help received for care coordination showed large increases from 2017 to 2018 for BCBS and PHP.
4. Help from adults' health plan, doctor's office, or clinic to coordinate care among doctors or other health providers shows an increase for PHP from 2017 to 2018, while BCBS remained the same.
5. Help to coordinate care for adults has most often been provided by the member and someone from the member's doctor's office or clinic from 2014 to 2018.
6. Satisfaction with help received to coordinate adults' care shows a decrease for PHP from 2017 to 2018, while BCBS remained the same.
7. From 2017 to 2018, PHP showed an increase while BCBS showed a decrease in the adults' receipt of material from their health plan about good health and how to stay healthy.
8. In the adults' receipt of care coordination material and how to contact the care coordination unit BCBS showed a decrease while PHP showed an increase from 2017 to 2018.
9. Both BCBS and PHP showed decreases from 2017 to 2018 regarding if their care coordinator sat down with them to create a Plan of Care.
10. Satisfaction with the adults' care plan talks about the help they need to stay healthy and remain in their home showed an increase for BCBS and a decrease for PHP from 2017 to 2018.

11. Adults who talked with their doctor or other health provider about falling or problems with balance or walking increased from 2017 to 2018 for BCBS but decreased for PHP.
12. Adults who fell in the last six months increased from 2017 to 2018 for BCBS and PHP.
13. Adults who had a problem with balance or walking increased from 2017 to 2018 for BCBS but decreased for PHP.
14. Adults whose doctor or other health provider did anything to help prevent falls or treat problems with balance or walking decreased for BCBS and PHP from 2017 to 2018.

Table 3: CAHPS State Specific Questions 2014-2018

CAHPS Supplemental Questions	Year	BCBS		MHC		PHP		UHC	
Child/Children with Chronic Conditions Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2014	27%	39% CCC	24%	44% CCC	24%	44% CCC	*ND	*ND
	2015	24%	37% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
	2016	25%	37% CCC	22%	40% CCC	20%	38% CCC	31%	44% CCC
	2017	23%	40% CCC	22%	39% CCC	24%	42% CCC	29%	41% CCC
	2018	25%	40% CCC	N/A	N/A	25%	42% CCC	N/A	N/A
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2014	4%	8% CCC	13%	14% CCC	4%	9% CCC	*ND	*ND
	2015	5%	7% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
	2016	6%	7% CCC	3%	7% CCC	14%	19% CCC	5%	8% CCC
	2017	5%	7% CCC	4%	4% CCC	21%	23% CCC	11%	12% CCC
	2018	5%	6% CCC	N/A	N/A	3%	7% CCC	N/A	N/A

Someone from your child's doctor's office or clinic	2014	19%	22% CCC	55%	48% CCC	48%	50% CCC	*ND	*ND
	2015	20%	26% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
	2016	20%	23% CCC	23%	29% CCC	46%	54% CCC	22%	23% CCC
	2017	25%	28% CCC	20%	30% CCC	52%	53% CCC	43%	44% CCC
	2018	24%	28% CCC	N/A	N/A	22%	28% CCC	N/A	N/A
Someone from another organization	2014	1%	4% CCC	6%	10% CCC	6%	7% CCC	*ND	*ND
	2015	2%	5% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
	2016	3%	5% CCC	2%	7% CCC	6%	8% CCC	2%	5% CCC
	2017	3%	5% CCC	3%	5% CCC	5%	4% CCC	1%	9% CCC
	2018	2%	7% CCC	N/A	N/A	3%	5% CCC	N/A	N/A
A friend or family member	2014	5%	6% CCC	1%	1% CCC	3%	3% CCC	*ND	*ND
	2015	5%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
	2016	6%	3% CCC	5%	3% CCC	2%	1% CCC	6%	5% CCC
	2017	6%	4% CCC	5%	3% CCC	0%	1% CCC	7%	4% CCC
	2018	4%	2% CCC	N/A	N/A	5%	6% CCC	N/A	N/A
You	2014	71%	60% CCC	25%	27% CCC	39%	31% CCC	*ND	*ND
	2015	68%	57% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
	2016	65%	61% CCC	67%	54% CCC	32%	19% CCC	65%	59% CCC
	2017	62%	56% CCC	69%	59% CCC	23%	20% CCC	38%	31% CCC
	2018	65%	57% CCC	N/A	N/A	67%	55% CCC	N/A	N/A

3. How satisfied are you with the help you got to coordinate your child's care in the last 6 months? (Satisfied or Very Satisfied)	2014	81%	74% CCC	86%	87% CCC	91%	88% CCC	*ND	*ND
	2015	77%	73% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
	2016	75%	72% CCC	85%	84% CCC	96%	93% CCC	82%	81% CCC
	2017	76%	61% CCC	85%	54% CCC	94%	19% CCC	95%	59% CCC
	2018	76%	73% CCC	N/A	N/A	86%	85% CCC	N/A	N/A
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2014	33%		24%		27%		*ND	
	2015	38%		30%		29%		37%	
	2016	35%		26%		29%		32%	
	2017	37%		33%		31%		29%	
	2018	37%		N/A		35%		N/A	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2014	9%		19%		17%		*ND	
	2015	14%		12%		34%		12%	
	2016	14%		17%		27%		18%	
	2017	11%		9%		31%		18%	
	2018	11%		N/A		12%		N/A	
Someone from your doctor's office or clinic	2014	25%		48%		47%		*ND	
	2015	26%		23%		48%		21%	
	2016	24%		50%		47%		24%	
	2017	24%		25%		43%		51%	
	2018	32%		N/A		27%		N/A	
Someone from another organization	2014	2%		3%		4%		*ND	
	2015	4%		1%		1%		5%	

	2016	2%	4%	2%	2%
	2017	3%	1%	4%	6%
	2018	3%	N/A	2%	N/A
A friend or family member	2014	14%	15%	13%	*ND
	2015	14%	11%	8%	23%
	2016	14%	4%	12%	5%
	2017	17%	14%	10%	10%
	2018	15%	N/A	17%	N/A
You	2014	50%	16%	19%	*ND
	2015	43%	53%	9%	39%
	2016	46%	29%	12%	51%
	2017	45%	51%	13%	15%
	2018	40%	N/A	42%	N/A
6. How satisfied are you with the help you received to coordinate your care in the last 6 months? (Satisfied or Very Satisfied)	2014	80%	87%	88%	*ND
	2015	74%	81%	94%	79%
	2016	73%	70%	87%	81%
	2017	72%	78%	86%	76%
	2018	72%	N/A	73%	N/A
Member Education					
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)	2014	58%	59%	62%	*ND
	2015	73%	57%	63%	67%
	2016	61%	55%	58%	60%
	2017	67%	56%	55%	59%
	2018	63%	N/A	56%	N/A

8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)	2014	50%	48%	50%	*ND
	2015	60%	54%	51%	59%
	2016	58%	39%	51%	48%
	2017	60%	44%	51%	53%
	2018	52%	N/A	52%	N/A
Care Plan					
9. Did your care coordinator sit down with you and create a Plan of Care? (% answering Yes)	2014	24%	24%	64%	*ND
	2015	28%	25%	54%	35%
	2016	33%	32%	59%	33%
	2017	31%	22%	64%	29%
	2018	27%	N/A	33%	N/A
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home? (% answering Satisfied or Very Satisfied)	2014	70%	71%	*ND	*ND
	2015	70%	83%	84%	71%
	2016	73%	72%	89%	71%
	2017	68%	67%	82%	71%
	2018	69%	N/A	71%	N/A
Fall Risk					
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did	2014	22% (12 mo.)	18%	22%	*ND
	2015	23% (12 mo.)	17%	57%	29%

you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)	2016	22%	19%	72%	27%
	2017	26%	24%	67%	25%
	2018	29%	N/A	65%	N/A
12. Did you Fall in the past 6 months? (% answering Yes)	2014	19%	18%	17%	*ND
	2015	21%	15%	52%	25%
	2016	18%	14%	46%	26%
	2017	17%	18%	42%	20%
	2018	21%	N/A	44%	N/A
13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)	2014	27%	24%	25%	*ND
	2015	26%	20%	21%	40%
	2016	29%	25%	30%	38%
	2017	29%	30%	31%	36%
	2018	30%	N/A	29%	N/A
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)	2014	23%	23%	26%	*ND
	2015	26%	21%	58%	38%
	2016	27%	22%	63%	35%
	2017	39%	36%	66%	30%
	2018	37%	N/A	63%	N/A

Performance Improvement Projects 2014 through 2018

In 2014 the MCO were directed to implement four (4) PIPS in the following service areas:

- One (1) Long Term Care
- One (1) Services to Children
- One (1) Behavioral Health
- One (1) Women's Health

In October of 2014 HSD amended the MCO contract and directed to implement four (4) PIPs in the following areas:

- One (1) Long Term Care

- One (1) Services to Children
- Two (2) State Specific PIPs that align with the initiatives from the Adult Medicaid Quality Grant:
    - Diabetes Prevention and Management to include the following two (2) state directed measurement indicators:
        - Diabetes Short-Term Complications Admissions
        - HbA1c testing
    - Screening and Management for Clinical Depression to include the following two (2) state directed measurement indicators:
        - Screening for Clinical Depression
        - Follow-up plan for members screening positive

HSD directed the MCOs to implement PIPs for the above-mentioned services areas from 2015 through 2018. The information below provides a summary of MCO interventions and measurement indicator rates for each of the PIPs from 2014 through 2018.

PIP #1- Children's Services

- BCBS- Annual Dental Visit:
    - Measurement indicators: 2% year-over-year increase equaling or greater than 63.02% indicator for Annual Dental Visits.
    - Interventions: *It's Time for a Dental Checkup* postcard; Campaign Manager script and member benefit and guidance; CareNet telephonic outreach.
- MHC- Body Mass Index
    - Measurement indicators: 10% yearly increase for all three indicators BMI Percentile Documentation, Counseling for Nutrition, Counseling for Physical Activity BMI Percentile Documentation, Counseling for Nutrition, and Counseling for Physical Activity.
    - Interventions: Identification of high-volume pediatric providers, Provider Engagement Team Visits, and Molina Provider.

- PHP- Adolescent Well-Child Visits
    - Measurement indicators: 2% increase for both indicators HEDIS Adolescent Well-Care Visit and Percentage of members who qualify for the inclusion the HEDIS Adolescent Well-Care Visit denominator, and 2% increase of the HEDIS Adolescent Well-Care Visit.
    - Interventions: Telephonic Outreach, and distribution of Provider scorecards.

- UHC- Annual Dental Visit
    - Measurement indicators: 2% increase annually for Annual Dental Visits
    - Interventions: Care Coordinator education on dental benefits, member. information on dental visit enrollment, and Centennial Rewards program.

PIP #2- Long-term services and supports

- BCBS- LTSS and Diabetic Eye Exams
    - Measurement indicators: 2 percentage point year-over-year increase or 48.61% for HbA1c testing for members who resided in a long-term care (LTC) facility who met the low nursing facility level of care criteria.
    - Interventions: Utilization of Member Gap Lists, Mailing to LTC facilities, Telephonic Outreach, and Diabetic Educational Materials (2% year-over-year increase or 48.61% of the indicator).
- MHC- LTSS Member Falls
    - Measurement indicators: 10% yearly decrease for percentage of members who had a fall or had problems with balance or walking during the 12-month measurement period.
    - Interventions: Implementation of an online self-paced training (10% yearly decrease for indicator Percentage of members who had a fall or had problems with balance or walking during the 12-month measurement period).
- PHP- Inter-Rater Reliability for PCS Allocation
    - Measurement indicators: 2 percentage point increase annually of Inter-Rater Reliability for Personal Care Services Allocation.
    - Interventions: Screening events, on the spot testing rewards, Healthy Solution coaching with rewards, disease management outreach and distribution of member newsletter articles.

- UHC- Influenza Vaccination for LTSS Population
    - Measurement indicators: 2% increase annually for percentage of LTC members (excluding healthy dual eligible members) ages 18 to 64 years who received an influenza vaccination during the measurement period and the percentage of LTC members (excluding healthy dual eligible members) ages 65 years and older who received an influenza vaccination during the measurement period.
    - Interventions: Member and family education, Member transportation provision, Care Coordination and member advocate training, and promotion of practical clinical guidelines.

PIP #3- Diabetes Prevention and Management

- BCBS- Diabetes Management and Short-Term Complications Admission Rate
    - Measurement indicators: Year-over-year decrease with the overall goal of a lower rate over time, and 2% year-over-year increase for HbA1c Testing.
    - Interventions: Member outreach for Members with one or more gaps in care, Short-Term Complication of Diabetes Admission Notification Mailing.
- MHC- Diabetes Prevention and Management
    - Measurement indicators: 2% yearly decrease for both indicators Diabetes, Short-Term Complications Admission Rate and HbA1c Testing indicator).
    - Interventions: Provider education and Provider engagement teams.
- PHP- Diabetes Short-Term Complications Admission Rate and HbA1c Testing Rates

    - Measurement indicators: 1 percentage point increase for HbA1c indicator and 2 percentage point decrease in Diabetes STCA Rates for 18-64 and 65+.
    - Interventions: Screening events, Provider incentives for completion of the HbA1c test and Distribution of gaps in care lists to providers.
- UHC- Diabetes Short-Term Complications Admission Rate and HbA1c Testing
    - Measurement indicators: 2% decrease annually for both Diabetes STCA 18-64 and 65-75 age group indicators, and HbA1c testing for 18-64 and 65-75 age group indicators.
    - Interventions: Collaboration with other MCOs for a one-page practice guideline handout, Clinical practice guidelines for diabetes, Distribution of gaps in care data, and Utilization of the mobile unit to perform HbA1c testing for members.

PIP #4- Clinical Depression Screening and Follow-Up

- BCBS- Screening for Clinical Depression and Follow-Up Rates
    - Measurement indicators: 10% increase year-over-year, and 2% increase year-over-year for acute and continuous phases.
    - Interventions: Community Health Coordinators conducted telephonic outreach, and Implementation of a Provider Incentive program.
- MHC- Clinical Depression Screening and Antidepressant Medication Management
    - Measurement indicators: 2% increase year-over-year for Screening for Clinical Depression and Follow-Up Plan and 2% increase from baseline for Acute and Continuous Phase indicators.
    - Interventions: BH Provider toolkit, Provider workbench, and Member outreach
- PHP- Screening and Management of Clinical Depression
    - Measurement indicators: 53.88% for Acute Phase, 37.55% Continuous Phase and 2% increase year-over-year for both Screening for Clinical Depression and Follow-Up Plan 18-64 and 65+.
    - Interventions: Outreach calls, treatment interventions, Provider notification of high-risk members and Distribution of Krames on Demand Educational materials.
- UHC- Antidepressant Medication Management Rates
    - Measurement indicators: 2 percentage point increase annually for Screening for Clinical Depression and Follow-Up Plan, and Antidepressant Medication Management for both Acute and Continuous phases.
    - Interventions: Clinical Practice Consultant, Outreach to providers on depression screening, development of continuity and coordination of care tip sheet, Provider Outreach and Web-based training.

Table 4: Performance Improvement Projects 2014-2018

Performance Improvement Projects PIP #1	**2014**	**2015**	**2016**	**2017**	**2018**
BCBS- Annual Dental Rates	57.46%	59.83%	61.78%	64.38%	67.90%
MHC- BMI Percentile Documentation Rates (3-17 Years)	*	*	7.79%	10.53%	10.07

Counseling for Nutrition Rates (3-17 Years)	*	*	3.82%	3.89%	2.66%
Counseling for Physical Activity Rates (3-17 Years)	*	*	2.95%	3.10%	3.45%
PHP- Adolescent Well-Care Visit Rates	*	*	*	33.43%	43.10%
PHP- Adolescent Well-Care Visit Rates Among PQIP Providers	*	*	*	11.00%	N/R
UHC- Annual Dental Visit Rates	41.52%	49.88%	53.93%	61.02%	51.89%
Performance Improvement Projects PIP #2					
BCBS- Diabetic Eye Exams Rates for LTC Members (18-75)	8.90%	20.35%	22.76%	20.50%	27.91%
Adult Members (18-75)	54.23%	47.76%	51.21%	51.90%	53.77%
MHC- LTSS Members who Reported a Fall or Issues with Walking or Balance	18.47%	24.13%	26.38%	23.33%	20.10%
PHP- Inter-Rater Reliability for Personal Care Services Allocation Accuracy Rates	93.00%	99.40%	99.70%	99.80%	N/R
UHC- Influenza Vaccination for LTC Population	*	*	*	33.36%	13.21%
(18-64 Years) (65+)	*	*	*	37.67%	17.43%
Performance Improvement Projects PIP #3					
BCBS- Diabetes, Short-Term Complications Admission Rates (18-64 Years)	23.35%	22.16%	17.93%	18.98%	14.56%
HbA1c Testing Rates (18-75 Years)	83.42%	80.43%	82.56%	82.00%	82.97%
MHC- Diabetes, Short-Term Complications Admission Rates (18-64 Years)	14.81%	9.75%	11.89%	9.27%	5.99%
HbA1c Testing Rates 18-75 Years)	73.78%	77.03%	77.61%	76.84%	76.87%
PHP- Diabetes, Short-Term Complications Admission Rates 18- 64, and 65+	*	14.56%	11.81%	12.37%	19.02%
	*	37.11%	11.14%	14.96%	13.14%
HbA1c Testing Rates		88.64%	83.25%	84.85%	84.85%
UHC- Diabetes, Short-Term Complications Admission Rates (18-64 Years) (65-75 Years)	38.35%	33.42%	37.50%	21.60%	22.75%
	98.80%	270.89%	150.80%	24.70%	48.53%
HbA1c Testing Rates	62.31%	65.79%	67.48%	70.49%	73.68%
(18-64 Years) (65-75 Years)	51.44%	56.32%	60.65%	85.75%	88.81%

Performance Improvement Projects PIP #4					
BCBS- Screening for Clinical Depression and Follow-Up Rates (18 to 64 Years)	*	0.36%	0.49%	0.77%	1.04%
Screening for Clinical Depression and Follow-up Rates (65+)	*	4.55%	2.37%	3.45%	3.76%
Antidepressant Medication Management – Acute Phase			50.63%	46.54%	42.74%
(18-64 Years) (65+)			47.17%	60.00%	64.29%
Antidepressant Medication Management – Continuous Phase (18-64 Years) (65+)			34.56%	30.83%	21.59%
			32.08%	53.33%	50.00%
MHC- Clinical Depression Screening and Follow-Up Rates (18+)	0.01%	0.06%	0.07%	0.16%	N/R
Antidepressant Medication Management Acute Phase Rates (18+)	53.50%	49.55%	47.19%	45.77%	49.33%
Antidepressant Medication Management Continuous Rates (18+)	38.63%	34.67%	32.11%	30.54%	32.55%
PHP- Antidepressant Medication Management Rates Acute Phase, Continuous Phase (18-65)	*	53.35%	51.88%	50.59%	53.74%
	*	36.24%	35.55%	36.40%	
Clinical Depression Screening and Follow-Up Rates (18-64 years) (65+)	*	*	*	15.04%	76.08%
	*	*	*	22.73%	78.05%
UHC- Clinical Depression Screening and Follow-Up Rates (18-64 Years)	0.93%	0.01%	0.02%	0.01%	0.03%
Antidepressant Medication Management Rates (Acute Phase) (18+ Years)	62.50%	56.62%	53.16%	52.32%	58.28%
(Continuous Phase) (18+ Years)	48.34%	42.89%	38.97%	37.48%	44.73%

*indicates a change in the PIP topic, study population, measurement indicators, or interventions that required a new baseline measurement.

External Quality Review

CMS requirement CFR §438.340(b)(4)

Detail the arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO.

HSD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), HealthInsight New Mexico, to provide External Quality Review

(EQR). The EQRO will conduct all mandatory and optional EQR reviews to assess quality outcomes and timeliness of, and access to, the services provided to Medicaid beneficiaries and covered under each MCO.
The EQRO will follow CMS protocols that set forth the parameters that must be followed in conducting the EQR for the following activities:

- Compliance Monitoring, an annual review designed to determine the MCO compliance with State and Federal Medicaid regulations and applicable elements of the contract between the MCO and State. As an extension of Compliance Monitoring, the EQRO has conducted numerous educational sessions for the MCOs regarding Transition of Care 2015 and 2016 requirements;
- Validation of PMs, an annual review designed to evaluate the accuracy of the State defined performance measures reported by the MCOs;
- Validation of PIPs, an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by the State;
- Validation of Encounter Data, a review conducted every three (3) years as an independent validation to measure the consistency between submitted encounter data and corresponding health record entries;
- Independent Assessment, a review conducted every three (3) years to assess the State's activities and efforts to monitor the MCOs' access to services, quality of services and cost effectiveness; and
- Audit of the MCO NFLOC determinations every quarter. HSD monitors the EQRO audit of MCO NFLOC determinations and addresses trends identified.

The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico's managed care regulations and quality standards as set forth in federal regulation and State policy.

The EQRO reports findings and recommendations to the State.

CMS requirement CFR §438.340(b)(10)
Describe how the state will ensure non-duplication of EQR **activities.**
To ensure non-duplication of EQR activities, HSD/MAD has a designated Contract Administrator authorized to represent HSD/MAD in all matters related to EQR. The Contract Administrator utilizes tracking sheets to monitor scope of work activities with relevant contractors within the division.

HSD conducts internal quality review activities such as:

- NF LOC audits by the HSD/MAD Nurse Auditor for review of service plan reduction determinations by the MCOs;
- NF LOC audits by the HSD/MAD Nurse Auditor for review of high NF LOC and low NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria;
- Service Plan audits by the HSD/MAD Nurse Contractor to review service plans ensuring that the MCOs are using the correct tools and processes to create service plans. The

review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan;

- Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs' efforts to improve care coordination practices according to HSD/MAD's findings that required follow-up to recommendations and action steps;
- "Ride-alongs" by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016 and 2017 to observe member visits in the home setting. HSD/MAD ride-along experiences with the MCOs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available home and community based services. HSD/MAD observes the care coordinator's use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services;
- Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value-based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives.
- Delivery System Improvement Performance Targets (DSIPTs) allow MCOs to be recognized for their quality improvements in specific areas. Below is a list of yearly Centennial Care DSIPTs

Delivery System Improvement Targets				
2014 HIE/HIT Increase the use of electronic health records by Contract Providers and increase the number of Contract Providers who participate in the exchange of electronic	**2015 Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages	**2016 Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages	**2017 Community Health Workers** A minimum 10% increase in the number of members served by CHW for care coordination activities, health education, health literacy, translation and community support linkages in Rural Frontier, and underserved communities in Urban regions of the State.	**2018 Community Health Workers** A minimum 10% increase in the number of members served by CHW for care coordination activities, health education, health literacy, translation and community support linkages in Rural Frontier, and underserved communities in Urban regions of the State.

health information.	in Rural, Frontier, and underserved communities in Urban regions of the State.	in Rural, Frontier, and underserved communities in Urban regions of the State.		
Telehealth A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telehealth** A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**
PCMH A minimum of a 5% of members served by PCMHs.	**PCMH** A minimum of a 5% increase in members served by PCMHs.	**PCMH** A minimum of a 5% increase of members being served by PCMHs, maintaining a minimum of 40% of membership being served by PCMHs.	**PCMH** A minimum of 5% increase of members being served by PCMHs, maintaining a minimum of 45% of membership being served by PCMHs.	**PCMH** A minimum of 5% increase of members being served by PCMHs, maintaining a minimum of 45% of membership being served by PCMHs.
ER Diversion A minimum of a 10% reduction of non-emergent use of the ER.	**ER Diversion** A minimum of a 10% reduction in the per capita use of emergency room.	**Behavioral Health** Percent of 7-day follow-up visits into community-based BH care for child and adult members released from inpatient	**Hepatitis C** Treat at least 75% of Hepatitis C drug treatments including in the capitated rate during the contract period	**Hepatitis C** Treat at least 80% of Hepatitis C drug treatments including in the capitated rate during the contract period

		psychiatric hospitalizations stays of 4 or more days. **Hepatitis C** Treat at least 50% of Hepatitis C drug treatments included in the capitated rate during the contract period.	**Value Based Purchasing** Implement value-based purchasing as outlined in the table below **Level 1 minimum of 5% of all provider payments** **Level 2 minimum of 8% of all provider payments.** **Level 3 minimum of 3% of all provider payments** **Additional Requirements for VBP** • At least 3% of the overall 16% in VBP must be with high volume hospitals and require readmission reduction targets of at least 5% of the baseline. • Include payments to behavioral health community providers in calculating the percentage of overall spend in the VBP arrangements.	**Value Based Purchasing** Implement value-based purchasing as outlined in the table below **Level 1 minimum of 7% of all provider payments** **Level 2 minimum of 10% of all provider payments.** **Level 3 minimum of 3% of all provider payments** **Additional Requirements for VBP** • At least 3% of the overall 20% in VBP must be with high volume hospitals and require readmission reduction targets of at least 5% of the baseline. • Include payments to behavioral health community providers calculating the percentage of overall spend in the VBP arrangements.

Centennial Care Summary

Accomplishments for Centennial Care through the close of 2018, include the following:

- Continues to streamline program administration through the consolidation of federal waivers that segregate the care of populations. Four MCOs administer the full array of services in an integrated model of care, serving over 700,000 Medicaid members. On August 31, 2018 United Health Care terminated its participation in the Centennial Care Medicaid Program. On September 1st, 2018 UHC transitioned approximately 86,000 to Presbyterian Health Plan. HSD completed all the required reconciliations and has successfully transitioned UHC out of the Centennial Care program.

- Continues to maintain a care coordination infrastructure that promotes a person-centered approach to care. More than 900 care coordinators ensure members receive services when they need them;

- Continues to be a leader in the nation in spending more of its LTSS dollars to maintain the number of members receiving services in their homes and in community settings rather than in institutional settings;

- Advanced payment reforms in partnership with the MCOs and, in 2018, requiring VBP arrangements for at least 16% of all medical payments to providers;

- Demonstrated increased access to Patient Centered Medical Homes. In 2014 there were a total of 180,874 members receiving care in a Patient Centered Medical Home. By the close of 2018 members receiving care in a Patient Centered Medical Home increased to 424,062 which represents an increase of 27% per year from 2014 to 2018;

- Demonstrated increased member participation in Health Homes. In 2016 there were a total of 444 members enrolled with the two (2) newly launched Health Homes. In 2018 HSD added seven (7) additional Health Home providers and expanded services in eight (8) additional counties. By the close of December 2018, the total number of members participating with Health Homes increased to almost 2,000;

- Demonstrated increased access to providers by leveraging telemedicine as a Delivery System Improvement Project with a focus on increasing access to behavioral health services. In 2014 there were a total of 7,401 telemedicine visits provided by both Behavioral Health Provider and Physical Health Providers, by 2018 that number increased to 32,327. This represents an average yearly increase of 67% from 2014 to 2018. Of the total Telemedicine visits in 2018, 86% were with a Behavioral Health Provider.