New Mexico Medicaid Managed Care Centennial Care 2.0 Program

2021 External Quality Review Annual Technical Report

April 2023

Prepared on behalf of:

The New Mexico Human Services Department

ipro.org

Per *Title 42 Code of Federal Regulations 438.362*, this *2021 External Quality Review Annual Technical Report* does not include Highly Integrated Dual Eligible Special Needs Plans offered by Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, Inc., or Centene Corporation (parent company of Western Sky Community Care).

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About This Report

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care organizations (hereafter referred to as MCO) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted MCOs. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid MCO. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare & Medicaid Services.[1] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through *(d)* requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the New Mexico Human Services Department (hereafter referred to as Human Services Department) contracted with Island Peer Review Organization, Inc. (doing business as IPRO), an external quality review organization, to conduct the 2021 external quality review of the MCOs that comprised New Mexico's Centennial Care 2.0. Specifically, this report provides IPRO's independent evaluation of the services provided by Blue Cross and Blue Shield of New Mexico (hereafter referred to as BCBS), Presbyterian Health Plan, Inc. (hereafter referred to as PHP), and Western Sky Community Care, Inc. (hereafter referred to has WSCC).

It is important to note that the provision of health care services to Medicaid and Child Health Insurance Program enrollees is evaluated in this report.

2021 External Quality Review

This external quality review technical report focuses on four federally mandatory external quality review activities (validation of performance improvement projects, validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional external quality review activity (validation of quality-of-care surveys) that were conducted for measurement year 2021. IPRO's external quality

[1] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.
[2] prepaid inpatient health plan.
[3] prepaid ambulatory health plan.
[4] primary care case management.

review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[5] published in October 2019. The external quality review activities and corresponding protocols are described in Table 1.

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed the MCOs' performance improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS®[6]) audit results provided by the MCOs' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance audit licensed organizations and reported rates to validate that performance measures were calculated according to Human Services Department specifications.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO evaluated the MCOs' compliance with Medicaid standards. Specifically, the review assessed compliance with *Title 42 Code of Federal Regulations Part 438 Subpart D*, *Title 42 Code of Federal Regulations 438.330, Medicaid Managed Care Services Agreement,* and the *New Mexico Administrative Code*.
Activity 4. Validation of Network Adequacy (Required)	Protocol 4	IPRO evaluated the MCOs' adherence to the provider network standards outlined in the *Medicaid Managed Care Services Agreement* and the *New Mexico Administrative Code* for specific provider types, as well as the MCOs' ability to provide an adequate provider network to its Medicaid population.
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO verified that the MCOs complied with the requirement to conduct a member satisfaction survey using a Consumer Assessment of Healthcare Providers and Systems (CAHPS®[7]) tool.

The results of IPRO's external quality review are reported under each activity section.

[5] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.
[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

New Mexico State Medicaid Managed Care Program and Medicaid Quality Strategy

History of the New Mexico Medicaid Managed Care Program

New Mexico's Medicaid managed care program, 'Salud!,' was is initiated in 1997. 'Salud!' covered acute, primary and specialty care, pharmacy, dental care, and transportation for children, low-income adults, and non-dual eligible aged adults. Medicaid managed care in New Mexico has evolved to now include a full array of services in an integrated model of care.

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve "demonstration" projects to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The Secretary of Health and Human Services may waive certain provisions of the Medicaid law through a Section 1115 Demonstration Waiver to give states additional flexibility to design and improve their programs.

In July 2013, the Centers for Medicare & Medicaid Services approved New Mexico's Section 1115 Demonstration Waiver application. The waiver permitted New Mexico to establish the Centennial Care managed care program and to mandatorily enroll Medicaid members to the program. The Centennial Care program waiver was approved for an initial five-year demonstration period of January 1, 2014, through December 31, 2018. Centennial Care was designed to consolidate nine waiver programs into a single, comprehensive Medicaid managed care delivery system, and became operational on January 1, 2014.

In December 2018, New Mexico received approval for an extension of the Section 1115 Demonstration Waiver. The waiver was approved for a second five-year demonstration period of January 1, 2019, through December 31, 2023. As of January 2019, the New Mexico Medicaid managed care program was rebranded as Centennial Care 2.0. In June 2019, New Mexico submitted an amendment application that was approved on February 7, 2020, effective February 8, 2020, through December 31, 2023.

In 2021, the Human Services Department contracted with three MCOs to administer health care benefits under the Centennial Care 2.0 program: BCBS, PHP, and WSCC. Profiles on these MCOs are available in the Medicaid Managed Care Organization Profiles section of this report.

New Mexico State Medicaid Quality Strategy

New Mexico maintains rigorous standards to ensure that participating MCOs have networks and quality management programs necessary to serve all enrolled populations. The quality strategy developed by the Human Services Department is intended to be the quality framework for the New Mexico State Medicaid program and participating MCOs. The Human Services Department performs periodic reviews of its Medicaid quality strategy using a continuous quality improvement model to determine the need for revision.

New Mexico's 2021 Medicaid Quality Strategy focuses on driving quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The quality strategy is designed to ensure that services provided to Medicaid members 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. New Mexico's quality strategy goals are:

- Assure that Medicaid members in the program receive the right amount of care, delivered at the right time, and in the right setting.
- Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity.

- Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility, or provider rates; and streamline and modernize the Medicaid program in the state.
- Provide an integrated, comprehensive Medicaid delivery system in which a member's MCO is responsible for coordinating their full array of services, including acute care (including pharmacy), behavioral health services, institutional services, and home and community-based services.

To achieve the overall objectives of the Centennial Care 2.0 program and to ensure New Mexico Medicaid recipients have access to the highest quality of health care, the state targets improvement efforts through several initiatives. Descriptions of these initiatives are described below.

Performance Improvement Projects

New Mexico identifies performance improvement projects 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. The performance improvement projects are included in the MCO contracts and revised and updated based on the Human Services Department's review of the positive outcomes or the identification of needed attention to specific gaps in care. Beginning in 2019, each MCO is required to conduct five performance improvement projects annually on the following topics: long-term care services, prenatal and postpartum care, adult obesity, diabetes prevention and management, and screening for and management of clinical depression.

The Human Services Department requires that each MCO implement work plans and activities consistent with performance improvement projects, as required by federal and state regulations. The external quality review organization reviews performance improvement project proposals and interim performance improvement project reports and provides technical assistance throughout the life of the performance improvement project. Performance improvement project validation activities and results are summarized annually by the external quality review organization for the state.

The objectives, technical methods of data collection and analysis, description of data obtained, and comparative results are presented in the Technical Summary – Validation of Performance Improvement Projects section of this report.

Performance Measures

New Mexico selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. The Human Services Department monitors and utilizes data that evaluate the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying performance measures. The selected performance measures and performance targets are reasonable, based on industry standards, and consistent with the Centers for Medicare & Medicaid Services' External Quality Review Protocols. The Human Services Department generally conducts quarterly monitoring of the performance measures to observe trends and to identify potential risks to meeting performance targets. A monthly monitoring plan was initiated by the Human Services Department in 2019 for all MCOs in response to declines in performance between measurement years 2017 and 2018 for two HEDIS measures: *Follow-Up After Hospitalization for Mental Illness – 30 Days* and *Follow-Up After Emergency Visit for Mental Illness – 30 Days*. The monthly monitoring plan required the MCOs to report interventions, improvement strategies, and barriers associated with improving performance outcomes for these measures. This information is shared with the MCOs during quarterly quality meetings. The MCOs are required to follow NCQA HEDIS technical specifications for reporting. Annually, the external quality review organization validates the MCOs' reported performance rates.

The objectives, technical methods of data collection and analysis, description of data obtained, and comparative analyses are presented in the Technical Summary – Validation of Performance Measures section of this report.

Consumer Assessment of Healthcare Providers and Systems

New Mexico incorporates the CAHPS 5.1H survey required by NCQA for MCO accreditation as part of the required Centennial Care 2.0 annual report submissions. CAHPS 5.1H allows for inclusion of state-specific questions, which currently focus on member satisfaction with care coordination services received from the MCOs. The results of the annual CAHPS survey are reviewed and analyzed by the Human Services Department to determine gaps in member satisfaction. Results are discussed with the MCOs during the quarterly quality meetings to identify interventions and strategies that the MCOs are applying to improve member satisfaction. The external quality review organization validated the MCOs' 2021 CAHPS results.

The10 objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in the Technical Summary – Validation of Quality-of-Care Surveys section of this report.

Managed Care Organization Accreditation Standards

New Mexico requires Centennial Care 2.0 MCOs to achieve and maintain NCQA Accreditation. Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with the Human Services Department. Violation, breach, or noncompliance with the accreditation standards may be subject to termination for cause, as detailed in the contract. MCO accreditation status is reviewed annually by the external quality review organization.

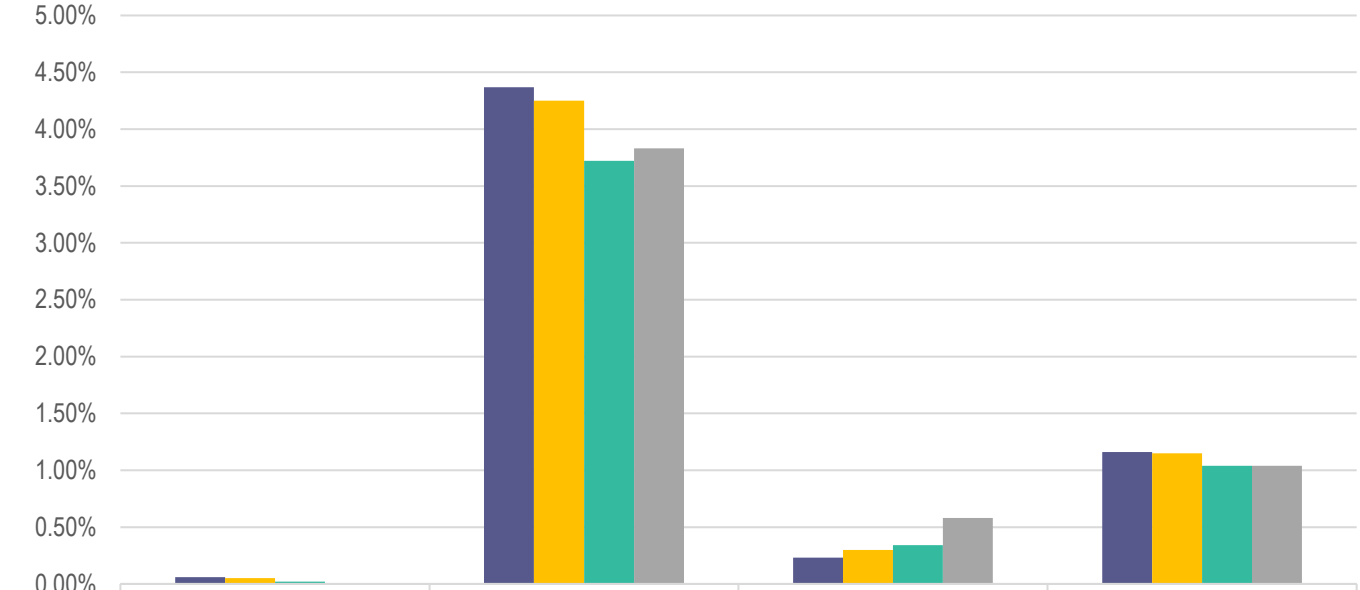
The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in the Technical Summary – NCQA Accreditation section of this report.

Tracking Measures

New Mexico requires Centennial Care 2.0 MCOs to report on tracking measures with the goal of focusing on areas of care that require statewide improvement and specific populations with undesirable health outcomes. Through the quarterly reporting of MCO tracking measure data, the Human Services Department frequently monitors MCO performance toward addressing areas of concern and closing gaps in care. The data are also used to compare MCO performance, identify best practices, and develop statewide interventions. Feedback is shared and discussed with the MCOs during quarterly quality meetings. The tracking measures and descriptions are available in Appendix A of this report.

Figure 1 through Figure 14 display the tracking measure rates at the MCO and statewide level for each quarter of 2021. Figures are not presented for the discharge measures of tracking measure #4 *Follow-Up After Hospitalization for Mental Illness*; however, technical specifications for the discharge measures are in Appendix A of this report.

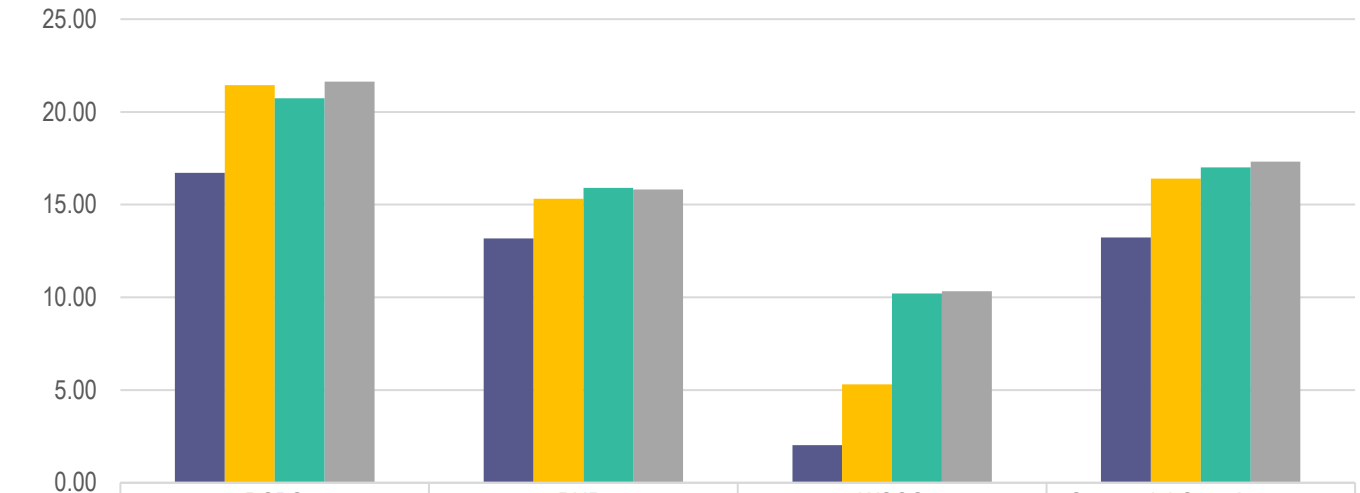
Figure 1. Tracking Measure #1 Fall Risk Management



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	0.06%	4.37%	0.23%	1.16%
Q2 2021	0.05%	4.25%	0.30%	1.15%
Q3 2021	0.02%	3.72%	0.34%	1.04%
Q4 2021	0.00%	3.83%	0.58%	1.04%

Note: MCO and aggregate rates are not accumulative.

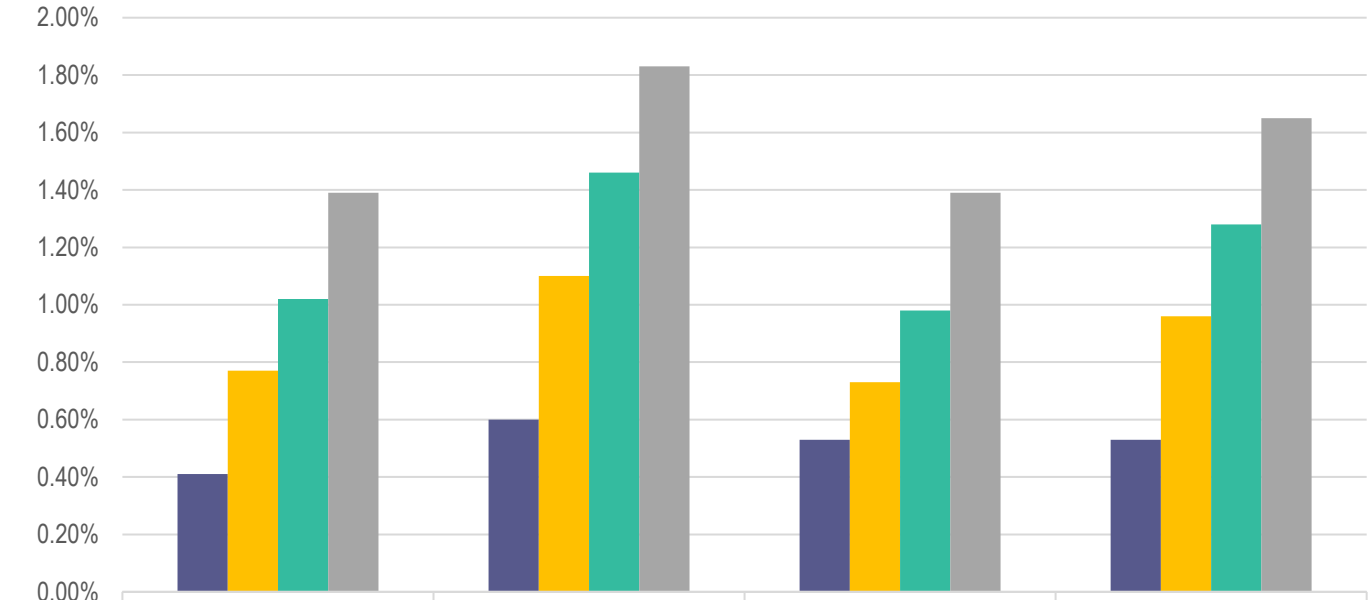
Figure 2. Tracking Measure #2 Diabetes Short-Term Complications Admission Rate *(Lower Rate Indicates Better Performance)*



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	16.72	13.17	2.03	13.22
Q2 2021	21.45	15.31	5.30	16.41
Q3 2021	20.73	15.90	10.21	17.01
Q4 2021	21.64	15.82	10.33	17.32

Note: MCO and aggregate rates are accumulative.

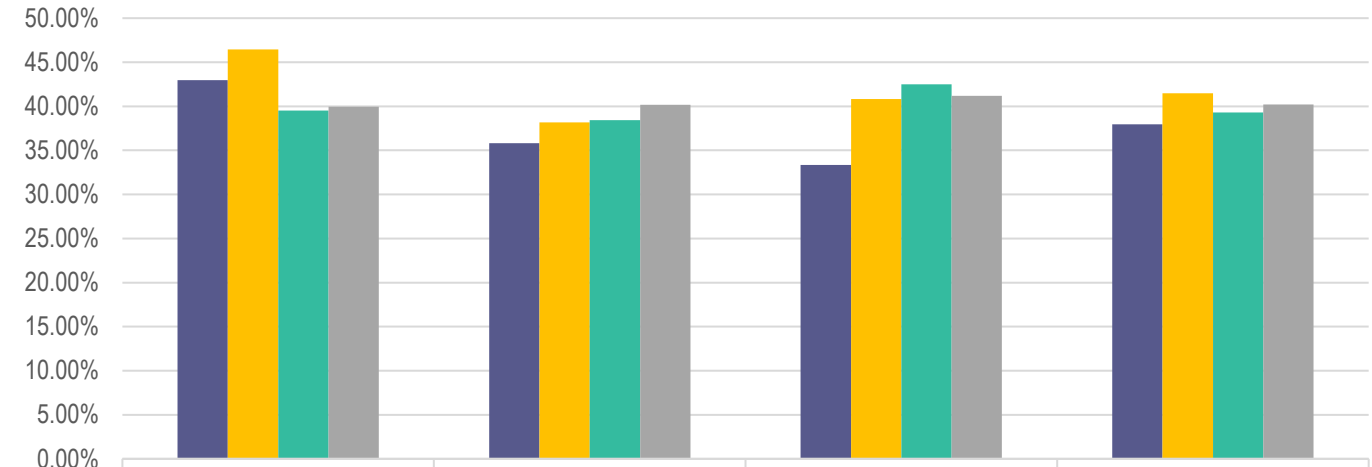
Figure 3. Tracking Measure #3 Screening for Clinical Depression



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	0.41%	0.60%	0.53%	0.53%
Q2 2021	0.77%	1.10%	0.73%	0.96%
Q3 2021	1.02%	1.46%	0.98%	1.28%
Q4 2021	1.39%	1.83%	1.39%	1.65%

Note: MCO and aggregate rates are accumulative.

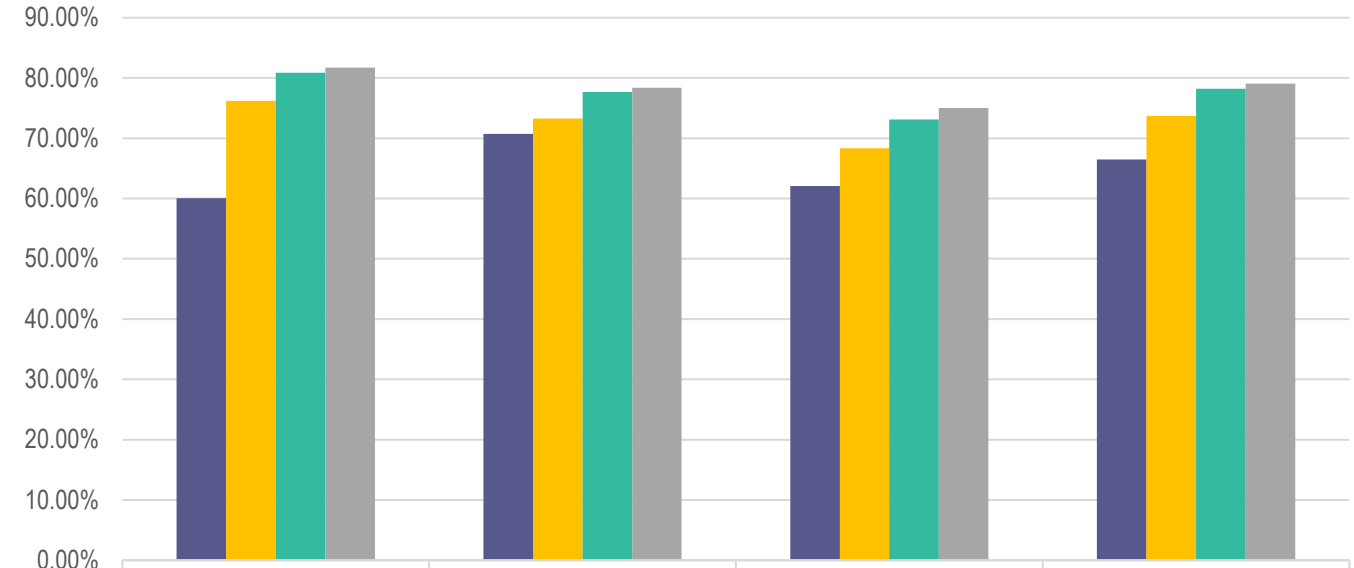
Figure 4. Tracking Measure #4 Follow-Up After Hospitalization for Mental Illness



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	42.96%	35.83%	33.33%	37.94%
Q2 2021	46.45%	38.17%	40.84%	41.48%
Q3 2021	39.52%	38.44%	42.49%	39.30%
Q4 2021	39.97%	40.17%	41.20%	40.21%

Note: MCO and aggregate rates are not accumulative.

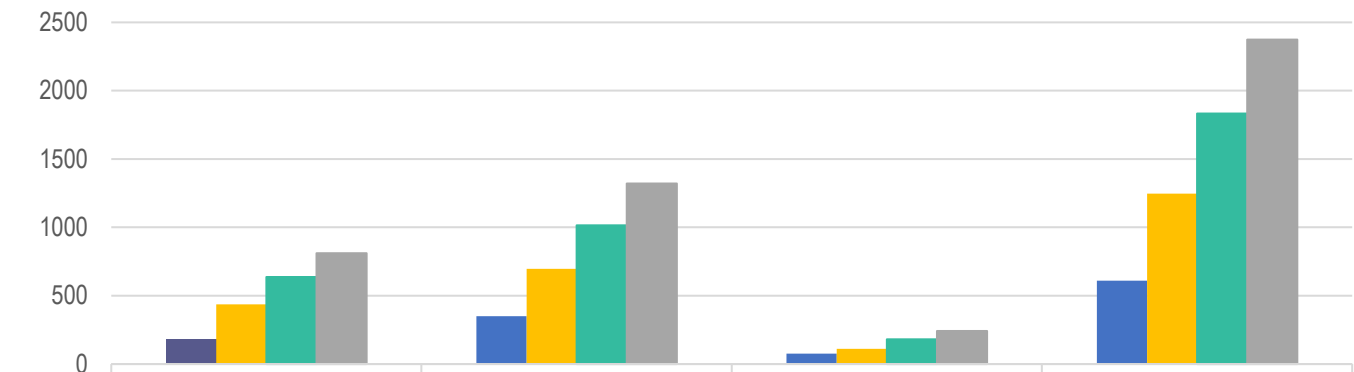
Figure 5. Tracking Measure #5 Immunizations for Adolescents



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	60.07%	70.74%	62.07%	66.50%
Q2 2021	76.20%	73.26%	68.36%	73.69%
Q3 2021	80.88%	77.67%	73.14%	78.22%
Q4 2021	81.69%	78.39%	75.00%	79.08%

Note: MCO and aggregate rates are accumulative.

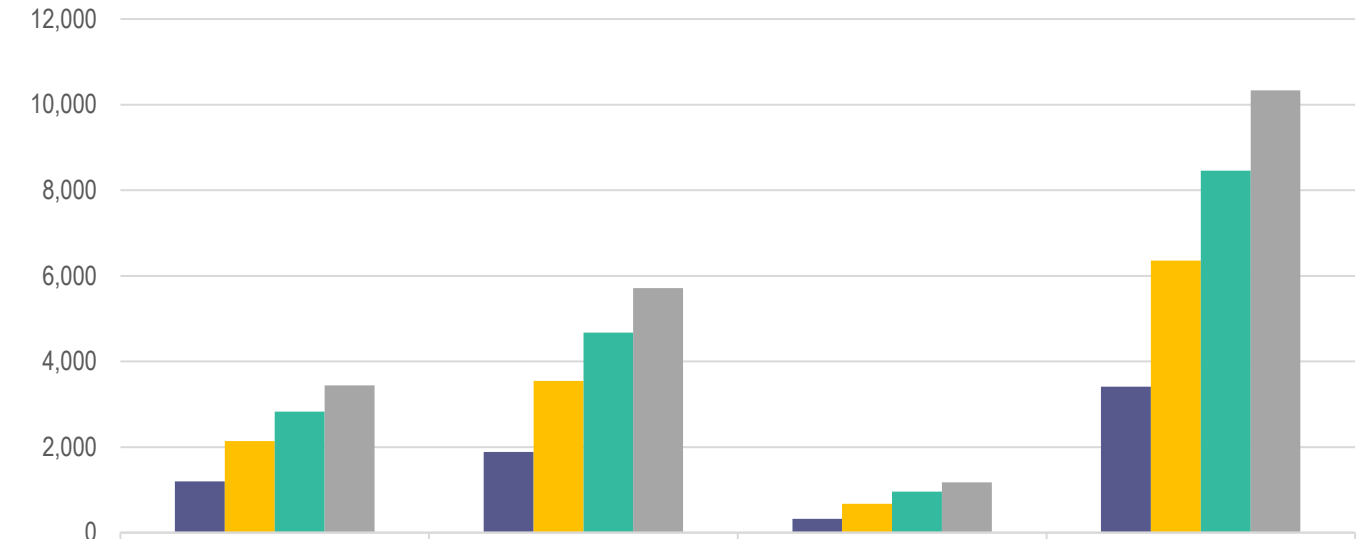
Figure 6. Tracking Measure #6 Long-Acting Reversible Contraceptive



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	183	350	77	610
Q2 2021	438	697	112	1,247
Q3 2021	637	1,015	181	1,833
Q4 2021	811	1,321	242	2,374

Note: MCO and aggregate counts are not accumulative.

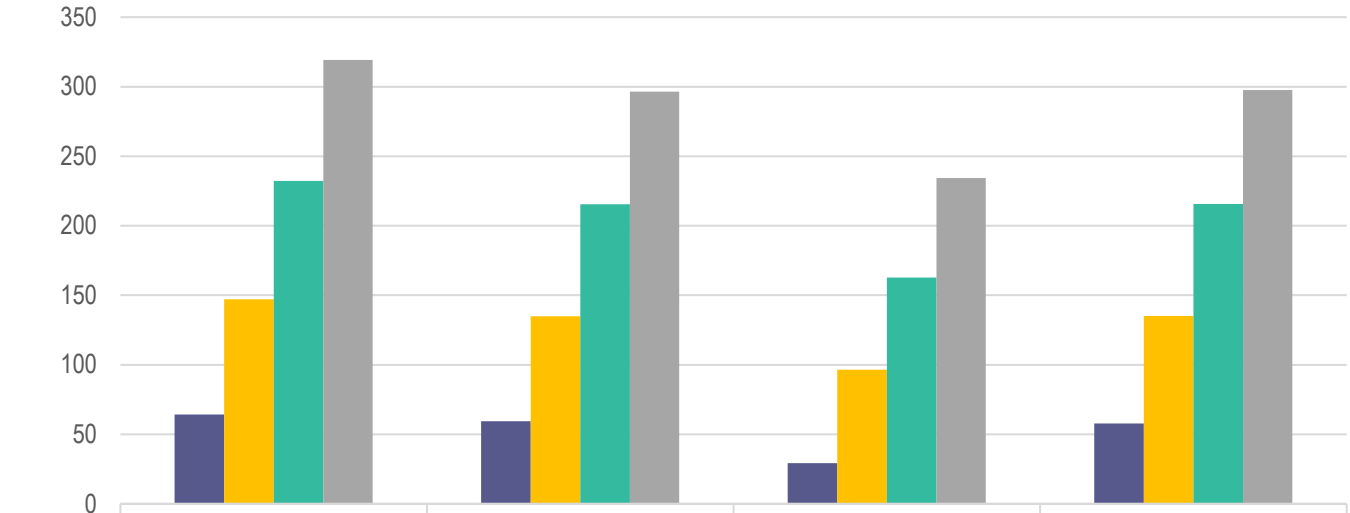
Figure 7. Tracking Measure #7 Smoking Cessation
(Unduplicated Member Quit Attempts)



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	1,201	1,886	326	3,413
Q2 2021	2,139	3,547	674	6,360
Q3 2021	2,826	4,674	958	8,458
Q4 2021	3,443	5,715	1,178	10,336

Note: MCO and aggregate rates are accumulative.

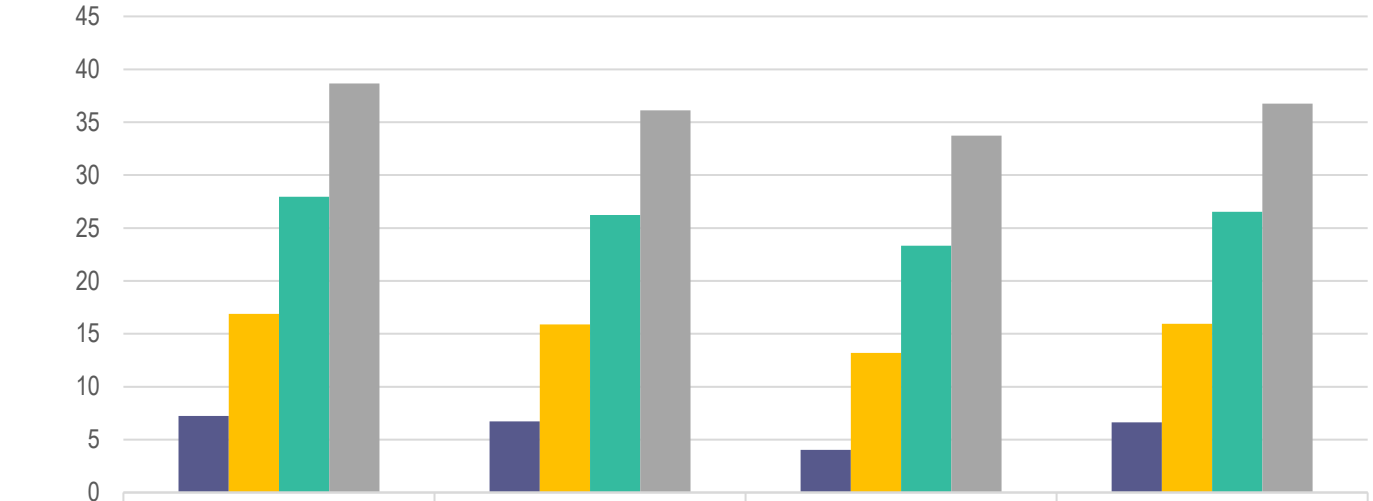
Figure 8. Tracking Measure #8a Ambulatory Outpatient Visits Per 1,000 Member Months



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	64.14	59.35	29.31	57.83
Q2 2021	147.03	134.89	96.43	135.06
Q3 2021	232.18	215.48	162.73	215.7
Q4 2021	319.16	296.34	234.42	297.68

Note: MCO and aggregate rates are accumulative.

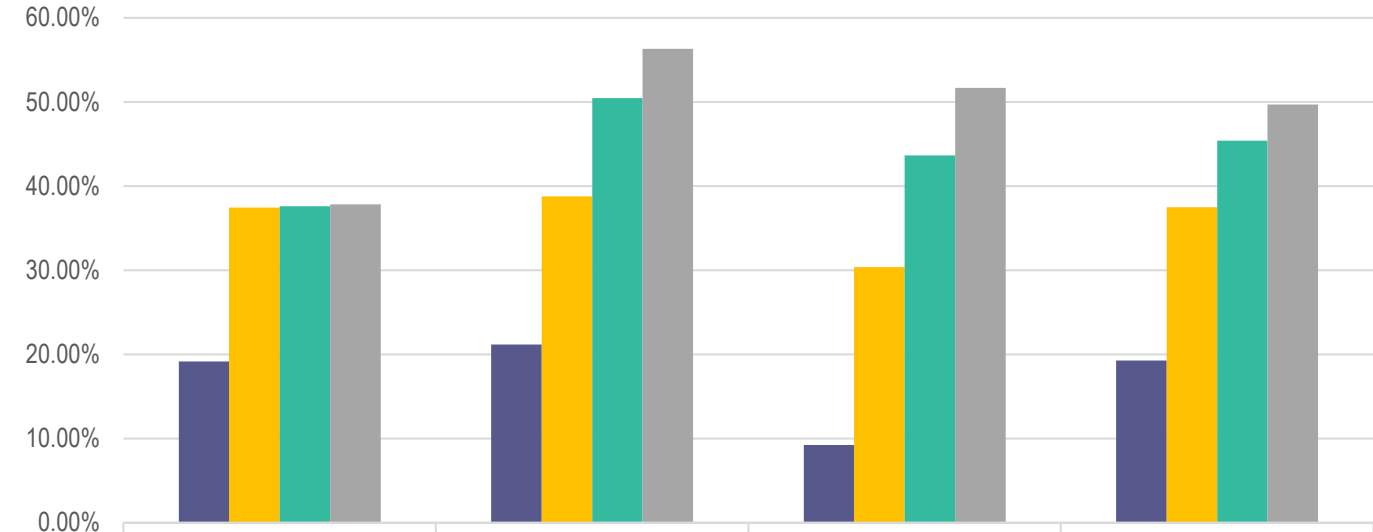
Figure 9. Tracking Measure #8b Ambulatory Care Emergency Department Visits Per 1,000 Member Months *(Lower Rate Indicates Better Performance)*



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	7.24	6.73	4.03	6.62
Q2 2021	16.88	15.9	13.18	15.96
Q3 2021	27.95	26.22	23.33	26.52
Q4 2021	38.67	36.13	33.73	36.77

Note: MCO and aggregate rates are accumulative.

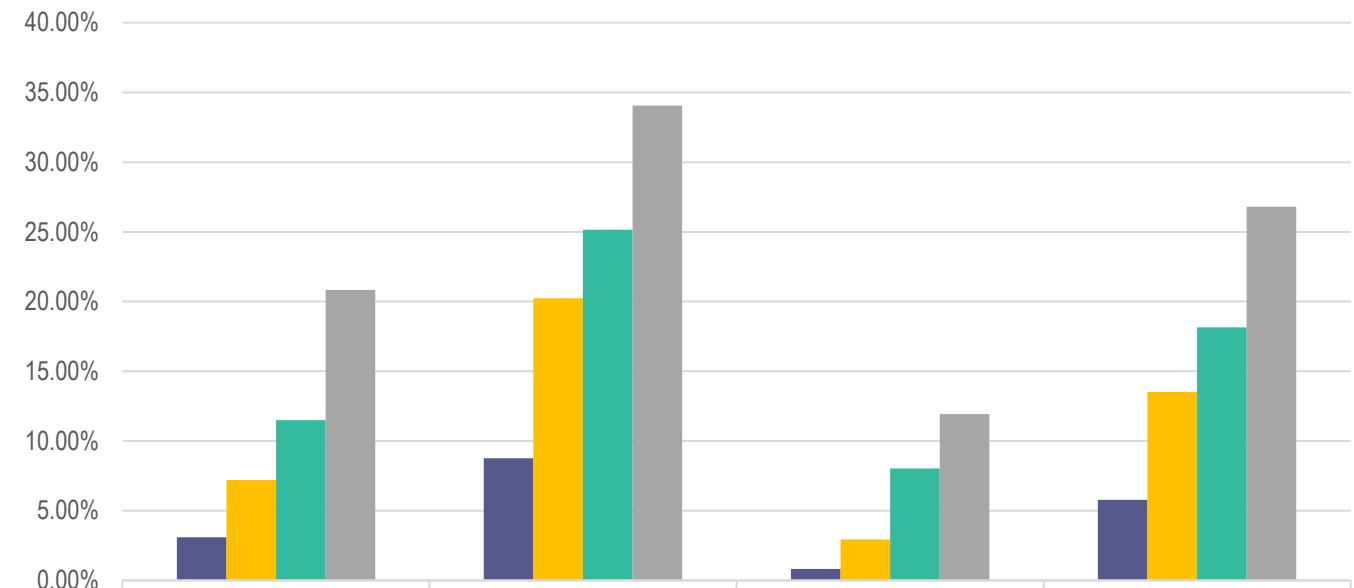
Figure 10. Tracking Measure #9 Annual Dental Visit



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	19.17%	21.17%	9.23%	19.27%
Q2 2021	37.46%	38.79%	30.37%	37.48%
Q3 2021	37.61%	50.44%	43.66%	45.42%
Q4 2021	37.84%	56.33%	51.66%	49.69%

Note: MCO and aggregate rates are accumulative.

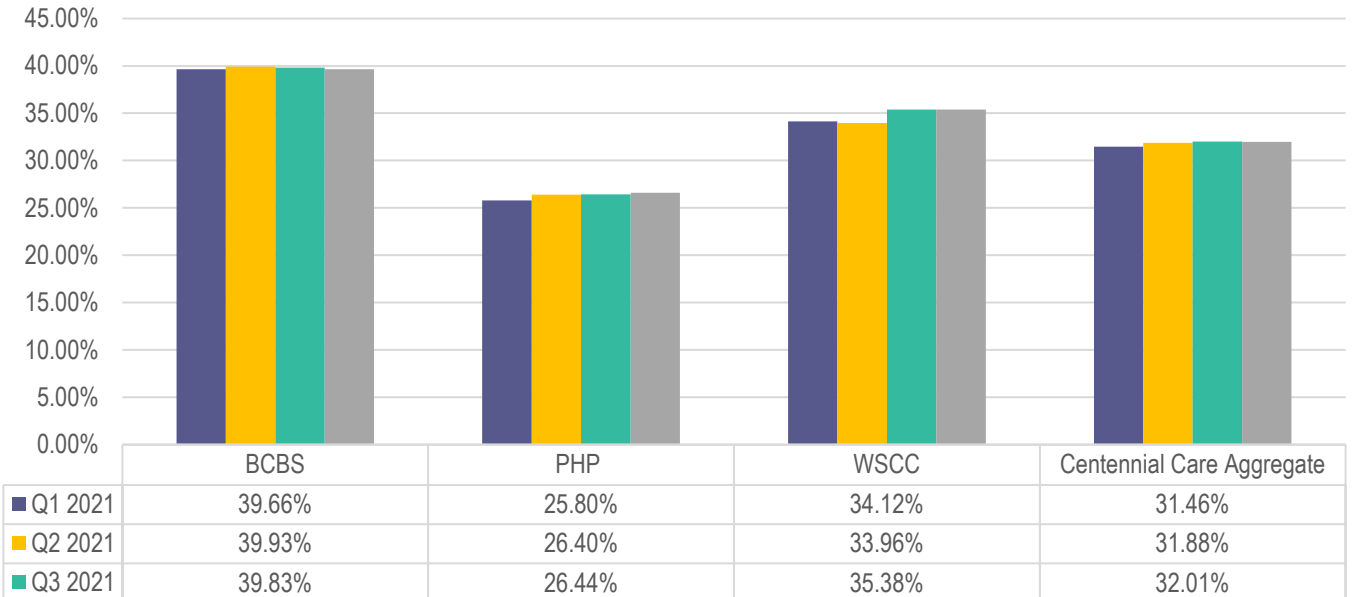
Figure 11. Tracking Measure #10 Controlling High Blood Pressure



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	3.10%	8.77%	0.83%	5.79%
Q2 2021	7.20%	20.25%	2.94%	13.52%
Q3 2021	11.50%	25.15%	8.03%	18.15%
Q4 2021	20.83%	34.05%	11.93%	26.80%

Note: MCO and aggregate rates are accumulative.

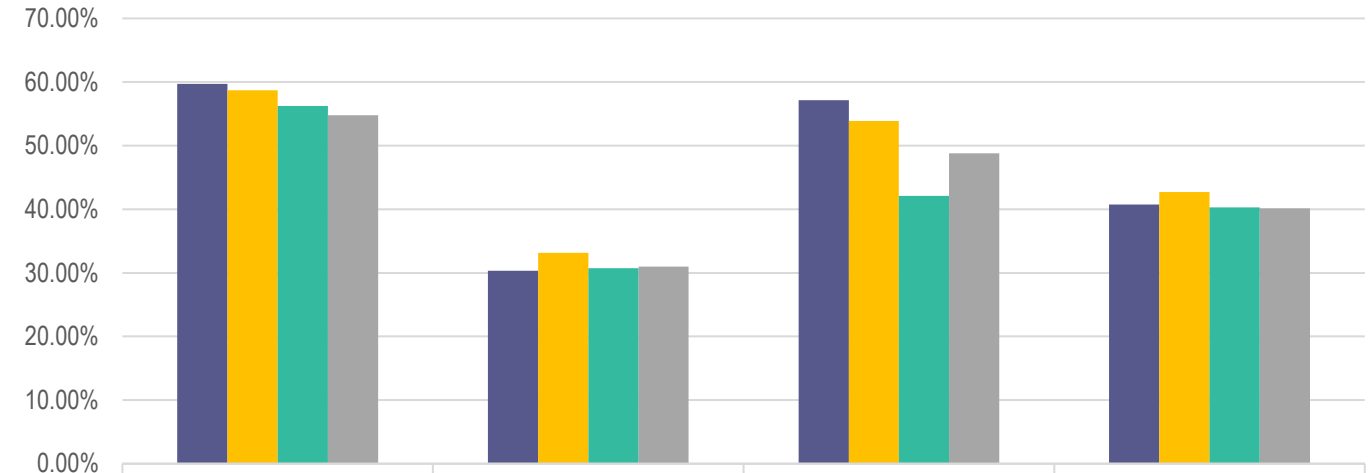
Figure 12. Tracking Measure #11a Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication - Initiation Phase



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	39.66%	25.80%	34.12%	31.46%
Q2 2021	39.93%	26.40%	33.96%	31.88%
Q3 2021	39.83%	26.44%	35.38%	32.01%
Q4 2021	39.65%	26.60%	35.38%	31.97%

Note: MCO and aggregate rates are accumulative.

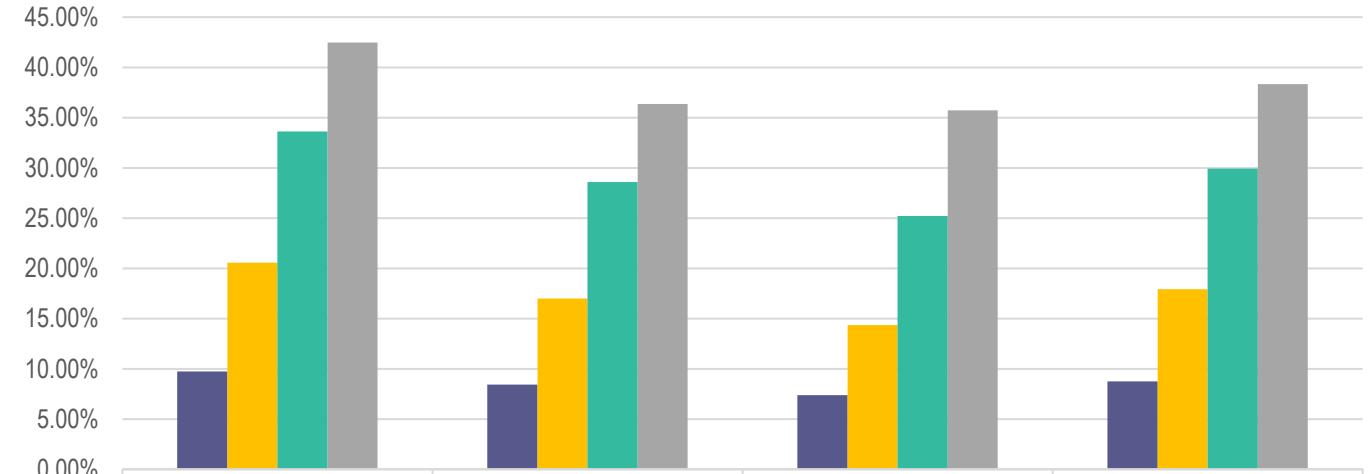
Figure 13. Tracking Measure #11b Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication - Continuation and Maintenance Phase



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	59.70%	30.33%	57.14%	40.74%
Q2 2021	58.68%	33.17%	53.85%	42.72%
Q3 2021	56.25%	30.71%	42.11%	40.28%
Q4 2021	54.80%	30.99%	48.78%	40.13%

Note: MCO and aggregate rates are accumulative.

Figure 14. Tracking Measure #12 Child and Adolescent Well-Care Visits



	BCBS	PHP	WSCC	Centennial Care Aggregate
Q1 2021	9.73%	8.44%	7.38%	8.76%
Q2 2021	20.58%	16.99%	14.35%	17.92%
Q3 2021	33.62%	28.59%	25.22%	29.92%
Q4 2021	42.49%	36.37%	35.71%	38.33%

Note: MCO and aggregate rates are accumulative.

Hospital Quality Measure Monitoring

State strategies and initiatives that focus on reducing readmission within 30 days of discharge from a hospital include the state directed tracking measure, ambulatory care, which tracks utilization of outpatient visits and emergency department visits. The MCOs are required to submit quarterly reports that detail rates for both indicators as well as strategies and interventions initiated to encourage members to establish care with a primary care provider.

State strategies and initiatives implemented to improve follow-up visits for members discharged from a hospital stay for mental illness include the requirement for MCOs to report rates, annually, for the HEDIS Follow-Up After Hospitalization for Mental Illness – 30 Days measure and to achieve contractual targets to avoid monetary penalties. The MCOs are required to submit monthly reporting of outcomes, strategies and interventions, and barriers to improving outcomes.

State strategies and initiatives implemented to improve the rate of diabetic members receiving a HbA1c test includes the requirement for MCOs to utilize the HEDIS Comprehensive Diabetes Care – HbA1c measure as a key indicator of health outcome in the state directed performance improvement project on diabetes prevention and management.

The Human Services Department selected 2019 aggregate facility rates as the baseline statistic and the MCO aggregate 2019 audited HEDIS rates reported for 2019 as the target. The Human Services Department aligned the selected metrics that are associated with the overarching state selected measures to improve outcomes for members. Table 2 displays aggregate facility rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target.

Table 2: Hospital Quality Monitoring – Not for Profit, For Profit, and Community Tribal Hospitals, Measurement Years 2019 to 2021

Metric	Baseline 2019 Rate	Remeasurement 2020 Rate	Remeasurement 2021 Rate	+/- Difference between 2019 and 2021 Rates	Target Rate	+/- Difference Between 2021 Rate and Target
Not For Profit Hospitals						
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.89%	14.47%	12.16%	+1.73	9.87%	-2.29
Comprehensive Diabetes Care: HbA1c Testing	46.59%	43.69%	55.32%	+8.73	83.41%	-28.09
Follow-Up After Hospitalization for Mental Illness – 30 Days	11.92%	14.45%	23.04%	+11.12	40.29%	-17.25
For Profit Hospitals						
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	17.20%	15.25%	8.10%	-9.10	9.87%	+1.77
Comprehensive Diabetes Care: HbA1c Testing	62.52%	59.29%	74.21%	+11.69	83.41%	-9.20
Follow-Up After Hospitalization for Mental Illness – 30 Days	13.13%	16.67%	25.20%	+12.07	40.29%	-15.09
Community Tribal Hospitals						
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.28%	12.91%	9.87%	-3.41	9.87%	0
Comprehensive Diabetes Care: HbA1c Testing	44.70%	46.87%	56.48%	+11.78	83.41%	-26.93
Follow-Up After Hospitalization for Mental Illness – 30 Days	5.99%	8.58%	19.42%	+13.43	40.29%	-20.87

State strategies for improving health outcomes of members receiving care in a hospital setting include delivery system and provider payment initiatives. The Human Services Department established a uniform payment increase for inpatient and outpatient hospital services and performance-based quality payments for the University of New Mexico Hospital[8]. The MCOs are required to communicate directly with the University of New Mexico Hospital to identify gaps in care and coordinate follow-up care for members to improvement health outcomes.

Table 3 displays the University of New Mexico Hospital's rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target for the rating period covering January 1, 2021 through December 31, 2021. Performance targets were determined in conjunction with the provider based on a review of current performance by the provider, setting reasonably achievable goals for performance improvement.

[8] University of New Mexico Hospital website: https://unmhealth.org/locations/unm-hospital/.

Table 3: Hospital Quality Monitoring – University of New Mexico Hospital Metrics, Measurement Year 2021

Metric	University of New Mexico Hospital Measurement Year 2021 Rate	Target Rate	+/- Difference Between University of New Mexico Hospital Rate and Target Rate	Target Status (Met or Not Met)
1 – Deaths among patients with serious treatable complications after surgery *(Lower rate indicates better performance)*	149.11	150.77	-1.66	Met
2 – Percentage of outpatient computed tomography (CT) scans of the abdomen that were "combination," or double scans *(Lower rate indicates better performance)*	4.31%	4.5%	-0.19	Met
3 – Serious complications that patients experienced during a hospital stay or after having a certain inpatient procedure *(Lower rate indicates better performance)*	1.82	1.26	+0.56	Not Met
4 – Patients with alcohol abuse who received a brief intervention during their hospital stay[1]	81.25%	12.75%	+68.5	Not Met
5 – Communication with Doctors (HCAHPS)	79.6%	79.6%	0	Met
6 – Communication with Nurses (HCAHPS)	77.4%	77.3%	+.01	Met
7 – Follow-Up After Emergency Department Visit for Mental Health – 7 Day (HEDIS)	49.65%	38.30%	+11.35	Met
8 – Follow-Up After Emergency Department Visit for Mental Health – 30 Day (HEDIS)	63.80%	52.99%	+10.81	Met
9 – Follow-Up After Hospitalization for Mental Health – 7 Day (HEDIS)	32.50%	32.85%	-0.35	Not Met
10 – Follow-Up After Hospitalization for Mental Health – 30 Day (HEDIS)	53.75%	58.66%	-4.91	Not Met

[1] For measurement year 2021, the University of New Mexico Hospital did not apply the same methodology used by the Human Services Department to calculate the baseline and target rates. As a result, the measurement year 2021 rate reported for the University of New Mexico Hospital was deemed "not met" by the Human Services Department. The University of New Mexico Hospital agreed with the "not met" determination.
HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems.

State strategies to improve member experience with inpatient services include administration of the Hospital Consumer Assessment of Healthcare Providers and Systems[9] (HCAHPS) survey and establishment of new requirements that foster MCO and trauma hospital collaboration on monitoring and intervention activities.

The Human Services Department selected 2019 facility rates as the baseline statistic and the Hospital Compare National Average 2020 rates as the targets. The Human Services Department aligned the selected metrics that are associated with the overarching state selected measures to improve outcomes for members. Table 4 displays facility rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target.

[Space intentionally left blank.]

[9] Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) website: https://www.hcahpsonline.org/.

Table 4: Hospital Quality Monitoring – Trauma Hospitals, Measurement Years 2019 to 2021

Metric/Facility Name	Baseline 2019 Rate	Remeasurement 2020 Rate	Remeasurement 2021 Rate	+/- Difference Between 2020 and 2021 Rates	Target 2021 Rate	Target Status (Met/Not Met)
Communication with Doctors – Patient experience with how well doctors explained things, listened carefully, and treated patients with courtesy and respect during their hospital stay.						
University of New Mexico (level 1)	80	75	88	+8	80	Met
Carlsbad Medical Center (level 3)	75	69	88	+8	80	Met
Christus St. Vincent Regional Medical Center (level 3)	78	75	91	+11	80	Met
Eastern New Mexico Medical Center (level 3)	76	60	83	+3	80	Met
Gerald Champion Regional Medical Center (level 3)	75	74	86	+6	80	Met
Mountain View Regional Medical Center (level 3)	75	72	88	+8	80	Met
San Juan Regional Medical Center (level 3)	76	66	85	+5	80	Met
Cibola General Hospital (level 4)	Not Reported	95	71	-9	80	Not Met
Gila Regional Hospital (level 4)	Not Reported	78	69	-11	80	Not Met
Memorial Medical Center (level 4)	76	74	81	+1	80	Met
Miners' Colfax Medical Center (level 4)	94	91	84	+4	80	Met
Nor-Lea General Hospital (level 4)	Not Reported	86	93	+13	80	Met
Sierra Vista Hospital (level 4)	Not Reported	100	88	+8	80	Met
Union County General Hospital (level 4)	77	77	87	+7	80	Met
Discharge Information – Patient experience at discharge in receiving information about what to do during their recovery at home.						
University of New Mexico (level 1)	89	86	86	+2	84	Met
Carlsbad Medical Center (level 3)	79	84	81	-3	84	Not Met
Christus St. Vincent Regional Medical Center (level 3)	82	81	84	0	84	Met
Eastern New Mexico Medical Center (level 3)	80	73	77	-7	84	Not Met
Gerald Champion Regional Medical Center (level 3)	83	88	85	+1	84	Met
Mountain View Regional Medical Center (level 3)	84	81	81	-3	84	Not Met
San Juan Regional Medical Center (level 3)	83	86	82	-2	84	Not Met
Cibola General Hospital (level 4)	Not Reported	72	72	-12	84	Not Met
Gila Regional Hospital (level 4)	Not Reported	88	92	+8	84	Met
Memorial Medical Center (level 4)	86	96	86	+2	84	Met
Miners' Colfax Medical Center (level 4)	82	92	82	-2	84	Not Met
Nor-Lea General Hospital (level 4)	Not Reported	83	86	+2	84	Met
Sierra Vista Hospital (level 4)	Not Reported	85	84	0	84	Met
Union County General Hospital (level 4)	66	89	92	+8	84	Met

IPRO's Assessment of the New Mexico Medicaid Quality Strategy

New Mexico's 2021 Medicaid Quality Strategy meets the requirements of *42 Code of Federal Regulations 438.340 Managed Care State Quality Strategy* based on IPRO's review and it reinforces the Human Services Department's approach of providing direction to the MCOs toward improving the health of the New Mexico Medicaid population. The quality strategy includes state- and MCO-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

New Mexico's 2021 Medicaid Quality Strategy was developed with input from Medicaid members, the public, stakeholders, the Medicaid Advisory Committee, tribal leadership, Indian Health Services, tribal health providers, MCOs, external quality review organization, and the Behavioral Health Collaborative. The 2021 Medicaid Quality Strategy includes objectives, standards, and goals for the following overarching areas that impact health care services: network adequacy and availability; continuous quality improvement; quality metrics and performance targets; performance improvement projects; external independent reviews; transitions of care; health disparities; intermediate sanctions; long-term services and supports; and non-duplication of external quality review activities. It also includes an evaluation of the state's performance measure trends, tracking measures, and member satisfaction measures.

The strategy is a clear framework for the MCOs to follow while aiming to achieve improvements in the quality of, timeliness of, and access to care. Goals and aims are stated and supported by well-designed interventions, and methods for measuring and monitoring MCO progress toward improving health outcomes while incorporating external quality review activities. The strategy includes several activities focused on quality improvement designed to build an innovative, well-coordinated system of care addressing both medical and non-medical drivers of health such as performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

Between measurement years 2020 and 2021 statewide performance met or exceeded targets in areas related to child and adolescent counseling for physical activity, postpartum care, antidepressant medication management, initiation of treatment for substance use, and follow-up care after emergency department visits or hospitalizations for mental illness.

Opportunities to improve health outcomes exist statewide. As evidenced by 2021 state- and MCO-level performance, increased attention to primary and preventive care for children, prenatal care, and appropriate screenings for members on antipsychotic medications, is suggested.

Recommendations to the New Mexico Human Services Department

Per *Title 42 Code of Federal Regulations 438.364 External quality review results (a)(4)*, this report is required to include a description of how the Human Services Department can target the goals and the objectives outlined in its Medicaid Quality Strategy to better support improvement in the quality of, timeliness of, and access to health care services furnished to Centennial Care 2.0 enrollees. As such, IPRO recommends the following to the Human Services Department:

- Consider working with the New Mexico Legislature to address statewide provider shortages and continue to identify and utilize federal resources designed to address network gaps that the MCOs cannot address due to statewide health care professional shortages.
- Consider defining "adequate access to specialty providers" in the Centennial Care 2.0 contract and develop a standardized methodology for MCOs to calculate the optimal numbers of specialty providers needed to adequately service their Medicaid populations.
- Consider establishing meaningful thresholds or targets for the MCOs to achieve for the percentage of providers with open panels and percentage of timely appointments among surveyed providers.

- Consider incorporating a telehealth component to the contractually required MCO semi-annual secret shopper surveys to evaluate member access to telehealth services.
- Consider developing a template for MCOs to use when reporting the results of the semi-annual secret shopper surveys. This will ensure consistent, comparable reporting across the MCOs.
- Consider revising the way quarterly network development activities are reported by the MCOs to encourage detailed descriptions of activities and their outcomes.
- Consider establishing a defined threshold for the reporting of provider types with small counts by the MCOs.
- Leverage policy changes made in response to COVID-19 that have resulted in observed positive impacts on access to and timeliness of care.
- Consider how to maximize the patient-centered provisions in the Centennial Care 2.0 contract to direct the MCOs toward supporting initiatives that prioritize improving quality of care.
- Consider clarifying Centennial Care 2.0 contract requirements related to provider and pharmacy lock-ins, credentialing, and recredentialing.
- Consider strengthening the definition of "qualified care coordinator" in the Centennial Care 2.0 contract and Human Services Department Policy Manual.

Medicaid Managed Care Organization Profiles

In 2021, the Human Services Department contracted with three MCOs to administer health care benefits under the Centennial Care 2.0 program: BCBS, PHP, and WSCC.

Table 5 displays profiles for each Centennial Care 2.0 MCO. For each MCO, the table displays the total Medicaid enrollment for calendar year 2021, the most current NCQA accreditation rating achieved, and the MCO's website address.

Table 5: Centennial Care 2.0 MCO Profiles

MCO	Medicaid Managed Care Start Date	Medicaid Enrollment as of 12/2021[1]	NCQA Accreditation Status[2]
Blue Cross and Blue Shield of New Mexico (BCBS) https://www.bcbsnm.com/	01/01/2014	289,615	Accredited
Presbyterian Health Plan, Inc. (PHP) https://www.phs.org/	01/01/2014	421,840	Accredited
Western Sky Community Care, Inc. (WSCC) https://www.westernskycommunitycare.com/	01/01/2019	85,860	Accredited

[1] Data Sources: Medicaid Enrollment Report-December 2021.

[2] Status is as of June 30, 2022. NCQA Website: https://reportcards.ncqa.org/health-plans.

Technical Summary – Information Systems Capabilities Assessment

Objectives

The *CMS External Quality Review (EQR) Protocols* published in October 2019 by the Centers for Medicare & Medicaid Services state that an Information Systems Capabilities Assessment is a mandatory component of the external quality review as part of Protocols 1, 2, 3, and 4.

While the Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of the HEDIS Compliance Audit[10] may be substituted for an Information Systems Capabilities Assessment, the Human Services Department opted for all Medicaid MCOs to undergo a full Information Systems Capabilities Assessment in 2022[11]. IPRO conducted this activity on behalf of the Human Services Department.

Technical Methods of Data Collection and Analysis

IPRO conducted the 2021–2022 information systems capabilities assessment in accordance with Appendix A of the *CMS External Quality Review (EQR) Protocols* published in October 2019. *External Quality Review Protocol 2* specifies the activities to be undertaken by an EQRO for purposes of validating MCO reported performance measure rates. The activities defined in *External Quality Review Protocol 2* include assessment of the:

- structure and integrity of the MCO's underlying information systems;
- MCO's ability to collect valid data from various internal and external sources;
- vendor (or subcontractor) data and processes, and the relationship of these data sources to those of the MCO;
- MCO's ability to integrate different types of information from varied data sources (e.g., member enrollment data, claims data, pharmacy data, vendor data) into a data repository or set of consolidated files for use in calculating performance measure rates; and
- documentation of the MCO's processes to collect appropriate and accurate data, manipulate the data through programmed queries, internally validate results of the operations performed on the data sets, follow specified procedures for calculating rates for the specified performance measures, and report the measures appropriately.

BCBS and WSCC provided IPRO with completed information systems capabilities assessments and supplemental documentation on January 14, 2022. PHP provided IPRO a completed information systems capabilities assessment and supplemental documentation on January 28, 2022.

For each MCO, IPRO hosted a two-hour virtual onsite meeting to discuss the MCO's information systems capabilities assessment submission and to conduct reviews of the MCO's systems. BCBS's virtual onsite meeting was held on February 10, 2022; PHP's virtual onsite meeting was held on February 8, 2022; and WSCC's virtual onsite meeting was held on February 9, 2022.

The Centers for Medicare & Medicaid Services prescribes that at the conclusion of the information systems capabilities assessment review, the external quality review organization is to compile and analyze the information gathered through the preliminary information systems capabilities assessment review and from the MCO staff interviews. After completing its analysis, the external quality review organization writes a statement of findings

[10] HEDIS Compliance Audit is trademarked by the National Committee for Quality Assurance (NCQA).

[11] Centennial Care 2.0 plans are contractually required to participate in the HEDIS reporting process.

about the MCO's information systems. The assessment levels used by IPRO are displayed in Table 6 while the assessment results for each MCO are displayed in Table 7.

Table 6: IPRO's Information Systems Capabilities Assessment Determination Levels

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

Description of Data Obtained

The *2021–2022 Centennial Care Information Systems Capabilities Assessment Report* included the results of IPRO's assessments and MCO detailed information regarding data integration and systems architecture; enrollment systems and process; claims/encounter data systems; provider data systems and processes; and oversight of contracted vendors.

Comparative Results

IPRO's assessment determined that the Medicaid MCOs met or exceeded the standards reviewed. Table 7 displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO.

Table 7: MCO Information Systems Capabilities Assessment Results, 2021-2022

Information Systems Capabilities Assessment Topic	BCBS	PHP	WSCC
Completeness and accuracy of encounter data collected and submitted to the state	Met	Met	Met
Validation and/or calculation of performance measures	Met	Met	Met
Completeness and accuracy of tracking of grievances and appeals	Met	Met	Met
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	Met	Met
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	Met	Met
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	Met	Met
Ability of the information system to generate complete, accurate and timely Transformed Medicaid Statistical Information System data	Not Applicable	Not Applicable	Not Applicable
Utility of the information system for review of provider network adequacy	Met	Met	Met
Utility of the MCO's information system for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, vital statistics, public health data)	Met	Met	Met

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid MCOs to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by an MCO. Further, MCOs are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by citation *4.12.4.10* of the *Medicaid Managed Care Services Agreement* and S*ubsection 18.1* of the *Centennial Care Policy Manual*, New Mexico Medicaid MCOs must conduct at least five performance improvement projects on priority topic areas of the Human Services Department's choosing and consistent with federal requirements. For 2021, the MCOs were required to conduct performance improvement projects for the following areas:

- long-term care services,
- prenatal and postpartum care,
- adult obesity,
- diabetes prevention and management, and
- depression screening and follow-up.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Human Services Department for the 15 performance improvement projects that were underway in 2021.

BCBS initiated new performance improvement projects in 2021; while PHP and WSCC continued performance improvement projects that were initiated in 2018 and 2019, respectively. Table 8 displays the titles of the MCOs' performance improvement projects that were underway in 2021.

Table 8: MCO Performance Improvement Project Topics, 2021

MCO	Performance Improvement Project Titles
BCBS	▪ Long-Term Services and Supports – Urinary Tract Infection ▪ Timeliness of Prenatal Care and Postpartum Care ▪ Adult Obesity ▪ Diabetes Management and Short-Term Complications Admissions Rate and HbA1c Testing ▪ Screening and Management for Clinical Depression
PHP	▪ Transition of Care – Community Reintegration ▪ Prenatal-Postpartum ▪ Adult Obesity ▪ Diabetes Prevention and Management ▪ Screening and Management for Clinical Depression

MCO	Performance Improvement Project Titles
WSCC	▪ Fall Risk and Prevention Program ▪ Addiction in Pregnancy Program ▪ Adult Obesity ▪ Diabetes Prevention and Management ▪ Adult Depression

Technical Methods of Data Collection and Analysis

The Centers for Medicare & Medicaid Services' *Protocol 1 – Validation of Performance Improvement Projects* was used as the framework to assess the quality of each performance improvement project, as well as to score the compliance of each performance improvement project with both federal and state requirements. IPRO's evaluation involves the following elements:

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

Following the review of the listed elements, the review findings are considered to determine whether the performance improvement project outcomes should be accepted as valid and reliable. Specific to New Mexico, each performance improvement project is then scored based on MCO's compliance with elements 1–8[12] (listed above). The element is determined to be "met" or "not met." If the element was met, the MCO achieved one point. The total number of achievable points per performance improvement project was eight. Compliance levels are assigned based on the number of points (or percentage score) achieved. Table 9 displays the compliance levels and their applicable score ranges.

Table 9: Performance Improvement Project Validation Scoring and Compliance Levels

Compliance Level	Compliance Score Range
Full	90%–100%
Moderate	80%–89%
Minimal	50%–75%
Non-compliant	< 50%

[12] The outcomes of elements 9 and 10 may not be relative to the efforts of the MCO; therefore, MCO performance improvement project compliance scores are based on elements 1–8 only.

A determination was made as to the overall credibility of the results of each performance improvement project, with assignment of one of three categories:

- There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
- The validation findings generally indicate that the credibility of the performance improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias or inconsistency in the performance improvement project results. The concerns that put the conclusion at risk are enumerated.

IPRO's assessment of indicator performance was based on the following categories:

1. Performance improvement demonstrated and target met (or exceeded). (Denoted by green highlight.)
2. Performance decline demonstrated but target met (or exceeded). (Denoted by green highlight.)
3. Performance improvement demonstrated but target not met. (Denoted by yellow highlight.)
4. Performance decline demonstrated and target not met. (Denoted by red highlight.)
5. Unable to evaluate performance at this time. (Denoted by gray highlight.)

IPRO provided performance improvement project report templates to each MCO for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Obtained

For the 2021 external quality review, IPRO utilized performance improvement project reports populated by the MCOs during 2021 and 2022. Information obtained included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of each MCO's performance improvement project methodology found that there were no validation findings that indicated that the credibility of the performance improvement project results was at risk. However, PHP achieved a "minimal" validation score for one performance improvement project.

PHP's conduct of the Long-Term Care Services and Support performance improvement project did not fully align with the requirements of Protocol 1. Through the validation process IPRO determined that for PHP's Long-Term Care Services and Supports performance improvement project:

- The PIP topic was not selected through a comprehensive analysis of member needs, care, and services.
- The performance measures did not inform the selection and evaluation of quality improvement activities.
- The improvement strategies were not designed to addresses root causes or barriers identified through data analysis and quality improvement process; and the performance improvement project did not assess the extent to which the improvement strategy was successful.

A summary of the validation assessments is in Table 10.

Table 10: MCO Performance Improvement Project Validation Results, 2021

Medicaid MCO Performance Improvement Project Validation Results			
Topic Area	BCBS	PHP	WSCC
Long-Term Care Services and Supports	Full	Minimal	Full
Prenatal and Postpartum Care	Full	Full	Full
Adult Obesity	Full	Full	Full
Diabetes Management and Prevention	Full	Full	Full
Clinical Depression Screening and Follow-up	Full	Full	Full

Full means that the MCO received a validation score that was between 90% and 100%.
Minimal means that the MCO received a validation score that was between 50% and 75%.

Performance improvement project summaries, including aim, interventions, results, and validation findings are reported in **Table 12**, **Table 12**, and **Table 13** for BCBS, PHP and WSCC, respectively. **Table 14**, **Table 15**, **Table 16**, **Table 17**, and **Table 18** display summaries of IPRO's improvement assessment for each project indicator by performance improvement project topic by MCO.

Table 11: BCBS's Performance Improvement Project Summaries, 2021

Blue Cross Blue Shield's Performance Improvement Project Summaries
Title: Long-Term Care Services – Urinary Tract Infection **Initiation Year:** 2021. **End Year:** Unknown at this time. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to implement sustainable interventions that improve services and member outcomes by decreasing the occurrences of urinary tract infections as rate per 1000 days for the total long-term care residents by 10 percent overall in long-term care residents among BCBS Centennial Care community adults ages 18 years and older from 4.78 to 4.30 by December 31, 2022. Member-level Interventions in 2021: ▪ Published an article on hand hygiene in the member newsletter. Provider-level Interventions in 2021: ▪ Mailed materials to providers including a presentation on the topic of reducing urinary tract infections for long-term care facilities and a flyer on hand hygiene. ▪ Presented presentation on the topic of reducing urinary tract infections at two quarterly personal care services meetings. ▪ Posted related materials to the BCBS website. ▪ Identified providers for direct engagement based on urinary tract infections occurrences.
Title: Timeliness of Prenatal and Postpartum Care **Initiation Year:** 2021. **End Year:** Unknown at this time. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to increase baseline rates of timeliness of prenatal care (58.98%) and postpartum care (51.21%) to the goal of 82.73% and 65.95%, respectively, by December 31, 2022, for mothers who have had a live birth during the measurement year. Member-level Interventions in 2021:

- Continued the Special Beginnings Program, a voluntary maternity program that helps members better understand and manage their pregnancy through prenatal and postpartum health education and guidance.
- Continued to refer BCBS members to the Centennial Care Home Visiting Program with the University of New Mexico's Center of Development and Disability[13] and ENMRSH, Inc.[14]
- Conducted outreach calls to postpartum members to provide education on the importance of postpartum care and to provide these members with appointment scheduling assistance. Members who were unreachable received outreach letters.
- Published articles in the member newsletter on the topics of preconception health and prenatal care.
- Posted member education materials on the BCBS website, including a video on the importance of prenatal and postpartum care.
- Promoted the Centennial Care Rewards program, highlighting available rewards for prenatal and postpartum care.
- Promoted value-added services related to infant care.
- Promoted the availability of non-emergency transportation services to prenatal appointments.
- Staffed a 24-hour toll-free hotline with maternity nurses.
- Outreached through text messages and emails to members within their first trimester of pregnancy with educational material and appointment scheduling assistance.

Provider-level Interventions in 2021:

- Educated providers on appropriate medical record documentation for prenatal and postpartum in-person and virtual visits.
- Increased occurrence of joint operation meetings with providers as part of the provider incentive program.
- Published articles in the provider newsletter on the HEDIS *Prenatal and Postpartum Care* measures.

MCO-level Interventions in 2021:

- Accessed laboratory services to support early outreach to pregnant members.
- Discussed barriers and solutions for improving timeliness of prenatal and postpartum care at the Certified Nurse-Midwives Advisory Board Meeting.

Title: Adult Obesity
Initiation Year: 2021. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

Aim: BCBS aims to improve member health outcomes by decreasing the prevalence of adult members diagnosed with obesity by two percentage points from 4.79% to 4.69%; and by increasing the hybrid and administrative blood pressure control rates among members diagnosed with hypertension from 51.09% to 55.09% and from 7.52% to 25.00%, respectively, by December 31, 2022.

Member-level Interventions in 2021:

- Distributed member materials to annual body mass index assessments, recommendations on activity and nutrition, blood pressure monitoring and control, and signs of depression.
- Promoted the availability of non-emergency transportation services to medical appointments.

[13] The University of New Mexico's Center for Development and Disability website: https://hsc.unm.edu/cdd/.
[14] The ENMRSH, Inc. website: https://enmrsh.org/.

- Promoted the Centennial Care Rewards program in the member newsletter, highlighting available rewards for adult primary care check-ups and Step-Up challenges.
- Published social media messages on hypertension.

Provider-level Interventions in 2021:

- Distributed a member-targeted flyer on seeking treatment for overweight or obesity to providers to share with patients.
- Issued gaps in care reports to providers to support direct provider outreach to their patients.
- Published articles in the provider newsletter on blood pressure control and proper coding for obesity, morbid obesity, and body mass index assessments.

Title: Diabetes Management and Short-Term Complications Admissions Rate and HbA1c Testing
Initiation Year: 2021. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

Aim: BCBS aims to improve services and member outcomes through interventions focused on decreasing the rate of hospital admissions by four points per 100,000 member months among adult members with diabetes-related short-term complications by December 31, 2022.

Member-level Interventions in 2021:

- Distributed personal care trackers to members diagnosed with diabetes. The trackers included: reminders about diabetes testing, areas to document their biannual HbA1c and blood pressure values, annual eye exam results, and blood pressure readings.
- Continued the program to distribute home test kits for HbA1c and urinalysis. Results of the test kits were mailed to both the member and the member's provider.
- Targeted members with diabetes and a missing HbA1c test to receive recorded telephonic reminders for screening, education on diabetic resources, and how to access appointment scheduling assistance.

Provider-level Interventions in 2021:

- Notified providers of members who had a short-term complications admission event. Notified providers were invited to discuss plans of care with the assigned BCBS care coordinator.

MCO-level Interventions in 2021:

- Shared gaps in care lists with CareNet to support targeted member outreach calls.

Title: Screening and Management for Clinical Depression
Initiation Year: 2021. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

Aim: BCBS aims to improve services and health outcomes by increasing the percentage of members remaining on antidepressant medication for more than six months, and by increasing the percentage or members screened for depression. Specifically, BCBS aims to increase the antidepressant medication adherence for members ages 18 to 64 years to 56.7% for the acute phase and to 39.4% for the continuation phase, and for members ages 65 years and older to 84.0% for the acute phase and to 64.0% for the continuation phase over the next two years. BCBS aims to increase the rate of depression screening for members ages 18 to 64 years to 10.6% and for members ages 65 years and older to 11.4% over the next two years.

Member-level Interventions in 2021:

Blue Cross Blue Shield's Performance Improvement Project Summaries
▪ Conducted member engagement telephone calls prior to the member's medication refill date to encourage the member to refill their prescription for antidepressant medication. During the call, members were assessed for care coordination and support services. ▪ Referred members to a BCBS pharmacist for education and consultation. ▪ Delivered member education through video on medication management and the benefits of collaborating with providers. Provider-level Interventions in 2021: ▪ Provided educational materials on the HEDIS *Antidepressant Medication Management* measure and on depression screening to providers through the BCBS website and an online seminar. ▪ Published articles in the provider newsletter on topics related to the BCBS depression screening initiative, follow-up care for positive depression screenings, and appropriate documentation claims submission for depression screening and outcome. MCO-level Interventions in 2021: ▪ Utilized pharmacy reports of missed refills and rejected prescriptions to target members for outreach calls. ▪ Revised member assessment questionnaire to include a question on newly prescribed antidepressant medication. ▪ Utilized the Wellth, Inc.[15] application to assist members with appropriate medication management. ▪ Delivered education on depression screening during monthly provider meetings.

Table 12: PHP's Performance Improvement Project Summaries, 2021

PHP's Performance Improvement Project Summaries
Title: Transitions of Care – Community Reintegration **Initiation Year:** 2019. **End Year:** 2021. **Validation Summary:** The validation findings generally indicate that the credibility of the performance improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
Aim: PHP aimed to increase the volume of members who successfully reintegrate from an institutional nursing facility to the community while not experiencing an avoidable hospitalization, re-institutionalization, or failure to thrive. Member-level Interventions in 2021: ▪ Educated and referred members to the appropriate providers and services. ▪ Assisted members with locating a provider or caregiver or issued single case agreements when access was limited. ▪ Conducted interdisciplinary care plan meetings for members who refuse services. ▪ Monitored for potential self-neglect cases and made referrals when appropriate. Provider-level Interventions in 2021: ▪ Collaborated with nursing facility staff to educate members on the importance of establishing a community provider. MCO-level Interventions in 2021:

[15] Wellth, Inc. Website: https://www.wellthapp.com/.

PHP's Performance Improvement Project Summaries
▪ Met quarterly with the New Mexico Aging & Long-Term Services Department[16] to coordinate care and to address potential transition of care risks. ▪ PHP's Care Coordination team completed training led by the New Mexico's Aging and Long-Term Services team. ▪ Referred members to community health workers when appropriate. ▪ Identified and established wraparound supports.
Title: Prenatal-Postpartum **Initiation Year:** 2019. **End Year:** 2021. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: PHP aimed to increase the proportion of eligible pregnant Centennial Care members with deliveries who receive timely prenatal and postpartum care. Member-level Interventions in 2021: ▪ Increased telephonic and mail outreach to educate members on prenatal and postpartum care and to provide information about the PHP Baby Benefits[17] program.
Title: Adult Obesity **Initiation Year:** 2019. **End Year:** Unknown at this time. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: PHP aimed to increase the proportion of members who had body mass index assessments. PHP also aimed to increase the number of members who met the National Diabetes Prevention[18] criteria and were enrolled in an obesity-related support program. Member-level Interventions in 2021: ▪ Continued its statewide diabetes prevention program to deliver health education and lifestyle coaching to adult members. ▪ Continued its member communication campaign to inform members about obesity-related support resources and programs. Provider-level Interventions in 2021: ▪ Executed a referral communication campaign on the obesity-related programs available to members.
Title: Diabetes Prevention and Management **Initiation Year:** 2019. **End Year:** 2021. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: PHP aimed to increase HbA1c testing and decrease hospital admissions due to diabetes-related short-term complications among members diagnosed with diabetes.

[16] New Mexico Aging & Long-Term Services Department Website: https://aging.nm.gov/.
[17] PHP Baby Benefits Website: https://www.phs.org/health-plans/centennial-care-medicaid/presbyterian-baby-benefits/Pages/default.aspx.
[18] Bay A, Brill A, Porchia-Albert C, Gradilla M, Strauss N. *Advancing birth justice: Community-based doula models as a standard of care for ending racial disparities.* Syracuse, NY: Village Birth International; 2019). https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

PHP's Performance Improvement Project Summaries
Member-level Interventions in 2021: ▪ Targeted telephonic education and outreach to members identified by the MCO as non-adherent diabetics for diabetes-related screenings and diabetes management.
Title: Screening and Management of Clinical Depression **Initiation Year:** 2019. **End Year:** 2021. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: PHP aimed to increase member adherence to prescribed antidepressant medications by conducting outreach calls to members. Member-level Interventions in 2021: ▪ Continued its education initiative to increase member awareness of depression symptoms and management. Provider-level Interventions in 2021: ▪ Incentivized providers through its Provider Quality Incentive Program for the appropriate documentation of depression screening, diagnosis, and follow-up. ▪ Offered educational opportunities on depression screening and antidepressant medication management.

Table 13: WSCC's Performance Improvement Project Summaries, 2021

WSCC's Performance Improvement Project Summaries
Title: Fall Risk and Prevention Program **Initiation Year:** 2019. **End Year:** Unknown at this time. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to decrease the number of fall-related hospitalizations for members ages 60 years and older who are living in the community. Member-level Interventions in 2021: ▪ Conducted outreach to members who had a fall event or deemed to be at-risk for a fall event for referral to fall prevention programs. MCO-level Interventions in 2021: ▪ Trained care coordination, transitions of care, and utilization management staff on the referral process to available evidence-based fall prevention programs.
Title: Addiction in Pregnancy Program **Initiation Year:** 2019. **End Year:** Unknown at this time. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to increase the proportion of pregnant members, ages 13 years and older, with a new episode of alcohol and other drug addiction, who initiated treatment for alcohol and other substances and who had two or more additional alcohol and other drug services or medication-assisted treatment. Member-level Interventions in 2021: ▪ Assigned pregnant members who had indicators of substance abuse to a high-risk obstetrics care coordinator. Care coordination included motivational interviewing, prenatal and postpartum education

and support, primary care provider assignment, education on medication-assisted treatment, and initiation of a pregnancy substance use disorder journal.

MCO-level Interventions in 2021:

- Refined methods for the identification of pregnant members with a possible substance use disorder.

Title: Adult Weight Management Program
Initiation Year: 2019. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

Aim: WSCC aims to increase the proportion of members ages 18 to 74 years who had an outpatient visit and documented body mass index or weight assessment. WSCC also aimed to decrease the proportion of members ages 19 years and older who had a documented body mass index of greater than 30.

Member-level Interventions in 2021:

- WSCC continued with its weight management program in which health coaches engaged members to conduct health assessments and to develop individual goal-driven care plans. Under the weight management program, members received educational materials, nutritional coaching, and access to self-management tools.

Provider-level Interventions in 2021:

- Educated providers on appropriate billing for body mass index assessments and the importance on documenting body mass index.
- Distributed a provider toolkit on the topic of adult body mass index.

Title: Diabetes Prevention and Management
Initiation Year: 2019. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

Aim: WSCC aims to increase the proportion of members ages 18 to 75 years diagnosed with diabetes who had an HbA1c screening. WSCC also aimed to decrease hospital admissions related to diabetes short-term complications.

Member-level Interventions in 2021:

- Continued to conduct care coordination for members with a hospital admission for a diabetes-related short-term complication.

Provider-level Interventions in 2021:

- Continued to outreach to educate providers on appropriate billing for lab results, medication adherence, diabetes medications, and diabetic screening guidelines.
- Continued to work with behavioral health homes to assist high-performing primary care providers with managing care for members with diabetes and a behavioral health diagnosis.

MCO-level Interventions in 2021:

- Continued efforts to collaborate with community health workers and peer support workers to conduct member coaching for diabetes management.

Title: Management for Clinical Depression
Initiation Year: 2019. **End Year:** Unknown at this time.
Validation Summary: There are no validation findings that indicate that the credibility of the performance improvement project results was at risk.

WSCC's Performance Improvement Project Summaries
Aim: WSCC aims to improve medication adherence among members, ages 18 years and older, who had a diagnosis of depression and were treated with antidepressant medications. Member-level Interventions in 2021: ▪ Outreached to members who had a history of mediation non-adherence. ▪ Conducted polypharmacy counseling for members identified as having numerous chronic conditions and who struggle with both medication and disease management. Provider-level Interventions in 2021: ▪ Conducted outreach to educate providers on appropriate depression screening tools and the requirement to implement a follow-up plan for members diagnosed with depression. MCO-level Interventions in 2021: ▪ Collaborated with pharmacies to implement 90-day refills and to contact prescribing providers when a request for an updated prescription is needed.

Table 14, Table 15, Table 16, Table 17, and Table 18 display summaries of IPRO's improvement assessment for each project indicator by performance improvement project topic by MCO. In these tables, IPRO's assessment of indicator performance was based on the following categories:

1. Performance improvement demonstrated and target met (or exceeded). (Denoted by green highlight.)
2. Performance decline demonstrated but target met (or exceeded). (Denoted by green highlight.)
3. Performance improvement demonstrated but target not met. (Denoted by yellow highlight.)
4. Performance decline demonstrated and target not met. (Denoted by red highlight.)
5. Unable to evaluate performance at this time. (Denoted by gray highlight.)

Table 14: MCO Indicator Performance – Long-term Services and Supports Topic

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
BCBS	Indicator 1 – Rate of urinary tract infection events per 1,000 days for the total long-term care resident population *(lower rate indicates better performance)*	Performance improvement demonstrated but target not met.
PHP	Indicator 1 – Volume of members who have successfully reintegrated and did not experience an avoidable hospitalization within 120 calendar days post discharge	Performance improvement demonstrated. PHP's performance against the target was not assessed as PHP established a target rate for improvement that was lower than the baseline rate.
	Indicator 2 – Volume of members who have successfully reintegrated and did not experience an avoidable re-institutionalization within 120 calendar days post-discharge	Performance improvement demonstrated. PHP's performance against the target was not assessed as PHP established a target rate for improvement that was lower than the baseline rate.
	Indicator 3 – Members who were identified with the potential of failure to thrive yet successfully reintegrated with care coordination support	Performance improvement demonstrated. PHP's performance against the target was not assessed as PHP established a target rate for improvement that was lower than the baseline rate.
WSCC	Indicator 1 – Rate of members who experienced a fall-related hospitalization via claims in the	Performance improvement demonstrated but target not met.

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
	population of long-term services and supports members ages 60 years and older living in the community during the measurement year *(lower rate indicates better performance)*	

Table 15: MCO Indicator Performance – Prenatal and Postpartum Care Topic

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
BCBS	**Indicator 1** – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	Performance decline demonstrated and target not met.
	Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	Performance improvement demonstrated but target not met.
PHP	**Indicator 1** – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	Performance decline demonstrated and target not met.
	Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	Performance improvement demonstrated and target exceeded.
WSCC	**Indicator 1** – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who were initiated for treatment for alcohol and other substances 14 days within diagnosis	Performance decline demonstrated and target not met.
	Indicator 2 – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who engaged in treatment for alcohol and other substances within 34 days of initial treatment	Performance improvement demonstrated but target not met.
	Indicator 3 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	Performance improvement demonstrated and target exceeded.

Table 16: MCO Indicator Performance – Adult Obesity Topic

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
BCBS	**Indicator 1** – The percentage of members ages 18 to 74 years who had at least one claim with an obesity diagnosis during the measurement year *(lower rate indicates better performance)*	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (< 140/90) in the most recent blood pressure reading during the measurement year (hybrid methodology)	Performance decline demonstrated and target not met.
	Indicator 3 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (< 140/90) in the most recent blood pressure reading during the measurement year (administrative methodology)	Performance improvement demonstrated but target not met.
PHP	**Indicator 1** – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	Performance improvement demonstrated but target not met.
	Indicator 2 – The percent of members ages 18 years and older that are enrolled in an obesity-related support program	Performance improvement demonstrated and target exceeded.
WSCC	**Indicator 1** – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	Performance decline demonstrated and target not met.
	Indicator 2 – The percentage of members who are ages 19 years or older and had a documented body mass index of ≥ 30 for the measurement year *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.

Table 17: MCO Indicator Performance – Diabetes Prevention and Management Topic

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
BCBS	**Indicator 1** – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 18 to 64 years and older *(lower rate indicates better performance)*	Performance improvement demonstrated but target not met.
	Indicator 2 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 65 years and older *(lower rate indicates better performance)*	Performance improvement demonstrated but target not met.
	Indicator 3 – The percentage of members ages 18 to 75 years with diabetes during the measurement year who complete an HbA1c test	Performance improvement demonstrated but target not met.
	Indicator 4 – The percentage of providers satisfied with the timeliness of discharge information received	Performance improvement demonstrated and target exceeded.
	Indicator 5 – The percentage of providers indicating having received adequate information about medication at discharge	Performance improvement demonstrated and target exceeded.
	Indicator 6 – The percentage of members indicating ease of getting necessary care, tests or treatment needed (Always or Usually)	Performance decline demonstrated and target not met.
PHP	**Indicator 1** – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	Performance decline demonstrated but target exceeded.
	Indicator 2 – The percentage of members ages 18 to 74 years with diabetes (type 1 and type 2) who had HbA1c testing	Performance decline demonstrated and target not met.
WSCC	**Indicator 1** – Rate of admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
	Indicator 2 – The percentage of members ages 18 to 75 years with diabetes (type 1 and type 2) who had a HbA1c screening	Performance improvement demonstrated and target exceeded.

Table 18: MCO Indicator Performance – Clinical Depression Screening and Follow-up

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
BCBS	**Indicator 1** – The percentage of members ages 18 to 84 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance improvement demonstrated but target not met.
	Indicator 2 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance decline demonstrated and target not met.
	Indicator 3 – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance improvement demonstrated but target not met.
	Indicator 4 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance decline demonstrated and target not met.
	Indicator 5 – Percentage of patients ages 18 to 64 years screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen	Performance improvement demonstrated but target not met.
	Indicator 6 – Percentage of patients ages 65 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen	Performance improvement demonstrated but target not met.
PHP	**Indicator 1** – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance improvement demonstrated and target exceeded.

MCO	Indicator Description	Assessment of Performance Between Measurement Years 2020 to 2021
	Indicator 2 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance improvement demonstrated and target exceeded.
	Indicator 3 – The percentage of members ages 18 to 64 years with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen	Performance improvement demonstrated and target exceeded.
	Indicator 4 – The percentage of Medicaid members ages 65 years and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen	Performance improvement demonstrated and target exceeded.
WSCC	Indicator 1 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance improvement demonstrated and target exceeded.
	Indicator 3 – The percentage of members ages 18 years and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen	Performance decline demonstrated but target exceeded.

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must identify standard performance measures relating to the performance of MCOs and that the state requires each MCO to annually measure and report to the state on its performance using the standard measures required by the state.

The Human Services Department selects a set of performance measures to evaluate the quality of care delivered by the MCOs to Centennial Care 2.0 members. For 2021, the Human Services Department required the MCOs to report a total of 10 performance measures, of which two were related to maternal health, three to child and adolescent preventive care, and five to behavioral health care. The MCOs were also required to achieve specified levels of performance as determined by the Human Services Department-determined targets outlined in the *Medicaid Managed Care Services Agreement*. Measures required for the 2021 Human Services Department Performance Measure Program are presented in Table 22.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Human Services Department for measurement year 2021.

Technical Methods for Data Collection and Analysis

For measurement year 2021, the Centennial Care 2.0 MCOs were required to submit performance measure data to the Human Services Department based on NCQA's *HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans*. To ensure compliance with these reporting requirements, each MCO contracted with an NCQA-HEDIS certified software vendor and an NCQA-certified HEDIS compliance audit licensed organization. Table 19 displays vendors and compliance audit licensed organizations by MCO.

Table 19: MCO HEDIS Vendors and HEDIS Compliance Audit Licensed Organizations, Measurement Year 2021

MCO	NCQA-Certified HEDIS Vendor	NCQA-Certified HEDIS Compliance Audit Licensed Organization
BCBS	Symphony Performance Health	Attest Health Care Advisors
PHP	Inovalon, Inc.	Healthy People
WSCC	Symphony Performance Health	Attest Health Care Advisors

The HEDIS vendor collected data and calculated performance measure rates on behalf of the MCO for measurement year 2021. The HEDIS vendor calculated rates using NCQA's *HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans*.

The HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement, and they also validated the MCO's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated the MCO's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities, and
2. HEDIS Specification Standards.

HEDIS compliance auditors consider MCO compliance with the information system capabilities and HEDIS specification standards to fully assess the organization's HEDIS reporting capabilities.

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit, HEDIS compliance auditors assessed the MCO's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the MCO has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 20 displays these standards as well as the elements audited for the standard.

Table 20: Information System Capabilities Standards

Information System Capabilities Categories	Elements Audited
1.0 Medicaid Services Data	Sound Coding Methods and Data Capture, Transfer and Entry
2.0 Enrollment Data	Data Capture, Transfer and Entry
3.0 Practitioner Data	Data Capture, Transfer and Entry
4.0 Medical Record Review Processes	Training, Sampling, Abstraction and Oversight
5.0 Supplemental Data	Capture, Transfer and Entry
6.0 Data Preproduction Processing	Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
7.0 Data Integration and Reporting	Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the MCO had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

HEDIS Specification Standards

HEDIS compliance auditors use the HEDIS specification standards to assess the MCO's compliance with conventional reporting practices and HEDIS technical specifications. These standards describe the required procedures for specific information, such as proper identification of denominators and numerators, and verification of algorithms and rate calculations.

Performance Measure Validation

Each MCO's calculated rates for the NCQA HEDIS Measurement Year 2021, and the New Mexico 2021 Performance Measure Program measure sets were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 20 presents these outcome designations and their definitions. Performance measure validation activities included, but were not limited to:

- confirmation that rates were produced with certified code or Automated Source Code Review approved logic,
- medical record review validation,
- review of supplemental data sources,
- review of system conversions/upgrades, if applicable,
- review of vendor data, if applicable, and

- follow-up on issues identified during documentation review or previous audits.

Table 21: Performance Measure Outcome Designations

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The organization followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures when the denominator is fewer than 30. b. For utilization measures that count member months when the denominator is fewer than 360 member months. c. For all risk-adjusted utilization measures when the denominator is fewer than 150. d. For electronic clinical data systems measures when the denominator is fewer than 30.
NB	No Benefit. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported. The organization chose not to report the measure.
NQ	Not Required. The organization was not required to report the measure.
BR	Biased Rate. The calculated rate was materially biased.
UN	Unaudited. The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

Each MCO's NCQA-certified HEDIS auditor produced a Final Audit Report and Audit Review Table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each MCO submitted these documents, as well as other required files to the Human Services Department and IPRO.

To augment the performance measure validation conducted by each MCO's HEDIS auditor, IPRO validated the files submitted by the MCO for the New Mexico Performance Measure Program.

IPRO reviewed each MCO's Final Audit Report and Audit Review Table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with Human Services Department requirements. To assess the accuracy of the reported rates, IPRO:

- recalculated performance measure rates using denominator and numerator member-level data and compared these recalculated rates to the rates reported by the MCO to NCQA via the Interactive Data Submission System tool;
- compared performance measure rates reported by the MCO to NCQA's Quality Compass regional Medicaid benchmarks; and
- analyzed performance-measure-rate-level trends to identify drastic changes in performance.

Table 21 displays measure definitions, steward, method of data collection, available points, and targets. Each target is the result of the 2018 MCO aggregated audited HEDIS data, calculating an average increase for each year until reaching the *2018 Quality Compass* (measurement year 2017) regional averages plus one percentage point. Failure to meet the Human Services Department-assigned target for an individual performance resulted in a

monetary penalty based on 2% of the total capitation paid to the MCO for the agreement year, divided by the number of performance measures specified for the agreement year.

Table 22: Performance Measure Descriptions and Available Points, Measurement Year 2021

Performance Measures (PM)	Steward	Data Collection Method[1]	Available Points	Measurement Year 2021 Target
PM 1 Well-Child Visits in the First 30 Months of Life – First 15 Months (W30): The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits	NCQA	Administrative	1	63.72%
PM 2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Physical Activity (WCC): The percentage of members ages 3 to 17 years who had an outpatient visit with a primary care provider or obstetrician/gynecologist and who had evidence of the following during the measurement year: counseling for physical activity	NCQA	Hybrid	1	53.33%
PM 3 Timeliness of Prenatal and Postpartum Care – Prenatal Care (PPC): The percentage of member deliveries of live births that received a prenatal care visit within the first trimester or within 42 days calendar days of enrollment	NCQA	Hybrid	1	80.70%
PM 4 Timeliness of Prenatal and Postpartum Care –Postpartum Care (PPC): The percentage of deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery	NCQA	Hybrid	1	64.65%
PM 5 Childhood Immunization Status – Combination 3 (CIS): The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three inactivated polio vaccine (IPV); one measles, mumps, and rubella (MMR); three *Haemophilus influenza* type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday	NCQA	Hybrid	1	69.27%
PM 6 Antidepressant Medication Management – Continuation Phase (AMM): The percentage of members ages 18 years and older who were treated with medication,	NCQA	Administrative	1	34.76%

Performance Measures (PM)	Steward	Data Collection Method[1]	Available Points	Measurement Year 2021 Target
had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 calendar days (or 6 months)				
PM 7 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation (IET): The total percentage of adolescent and adult members with a new episode of alcohol and other drug dependence who received: initiation of alcohol and other drug treatment	NCQA	Administrative	1	44.74%
PM 8 Follow-Up After Hospitalization for Mental Illness – 30 Days (FUH): The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner within 30 days after discharge	NCQA	Administrative	1	50.22%
PM 9 Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM): The percentage of emergency department visits for members six years of age and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness within 30 days of the emergency department visit	NCQA	Administrative	1	45.01%
PM 10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD): The percentage of members ages 18 to 64 years with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year	NCQA	Administrative	1	81.35%

[1] Administrative rates are calculated from claims data. Hybrid rates are calculated from claims data and medical record documentation.

As part of the measurement year 2021 performance measure validation activity, IPRO reviewed MCO quality improvement plans to assess the impact of MCO-directed improvement activities on health outcomes related to the performance measures in Table 22.

Description of Data Obtained

To perform the 2021 external quality review, IPRO utilized *the 2021–2022 Centennial Care Information Systems Capabilities Assessment Report* and each MCO's HEDIS measurement year 2021 final audit report and measurement year 2021 audit review table.

The *2021–2022 Centennial Care Information Systems Capabilities Assessment Report* included the results of IPRO's assessments and MCO-detailed information regarding data integration and systems architecture; enrollment systems and process; claims/encounter data systems; provider data systems and processes; and oversight of contracted vendors.

The final audit report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental, descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited).

The audit review table produced by the HEDIS compliance auditor displayed performance measure-level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the audit review table: administrative rate before exclusions; minimum required sample size, and minimum required sample size numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

Comparative Results

Each MCO's HEDIS compliance auditor determined that the NCQA HEDIS and the Centennial Care 2.0 performance rates reported by the MCO for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditors for any MCO. Table 23 displays the results of the NCQA Information System Capabilities review for each MCO.

Table 23: MCO Compliance with NCQA Information Systems Capabilities Standards, Measurement Year 2021

Information Systems Capabilities Standards	BCBS	PHP	WSCC
1.0 Medical Services Data	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met

Further, at the conclusion of the 2021–2022 information systems capabilities assessment, IPRO determined that the MCOs met or exceeded the standards reviewed. Table 7 displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO.

Table 24 displays the performance measure rates for each MCO, points earned, and Centennial Care 2.0 aggregate rates for measurement year 2021. To earn a point, the MCO's report rate had to meet or exceed the

target rate. Green shading indicates that the displayed rate met or exceeded the measurement year target. BCBS earned eight points. PHP earned six points. WSCC earned two points. For two performance measures, all MCOs reported rates that exceeded the Human Services Department targets. Seven Centennial Care 2.0 rates exceeded their respective targets.

Table 24: MCO Performance Measure Rates, Measurement Year 2021

Performance Measure (PM)[1]	Measurement Year 2021 Target Rate	BCBS Measurement Year 2021 Rate	PHP Measurement Year 2021 Rate	WSCC Measurement Year 2021 Rate	Centennial Care 2.0 Measurement Year 2021 Rate	Difference Between Centennial Care 2.0 Rate and Measurement Year Target (Percentage Points)
PM 1 W30 First 15 Months	63.72%	58.54%	44.37%	51.18%	50.51%	-13.21%
PM 2 WCC Physical Activity	53.33%	55.72%	58.15%	51.82%	55.23%	+1.90%
PM 3 PPC Prenatal Care	80.70%	82.00%	67.22%	61.31%	70.30%	-10.40%
PM 4 PPC Postpartum Care	64.65%	69.10%	68.33%	60.10%	65.74%	+1.09%
PM 5 CIS Combination 3	69.27%	69.59%	63.02%	58.88%	63.83%	-5.44%
PM 6 AMM Continuation	34.76%	40.63%	44.80%	43.67%	43.08%	+8.32%
PM 7 IET Initiation	44.74%	42.91%	54.25%	44.91%	48.99%	+4.25%
PM 8 FUH 30 Day	50.22%	56.60%	53.84%	53.94%	54.90%	+4.68%
PM 9 FUM 30 Day	45.01%	56.57%	63.40%	46.62%	59.02%	+14.01%
PM 10 SSD	81.35%	77.59%	78.48%	77.54%	78.06%	-3.29%
Total Points Earned (Max 10)		7	6	4		

[1] Green shading indicates that the displayed rate met or exceeded the measurement year target.

MCO performance measure trends are available in **Appendix C** of this report.

Technical Summary – Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a MCO's compliance with the standards of *Title 42 Part 438 Managed Care Subpart D MCO, PIHP*[19] *and PAHP*[20] *Standards* and the standards of *Title 42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Human Services Department conducts a variety of oversight activities to ensure that the MCOs are in compliance with federal and state Medicaid requirements and the standards of *Code of Federal Regulations Part 438 Subpart D*, *Code of Federal Regulations 438.330*, the *Managed Care Services Agreement*, and *New Mexico Administrative Code*. These activities include the compliance review, which is conducted annually. This activity centers on the provision of Medicaid services and is conducted for the Centennial Care 2.0 MCOs.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review to determine managed care compliance with federal Medicaid standards. To meet this federal regulation, the Human Services Department contracted with IPRO to conduct the 2021 compliance reviews.

The period under review was January 1, 2021, through April 28, 2022.

Technical Methods of Data Collection and Analysis

The compliance review included a comprehensive evaluation of MCO policies, procedures, files, and other materials corresponding to the subjects in Table 25. For the areas that included file review, 30 files were requested for each area. In some instances, there were fewer than 30 files available for review.

Table 25: Compliance Review Subject Areas, 2021

Federal Medicaid Subject Under Review	Centennial Care 2.0 Contract Subject Under Review	Document Review	File Review
438.10 Information Requirements	3.5 Cultural and Linguistic Competence, 4.8 Provider Network, 4.14 Member Materials, 4.15 Member Services	Yes	No
438.12 Provider Discrimination Prohibited	4.8 Provider Network	Yes	No
438.206 Availability of Services	4.8 Provider Network	Yes	No
438.207 Assurances of Adequate Capacity and Services	4.8 Provider Network	Yes	No
438.208 Coordination and Continuity of Care	4.4 Care Coordination, 4.8 Provider Network, 7.16 Records and Audit	Yes	Yes
438.210 Coverage and Authorization of Services	4.5 Self-Directed Community Benefit, 4.10 Provider Payments, 4.12 Quality Assurance	Yes	Yes
438.214 Provider Selection	4.8 Provider Network	Yes	Yes

[19] Prepaid Inpatient Health Plan.

[20] Prepaid Ambulatory Health Plan.

Federal Medicaid Subject Under Review	Centennial Care 2.0 Contract Subject Under Review	Document Review	File Review
438.224 Confidentiality	7.26 Disclosure and Confidentiality of Information	Yes	No
438.228 Grievance and Appeal Systems	4.16 Grievances and Appeals Systems	Yes	Yes
438.230 Subcontractual Relationships and Delegation	7.14 Major Subcontractors and Subcontractors, 7.16 Records and Audit	Yes	No
438.236 Practice Guidelines	4.12 Quality Assurance	Yes	No
438.242 Health Information Systems	4.19 Claims Management, 4.20 Information Systems	Yes	No
438.330 Quality Assessment and Performance Improvement Program	4.6 Self-Directed Community Benefit, 4.12 Quality Assurance	Yes	No
Not Applicable	4.6 Self-Directed Community Benefit	Yes	No
Not Applicable	4.9 Provider Agreements	Yes	No
Not Applicable	4.11 Provider Services	Yes	No
Not Applicable	4.17 Program Integrity	Yes	No
Not Applicable	4.21 Reporting Requirements	Yes	No
Not Applicable	7.16 Medical Records	Yes	No
Not Applicable	4.22 Obligations Relating to Member Personal Responsibility Initiatives, Primary Care Provider and Pharmacy Lock-ins	No	Yes

For this review, determinations of "met" and "not met" were used for each element under review. Definitions of these review determinations are presented in Table 26.

Table 26: Review Determination Definitions

Review Determination	Definition
Met	The MCO has met or exceeded the standard.
Not Met	The MCO has not met the standard.

Each regulatory element is allocated one point. While the number of document elements reviewed was generally consistent across MCOs, the number of file elements reviewed was MCO specific. Variations in the number of file elements reviewed derive from final sample sizes and not applicable elements. The Available Points column in Table 27 display the exact points that the MCOs could achieve for document review by subject; while Table 28 displays the exact points that each MCO could achieve for file review by subject. The difference in available points across the MCOs was driven by the number of elements that were determined to be not applicable, as well as the total number of files reviewed for that subject.

Table 27: Available Points Per Subject – Document Review

Federal Subject Under Review	Centennial Care 2.0 Contract Subject Under Review	Available Points Per MCO
438.10 Information Requirements	3.5 Cultural and Linguistic Competence, 4.8 Provider Network, 4.14 Member Materials, 4.15 Member Services	100
438.12 Provider Discrimination	4.8 Provider Network	3
438.206 Availability of Services	4.8 Provider Network	22
438.207 Assurance of Adequate Capacity and Services	4.8 Provider Network	10
438.208 Coordination and Continuity of Care	4.4 Care Coordination, 4.8 Provider Network, 7.16 Records and Audit	25
438.210 Coverage and Authorization of Services	4.12 Quality Assurance	25
438.214 Provider Selection	4.8 Provider Network	8
438.224 Confidentiality	7.26 Disclosure and Confidentiality of Information	10
438.228 Grievance and Appeal System	4.16 Grievances and Appeals Systems	81
438.230 Subcontractual Relationships and Delegation	7.14 Major Subcontractors and Subcontractors, 7.16 Records and Audit	9
438.236 Practice Guidelines	4.12 Quality Assurance	6
438.242 Health Information Systems	4.20 Information Systems	13
438.330 Quality Assessment and Performance Improvement	4.6 Self-Directed Community Benefit, 4.12 Quality Assurance	15
Not Applicable	4.6 Self-Directed Community Benefit	98
Not Applicable	4.9 Provider Agreements	54
Not Applicable	4.11 Provider Services	68
Not Applicable	4.17 Program Integrity	49
Not Applicable	4.21 Reporting Requirements	7
Not Applicable	7.16 Medical Records	10

Table 28: Available Points Per Subject – File Review

Federal/State Subject Under Review	BCBS	PHP	WSCC
438.210 Coverage and Authorization of Services			
Adverse Benefit Determinations, Standard and Expedited	330	330	330
438.208 Coordination and Continuity of Care			
Care Coordination, Continuous	703	670	440
Care Coordination, New Members	1029	1007	612
Care Coordination, Transitions of Care	73	311	80
Care Coordination, Traumatic Brain Injury	157	217	206
438.214 Provider Selection			
Credentialing	239	228	212
Recredentialing	281	265	242
438.228 Grievance and Appeal System			

Federal/State Subject Under Review	BCBS	PHP	WSCC
Member Appeals, Standard	354	89	346
Member Appeals, Expedited	442	390	397
Member Grievances	240	240	240
4.22 Obligations Relating to Member Personal Responsibility Initiatives, Primary Care Provider and Pharmacy Lock-ins			
Primary Care Provider/Pharmacy Lock-Ins - New	86	6	82
Primary Care Provider/Pharmacy Lock-Ins - Continuing	44	37	34

Final scores were calculated using the following method:

1. Each regulatory element had a specific set of review criteria to be scored on a met/not met basis by the compliance officer. There were discreet review criteria for the policy documentation review and for the file reviews.
2. An evaluation of "met" for any given criteria was awarded one point. In the case of the file review, the total points available would be equal to the total number of criteria multiplied by the number of files reviewed.
3. Total points awarded for each element were calculated by dividing the number of criteria met by the number of total criteria. This result was the raw score for the element.
4. The sums of the scores for each element were totaled to produce a final score for the review area.
5. The overall scores for document review and file were averaged to determine the compliance level achieved.

During this review period, there were four compliance levels: full, moderate, minimal, and non-compliance. Table 29 displays the compliance levels, score ranges, and definitions.

Table 29: Compliance Level Definitions

Compliance Levels	Score Range	Definition
Full Compliance	90%-100%	MCO met or exceeded standard
Moderate Compliance	80%-89%	MCO met requirements of the standard but had deficiencies in certain areas
Minimal Compliance	50%-79%	MCO met some requirements of the standard but has significant deficiencies requiring corrective action
Non-Compliance	<50%	MCO did not meet standard and requires corrective action

Description of Data Obtained

To conduct the 2021 external quality review, IPRO utilized the *2021 Compliance Review Report* and the final audit review tools. These sources included detailed descriptions of the review methodology, scoring, and final results.

Comparative Results

All MCOs achieved full compliance with *overall compliance average* scores exceeding the 90% threshold. Table 30 displays the overall compliance average scores and compliance level achieved for each MCO; while Table 31 displays the results of the compliance review by federal Medicaid standard for each MCO; and Table 32 displays the results of the compliance review by Medicaid standards specific to Centennial Care 2.0 for each MCO.

Table 30: Summary of MCO Compliance Review Results, 2021

MCO	2021 Overall Average	2021 Compliance Level Achieved
BCBS	99.45%	Full
PHP	99.63%	Full
WSCC	99.26%	Full

Full means that the MCO met or exceeded standard.

Table 31: MCO Compliance With Federal Medicaid Standards, 2021

Subject Area Under Review	BCBS Score	PHP Score	WSCC Score
438.10 Information Requirements	Full	Full	Full
438.12 Provider Discrimination	Full	Full	Full
438.206 Availability of Services	Full	Full	Full
438.207 Assurance of Adequate Capacity and Services	Full	Full	Full
438.208 Coordination and Continuity of Care	Full	Full	Full
438.210 Coverage and Authorization of Services	Full	Full	Full
438.214 Provider Selection	Full	Full	Full
438.224 Confidentiality	Full	Full	Full
438.228 Grievance and Appeal System	Full	Full	Full
438.230 Subcontractual Relationships and Delegation	Full	Full	Full
438.236 Practice Guidelines	Full	Full	Full
438.242 Health Information Systems	Full	Full	Full
438.330 Quality Assessment and Performance Improvement	Full	Full	Full

Full means that the MCO met or exceeded standard.

Table 32: MCO Compliance With Centennial Care 2.0 Standards, 2021

Subject Area Under Review	BCBS Score	PHP Score	WSCC Score
Document Review			
4.6 Self Directed Community Benefit	Full	Full	Full
4.9 Provider Agreements	Full	Full	Full
4.11 Provider Services	Full	Full	Full
4.17 Program Integrity	Full	Full	Full
4.21 Reporting Requirements	Full	Full	Full
7.16 Medical Records	Full	Full	Full
File Review			
Adverse Benefit Determinations, Standard and Expedited	Full	Full	Full
Care Coordination, Continuing Members	Full	Full	Full
Care Coordination, New Members	Full	Full	Full
Care Coordination, Transitions of Care	Full	Full	Moderate
Care Coordination, Traumatic Brain Injury	Full	Full	Full
Credentialing	Full	Full	Full
Recredentialing	Full	Full	Full

Subject Area Under Review	BCBS Score	PHP Score	WSCC Score
Member Appeals, Standard	Full	Full	Full
Member Appeals, Expedited	Full	Full	Full
Member Grievances	Full	Full	Full
Primary Care Provider/Pharmacy Lock-Ins, New Members	Full	Full	Full
Primary Care Provider/Pharmacy Lock-Ins, Continuing Members	Full	Full	Full

Full means that the MCO met or exceeded standard.

Moderate means that MCO met requirements of the standard but had deficiencies in certain areas.

Technical Summary – Validation of Network Adequacy

Objectives

Title 42 Code of Federal Regulations 438.68 Network adequacy standards requires states that contract with an MCO to develop and enforce time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support. The State of New Mexico codified Medicaid access standards based on these federal requirements, and the Human Services Department enforces MCO adoption of these standards in the *Medicaid Managed Care Services Agreement* at *4.8.7 Access to Services*.

Title 42 Code of Federal Regulations 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations 438.358 Activities related to external quality review* establish that state agencies must contract with an external quality review organization to perform the annual validation of network adequacy. To meet these federal regulations, the Human Services Department contracted IPRO to perform the 2021 validation of network adequacy for Centennial Care 2.0 MCOs.

Technical Methods of Data Collection and Analysis

The Human Services Department–established access, distance, and time standards are presented for the three New Mexico geographical regions: urban, rural, and frontier. Table 33 displays the Human Services Department Medicaid provider network standards that were applicable in 2021, while a map of the state, highlighting these regions, is available in Appendix D of this report.

Table 33: New Mexico Access and Distance Standards for Medicaid Networks

New Mexico Medicaid Access and Distance Standards
Access Requirements
▪ Member caseload, or panel, of any primary care provider should not exceed 2,000 ▪ Members have adequate access to specialty providers ▪ The MCO shall increase the number of unique members with a telemedicine visit by 20% annually, in rural, frontier, and urban areas for physical health specialists and behavioral health specialists[1]
Distance Requirements for Primary Care Providers and Pharmacies
▪ 90% of urban members shall travel no farther than 30 miles ▪ 90% of rural members shall travel no farther than 45 miles ▪ 90% of frontier members shall travel no farther than 60 miles
Distance Requirements for Behavioral Health Providers, Specialty Providers, Long-Term Care Providers, Hospitals and Transportation Providers
▪ 90% of urban members shall travel no farther than 30 miles ▪ 90% of rural members shall travel no farther than 60 miles[2] ▪ 90% of frontier members shall travel no farther than 60 miles[2]
Timeliness Requirements
▪ No more than 30 calendar days for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care ▪ No more than 60 calendar days for routine, asymptomatic member-initiated dental appointments ▪ No more than 14 calendar days for routine, symptomatic member-initiated, outpatient appointments for nonurgent primary medical care, behavioral health, and dental care ▪ Within 24 hours primary medical, behavioral health, and dental care outpatient appointments for urgent conditions

New Mexico Medicaid Access and Distance Standards
▪ Consistent with clinical urgency, but no more than 21 calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health ▪ Consistent with clinical urgency, but no more than 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 48 hours for urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing ▪ No longer than 40 minutes for the in-person prescription fill time (ready for pickup) ▪ No longer than 90 minutes for the "called in by a practitioner" prescription fill time (ready for pickup) ▪ Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners ▪ Within 2 hours for face-to-face behavioral health crisis services

[1] If the MCO achieves a minimum of 5% of total membership with telemedicine visits, as of November 30th each year, then the MCO must maintain that same 5% at the end of each calendar year to meet this target.
[2] Unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the Human Services Department.

Further, the *Medicaid Managed Care Program Quality Strategy*[21] (revised March 2021) defines New Mexico's standards for network adequacy and service availability, as well as the accepted evidence-based practice guidelines for the Centennial Care 2.0 program. The Human Services Department network adequacy and availability standards require that MCOs:

- Coordinate health care services.
- Maintain a provider network sufficient to provider timely access.
- Have written policies and procedures that align with the provider network standards delineated in the *Medicaid Managed Care Services Agreement*[22] and *Centennial Care Policy Manual*. These 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.
- Have written policies and procedures that meet NCQA standards and state and federal regulations for credentialing and re-credentialing of contracted providers.
- Submit a network adequacy report that summarizes the MCO's adherence to the established standards for provider panel size; distance thresholds for primary care, behavioral health, and specialty care; and timeliness thresholds.
- Establish a mechanism to monitor adherence with provider network standards.

Description of Data Obtained

The data and information obtained from the MCOs were related to provider counts, member geographical access, provider panel status, primary care provider-to-member ratios, distance analysis, and MCO narrative on improvement activities. These data were generally reported by region (rural, urban, and frontier).

[21] New Mexico Medicaid Managed Care Program Quality Strategy, January 2019 Revision. https://www.hsd.state.nm.us/wp-content/uploads/Quality-Strategy_FINAL-2019.pdf.
[22] Refers to section 4.8 Provider Network of the *Medicaid Managed Care Agreement*.

Comparative Results

Annual Compliance Review Results Related to Provider Network

Through the *Medicaid Managed Care Services Agreement*, the Human Services Department meets the requirements at *Title 42 Code of Federal Regulations 438.68 Network adequacy standards*. The Human Services Department's assessment of MCO compliance with these standards is performed during the annual administrative compliance review conducted by the state's external quality review organization. In September 2022, IPRO concluded the compliance review of 2021 for the Centennial Care 2.0 MCOs. Review area results for each MCO are displayed in Table 34.

Table 34: MCO Compliance with Centennial Care 2.0 Provider Network Standards, 2021

Provider Network Policy and Procedure Compliance Review Results		
BCBS	PHP	WSCC
Full Compliance	Full Compliance	Full Compliance

Full compliance means that MCO has an achievement score between 90% and 100%.
Data Source: *2021 Compliance Review Report.*

The Centers for Medicare & Medicaid Services requires state agencies to comply with the network adequacy standards at *Title 42 Code of Federal Regulations 438.68*. To ensure its compliance with these standards, the Human Services Department contractually requires the Centennial Care 2.0 MCOs to adhere to these standards. Table 35 displays a summary of MCO compliance with the standards at *Title 42 Code of Federal Regulations 438.68*.

Table 35: MCO Compliance with *42 Code of Federal Regulations* 438.68 *Network Adequacy Standards*, 2021

Summary of MCO Compliance with *42 Code of Federal Regulations 438.68*				
(b) Provider-Specific Network Adequacy Standards		BCBS	PHP	WSCC
(1) *Provider types.* At a minimum, a State must develop a quantitative network adequacy standard for the following provider types, if covered under the contract:	(i) Primary care, adult and pediatric	Met	Met	Met
	(ii) Obstetrics/Gynecology	Met	Met	Met
	(iii) Behavioral health (mental health and substance use disorder), adult and pediatric	Met	Met	Met
	(iv) Specialist (as designated by the state), adult, and pediatric	Met	Met	Met
	(v) Hospital	Met	Met	Met
	(vi) Pharmacy	Met	Met	Met
	(vii) Pediatric dental	Met	Met	Met
(2) Long-Term Services and Supports. States with MCO, prepaid inpatient health plan, or prepaid ambulatory health plan contracts which cover long-term services and supports must develop a quantitative network adequacy standard for long-term services and supports provider types		Met	Met	Met
(c) Development of Network Adequacy Standards		BCBS	PHP	WSCC
(1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a	(i) The anticipated Medicaid enrollment	Met	Met	Met
	(ii) The expected utilization of services	Met	Met	Met
	(iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, prepaid inpatient health plan, and prepaid ambulatory health plan contract	Met	Met	Met

Summary of MCO Compliance with *42 Code of Federal Regulations 438.68*				
minimum, the following elements:	(iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services	Met	Met	Met
	(v) The numbers of network providers who are not accepting new Medicaid patients	Met	Met	Met
	(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees	Met	Met	Met
	(vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language	Met	Met	Met
	(viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities	Met	Partially Met	Met
	(ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions	Met	Met	Met

Met means that the MCO met or exceeded standard.
Partially met means the MCO met most standards but demonstrates an opportunity for improvement.

Compliance with State Access Standards

Provider to Member Ratios

Availability standards established by the state require that no primary care provider have more than 2,000 assigned members. At the end of 2021, two Centennial Care 2.0 providers, one in the BCBS network and one in the PHP network, were reported as having panel sizes of greater than 2,000.

Each quarter, the MCOs are required to calculate and report the primary care provider to member ratio to the Human Services Department. IPRO validates the MCO-calculated ratios reported for the 4th quarter of the calendar year. Table 36 displays the validated MCO ratios for 2018–2021. All MCOs met the provider-member ratio standard in 2021.

Table 36: Provider to Member Ratios – 2018–2021

Measurement Period	BCBS	PHP[1]	WSCC
January 1, 2018 – December 31, 2018	1:79	1:100	Not Applicable[2]
January 1, 2019 – December 31, 2019	1:113	1:110	1:28
January 1, 2020 – December 31, 2020	1:139	1:105	1:27
January 1, 2021 – December 31, 2021	1:128	1:107	1:25

[1] In 2018, PHP's membership saw a significant increase (due to a mass transfer of UnitedHealthcare members). Membership growth coupled with a decrease in the number of primary care providers impacted the 2018 ratio.
[2] WSCC began Centennial Care 2.0 enrollment in 2019.
Data Sources: *Human Services Department Report #3* for the 4th quarter of calendar years 2018–2021.

Member Patient-Centered Medical Home Assignment

For legacy MCOs, like BCBS and PHP, the Human Services Department requires a minimum of 5% increase of the MCO's members assigned to a patient-centered medical home primary care provider. If the MCO achieves a minimum of 50% of membership being served by patient-centered medical homes, then the MCO must maintain that same minimum percentage at the end of the calendar year to meet this target. For non-legacy MCOs, like WSCC, the Human Services Department requires a minimum of 10% of the MCO's total membership be assigned to a patient-centered medical home primary care provider by the end of the calendar year.

At the end of 2021, approximately 63% of individuals enrolled in Centennial Care 2.0 were assigned to a patient-centered medical home. Table 37 displays membership assignment to patient-centered medical homes in 2020 and 2021 by MCO.

Table 37: Patient-Centered Medical Home Assignment – 2020 and 2021

Measurement Period/Measure	BCBS	PHP	WSCC	Centennial Care
January 1, 2020 – December 31, 2020				
Members Assigned to a Patient-Centered Medical Home	135,066	271,763	34,769	441,598
% Of Membership Assigned	46.8%	64.2%	37.9%	55.0%
January 1, 2021 – December 31, 2021				
Members Assigned to a Patient-Centered Medical Home	175,158	287,898	41,990	505,046
% Of Membership Assigned	57.0%	65.1%	45.9%	63.34%

Data Sources: *Human Services Department Report #48* for the 4th quarters of 2020 and 2021.

Telemedicine Utilization

As part of the Delivery System Improvement Performance Target, MCOs focus on increasing telemedicine availability and utilization to achieve the Human Services Department–established goal of a 20% increase from the prior year. As part of its monitoring system, the Human Services Department collects quarterly MCO counts of unduplicated members served via telemedicine in rural, frontier, and urban areas. Table 38 displays the counts of unique members that received telemedicine services in 2020 and 2021, as well as the percentage change from year to year.

Table 38: Members with At Least One Telemedicine Visit – 2020 and 2021

Members with a Telemedicine Visit, Unduplicated				
Measurement Period	BCBS	PHP	WSCC	Centennial Care
January 1, 2020 – December 31, 2020	82,809	42,562	15,986	141,357
January 1, 2021 – December 31, 2021	80,147	119,316	16,957	216,420
Change +/- Between 2020 and 2021	-3.2%	+180.3%	+6.1%	+53.1%

Data Sources: *Human Services Department Report #TEL* for the 4th quarter of 2021.

Compliance with State Distance Standards

The Human Services Department requires that at least 90% of an MCO's membership has access to providers within the established distance standards. IPRO analyzed the Human Services Department Report #55 produced for the fourth quarter of 2021 by the MCOs to determine if the MCOs were compliant with state distance standards. Table 39 displays MCO performance in meeting the 90% threshold for distance.

Table 39: Compliance with State Distance Standards –2021, 4th Quarter

Specialty	Region	Standard	BCBS	PHP	WSCC
Physical Health					
Adult Primary Care	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 45 Miles	Met	Met	Met
	Frontier	1 in 60 Miles	Met	Met	Met
Cardiology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Certified Nurse Midwifery	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Certified Nurse Practitioner	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Dermatology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Dental	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Endocrinology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Ear, Nose, and Throat (Otolaryngology)	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Not Met	Met
	Frontier	1 in 90 Miles	Met	Not Met	Met
Federally Qualified Health Centers	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Federally Qualified Health Centers, Primary Care Providers, Only	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 45 Miles	Met	Met	Met
	Frontier	1 in 60 Miles	Met	Met	Met
Hematology/Oncology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Not Met
Indian Health Services/ Tribal 638/Urban Indian Health	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Neurology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Neurosurgery	Urban	1 in 30 Miles	Met	Not Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met

Specialty	Region	Standard	BCBS	PHP	WSCC
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Obstetrics/Gynecology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Orthopedics	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Pediatrics	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 45 Miles	Met	Met	Met
	Frontier	1 in 60 Miles	Met	Met	Met
Pharmacy	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 45 Miles	Met	Met	Met
	Frontier	1 in 60 Miles	Met	Met	Met
Physician Assistant	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Podiatry	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Rheumatology	Urban	1 in 30 Miles	Not Met	Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Rural Health Clinics	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Met	Met
Surgery	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Urology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Behavioral Health					
Accredited Residential Treatment Centers	Urban	1 in 30 Miles	Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Assertive Community Treatment	Urban	1 in 30 Miles	Not Met	Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Behavioral Management Services	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Community Mental Health	Urban	1 in 30 Miles	Met	Not Met	Not Met

Specialty	Region	Standard	BCBS	PHP	WSCC
Centers	Rural	1 in 60 Miles	Met	Met	Not Met
	Frontier	1 in 90 Miles	Met	Met	Not Met
Core Service Agencies	Urban	1 in 30 Miles	Met	Met	Not Met
	Rural	1 in 60 Miles	Met	Met	Not Met
	Frontier	1 in 90 Miles	Met	Met	Not Met
Day Treatment Services	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Freestanding Psychiatric Hospitals	Urban	1 in 30 Miles	Met	Not Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not met	Not Met
Federally Quality Health Centers Providing Behavioral Health Services	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
General Hospitals with Psychiatric Units	Urban	1 in 30 Miles	Met	Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Indian Health Service and Tribal 638s Providing Behavioral Health	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Inpatient Psychiatric Hospital	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Intensive Outpatient Services	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Not Met
	Frontier	1 in 90 Miles	Met	Met	Met
Methadone Clinic	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Multi-Systemic Therapy	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Non-Accredited Residential Treatment Centers and Group Homes	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Other Licensed Independent Behavioral Health Providers	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Outpatient Provider Agencies	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Partial Hospital Programs	Urban	1 in 30 Miles	Not Met	Not Met	Not Met

Specialty	Region	Standard	BCBS	PHP	WSCC
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Psychiatry	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Psychology	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Residential Health Centers Providing Behavioral Health Services	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Met
Suboxone-Certified Medical Doctors	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Treatment Foster Care I & II	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Long-Term Care					
Assisted Living Facilities	Urban	1 in 30 Miles	Not Met	Not Met	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Not Met
	Frontier	1 in 90 Miles	Not Met	Met	Not Met
General Hospitals	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Nursing Facilities	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Personal Care Service Agencies	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
Transportation	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met

Compliance with State Timeliness Requirements

The Human Services Department requires the Centennial Care 2.0 MCOs to conduct semi-annual secret shopper surveys to assess adult and child access to primary care within the urban, rural, and frontier regions. The MCOs were compliant with this requirement for 2021.

BCBS conducted two secret shopper surveys in 2021, with calls taking place April 26 to May 24 and November 29 to December 30. BCBS surveyed pediatric and adult providers for primary care and behavioral health. The combined results of these two surveys are displayed in Table 40.

Table 40: BCBS's Appointment Availability Results – 2021

Appointment Type	Total Providers Surveyed Who Accept New Patients	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers Who Accept New Patients
Physical Primary Care			
Routine, Asymptomatic	303	233	76.90%
Routine, Symptomatic	171	100	58.48%
Urgent	149	29	19.46%
Behavioral Health Care			
Routine, Substance Use Disorder	104	71	68.27%
Urgent, Substance Use Disorder	92	45	48.91%
Routine, Community Mental Health Centers	35	27	77.14%
Urgent, Community Mental Health Centers	28	14	50.00%
Routine, Clinics and Agencies	125	73	58.40%
Urgent, Clinics and Agencies	113	11	9.73%
Routine, Facilities	0	Not Applicable	Not Applicable
Urgent, Facilities	0	Not Applicable	Not Applicable
Routine, Practitioner	83	40	48.19%
Urgent, Practitioner	121	20	16.53%

Data Sources: *BCBS New Mexico Centennial Care Secret Shopper Report*, July 2021, and December 2021.

PHP conducted two secret shopper surveys in 2021. For the first survey, physical health calls took place January 4 to January 8, and behavioral calls took place March 8 to 12. For the second survey, physical health calls took place June 25 to July 2, and behavioral health calls taking place July 6 to July 16. In addition to surveying primary care practitioners, PHP also surveyed cardiologists, endocrinologists, gastroenterologists, obstetricians/ gynecologists, occupational medicine practitioners, ophthalmologists, orthopedists, otolaryngologists, pain management providers, and urologists. The combined results of these two surveys are displayed in Table 41.

Table 41: PHP's Appointment Availability Results – 2021

Appointment Type	Total Number of Appointments Made	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers
Physical Primary and Specialty Care			
Routine Care	35	22	62.94%
Preventive Care	31	19	61.32%
Urgent Care	21	6	28.29%
Specialty Care	122	56	45.90%
Behavioral Health Care			
Alcohol Use, Routine, Adult	4	3	75.00%
Substance Abuse, Child, and Adolescent	1	1	100.00%
Mental Health, Routine, Adult	30	21	69.83%
Mental Health, Routine, Child	58	17	29.38%
Mental Health, Urgent, Adult	35	4	11.49%
Mental Health, Urgent, Child	10	1	10.00%

Appointment Type	Total Number of Appointments Made	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers
Mental Health, Schizophrenia	8	4	50.00%
Community Mental Health Center/Core Service Agency/Behavioral Health	4	3	75.00%
Suboxone Use, Routine, Adult	0	0	0.00%
Suboxone Use, Routine, Child	1	1	100.00%
Suboxone Use, Urgent, Child	0	0	0.00%

Data Sources: *PHP Health Plan & PHP Insurance Company, Inc. Practitioner Services/Patient Access*, January 2021, *Presbyterian Health Plan Behavioral Health Mystery Shop*, March 2021, *PHP Health Plan & PHP Insurance Company, Inc. Practitioner Services/Patient Access*, July 2021, and *Presbyterian Health Plan Behavioral Health Mystery Shop*, July 2021.

WSCC conducted a secret shopper survey in 2021, with survey calls taking place November 12 to December 23. In addition to surveying primary care providers, WSCC also surveyed behavioral health providers. The results of these two surveys are displayed in Table 42.

Table 42: WSCC's Appointment Availability Results – 2021

Appointment Type	Total Number of Providers Who Completed the Survey	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers
Physical Primary Care			
Routine, Asymptomatic	557	240	43.09%
Urgent	542	295	54.43%
Behavioral Health Care			
Routine, Substance Use Disorder and Community Mental Health Centers, Adult and Child	265	136	51.32%
Urgent, Substance Use Disorder and Community Mental Health Centers, Adult and Child	275	155	56.36%

Data Sources: *WSCC Community Care January 2022 Physical Health Secret Shopper Survey Report* and *WSCC Community Care January 2022 Behavioral Health Secret Shopper Survey Report*.

Technical Summary – Validation of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each MCO, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *Title 42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

The Human Services Department requires Centennial Care 2.0 MCOs to sponsor a member experience survey annually. The goal of the survey is to get feedback from these members about how they view the health care services they receive. The Human Services Department uses results from the survey to determine variation in member satisfaction among the MCOs. Further, section *4.12.5 Member Satisfaction Survey* of the *Medicaid Managed Care Services Agreement* requires that the CAHPS survey tool be administered.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of care provided.

Each MCO independently contracted with a certified CAHPS vendor to administer the adult and child surveys for measurement year 2021.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for New Mexico's Centennial Care 2.0 program were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the chronic conditions measurement set). The CAHPS Medicaid questionnaire set includes separate versions for the adult and child populations.

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2021, continuously enrolled for at least five of the last six months of 2021, and currently enrolled in the MCO.

Table 43 provides a summary of the technical methods of data collection by MCO.

Table 43: CAHPS Technical Methods of Data Collection by MCO, Measurement Year 2021

	BCBS	PHP	WSCC
Adult CAHPS Survey			
Survey Vendor	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Adult	5.1H Medicaid Adult
Survey Period	03/01/2022-5/16/2022	03/08/2022-05/18/2022	03/01/2022-5/12/2022
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet	Mail, Telephone
Sample Size	1,553	2,025	1,350
Response Rate	13.0%	12.9%	8.6%
Child CAHPS Survey			
Survey Vendor	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Child	5.1H Medicaid Child	5.1H Medicaid Child

	BCBS	PHP	WSCC
Survey Period	03/01/2022-5/16/2022	03/08/2022-05/18/2022	03/01/2022-5/12/2022
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet	Mail, Telephone
Sample Size	1,898	2,310	1,650
Response Rate	10.0%	10.0%	9.1%

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 44 displays these categories and the measures by which these response categories are used.

Table 44: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Customer Service	Never, Sometimes, Usually, Always *(Top-level performance is considered responses of "usually" or "always.")*
Global Rating Measures	
▪ Rating of All Health Care ▪ Rating of Personal Doctor ▪ Rating of Specialist Talked to Most Often ▪ Rating of Health Plan ▪ Rating of Treatment or Counseling	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

To assess MCO performance, IPRO compared MCO scores to national Medicaid performance reported in the *2022 Quality Compass* (measurement year 2021) for all lines of business that reported measurement year 2021 CAHPS data to NCQA.

Description of Data Obtained

For each MCO, IPRO received a copy of the final measurement year 2021 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

Comparative Results

When compared to national Medicaid benchmarks for measurement year 2021, BCBS achieved one adult CAHPS score that exceeded the 90th percentile and one adult CAHPS score that exceeded the national Medicaid average. Each MCO achieved a single child CAHPS score that exceeded the national Medicaid average.

Table 45 displays the results of the 2022 CAHPS Adult Medicaid Survey for measurement year 2021 while Table 46 displays the results of the 2022 CAHPS Child Medicaid Survey for measurement year 2021. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2022 Quality Compass* for measurement year 2021.

Table 45: Adult Member CAHPS Results, Measurement Year 2021

	BCBS Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	PHP Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	WSCC Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	National 2021 Medicaid Average[1]
Rating of Health Plan[2]	84.5%	90th	78.2%	33.33rd	77.7%	33.33rd	77.98%
Rating of All Health Care[2]	76.0%	50th	68.7%	<10th	Small Sample	Not Applicable	75.41%
Rating of Personal Doctor[2]	80.7%	33.33rd	79.9%	25th	Small Sample	Not Applicable	82.38%
Rating of Specialist[2]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	83.52%
Getting Care Quickly[3]	Small Sample	Not Applicable	74.5%	10th	Small Sample	Not Applicable	80.22%
Getting Needed Care[3]	76.9%	10th	76.4%	10th	Small Sample	Not Applicable	81.86%
Customer Service[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	88.91%
How Well Doctors Communicate[3]	88.1%	<10th	90.2%	10th	Small Sample	Not Applicable	92.51%
Coordination of Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	83.96%

[1] National Medicaid benchmarks displayed in these tables come from *NCQA's 2022 Quality Compass* for measurement year 2021.

[2] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[3] Rates reflect responses of "always" or "usually."

Small sample means that the denominator was less than 100 members.

BCBS: Blue Cross Blue Shield of New Mexico; PHP: Presbyterian Health Plan, Inc.; WSCC: Western Sky Community Care, Inc.

Table 46: General Population-Child Member CAHPS Results, Measurement Year 2021

	BCBS Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	PHP Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	WSCC Measurement Year 2021	National 2021 Medicaid Percentile Rank Achieved[1]	National 2021 Medicaid Average[1]
Rating of Health Plan[2]	83.1%	10th	86.8%	50th	87.8%	50th	86.48%
Rating of All Health Care[2]	88.0%	50th	81.5%	<10th	Small Sample	Not Applicable	87.34%
Rating of Personal Doctor[2]	89.4%	33.33rd	90.4%	33.33rd	87.6%	10th	90.18%
Rating of Specialist[2]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	86.54%
Getting Care Quickly[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	86.74%
Getting Needed Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	84.19%
Customer Service[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	88.06%
How Well Doctors Communicate[3]	Small Sample	Not Applicable	91.4%	10th	Small Sample	Not Applicable	94.18%
Coordination of Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	84.71%

[1] National Medicaid benchmarks displayed in these tables come from *NCQA's 2022 Quality Compass* for measurement year 2021.

[2] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[3] Rates reflect responses of "always" or "usually."

Small sample means that the denominator was less than 100 members.

BCBS: Blue Cross Blue Shield of New Mexico; PHP: Presbyterian Health Plan, Inc.; WSCC: Western Sky Community Care, Inc.

Technical Summary – NCQA Accreditation

Objectives

Section *3.1.1 Licensure and Accreditation* of the *Medicaid Managed Care Services Agreement* requires that each MCO seek and maintain NCQA Accreditation.

NCQA's Health Plan Accreditation program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals.

Technical Methods of Data Collection and Analysis

The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

Beginning with Health Plan Accreditation 2020 and the 2020 HEDIS reporting year, the health plan ratings and accreditation were aligned to improve consistency between the two activities and to simplify the scoring methodology for accreditation. An aggregate summary of MCO performance on these two activities is summarized in the NCQA Health Plan Report Cards.

To earn NCQA accreditation, each MCO must meet at least 80% of applicable points in each standards category, submit HEDIS and CAHPS data during the reporting year after the first full year of accreditation, and submit HEDIS and CAHPS data annually thereafter. The standards categories include quality management, population health management, network management, utilization management, credentialing and re-credentialing, and member experience.

To earn points in each standards category, MCOs are evaluated on the factors satisfied in each applicable element and earn designation of "met," "partially met," or "not met" for each element. Elements are worth 1 or 2 points and are awarded based on the following:

- Met = Earns all applicable points (either 1 or 2);
- Partially Met = Earns half of applicable points (either 0.5 or 1); or
- Not Met = Earns no points (0).

Within each standards category, the total number of points is added. The MCOs achieve 1 of 3 accreditation levels based on how they score on each standards category. Table 47 displays the accreditation determination levels and points needed to achieve each level.

Table 47: NCQA Accreditation Statuses and Points

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with Provisional Status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55% of applicable points

To distinguish quality among the accredited MCOs, NCQA calculates an overall rating for each MCO as part of its Health Plan Ratings program. The overall rating is the weighted average of an MCO's HEDIS and CAHPS measure ratings, plus accreditation bonus points (if the plan is accredited by NCQA), rounded to the nearest half point and displayed as stars.

Overall ratings are recalculated annually and presented in the *Health Plan Ratings* report that is released every September. The *Health Insurance Plan Ratings 2022* methodology used to calculate an overall rating is based on MCO performance on dozens of measures of care and is calculated on a 0–5 scale in half points, with five being the highest. Performance includes these three subcategories (also scored 0–5 in half points):

1. Patient Experience: Patient-reported experience of care, including experience with doctors, services, and customer service (measures in the Patient Experience category).
2. Rates for Clinical Measures: The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. NCQA Health Plan Accreditation: For a plan with an accredited or provisional status, 0.5 bonus points are added to the overall rating before being rounded to the nearest half point and displayed as stars. A plan with an Interim status receives 0.15 bonus points added to the overall rating before being rounded to the nearest half point and displayed as stars.

The rating scale and definitions for each are displayed in Table 48.

Table 48: NCQA Health Plan Star Rating Scale

Ratings	Rating Definition
5	The top 10% of health plans, which are also statistically different from the mean.
4	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean.
3	The middle one-third of health plans and health plans that are not statistically different from the mean.
2	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean.
1	The bottom 10% of health plans, which are also statistically different from the mean.

Due to the continued impact of COVID-19, NCQA used the same measurement year percentiles as plan data for scoring in *Health Plan Ratings 2022.*

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website[23] to review the *Health Plan Report Cards 2022* for BCBS, PHP, and WSCC. For each MCO, star ratings, accreditation status, plan type, and distinctions were displayed. At the MCO-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall. The data presented here were current as of June 30, 2022.

[23] NCQA Health Plan Report Cards Website: https://reportcards.ncqa.org/health-plans.

Comparative Results

BCBS, PHP, and WSCC were compliant with the state's requirement to achieve and maintain NCQA health plan accreditation. Further, the MCOs have sought or are currently seeking NCQA distinction in other programs. **Table 49** displays each MCO's health plan accreditation level achieved, effective dates of the accreditation, and upcoming scheduled review dates, while **Table 51** displays a summary of MCO participation in other NCQA programs.

Table 49: MCO Medicaid Health Plan Accreditation Status

MCO	Accreditation Level Achieved	Start Date	Expiration Date	Next Review Date
BCBS	Accredited	11/4/2021	11/4/2024	6/6/2023
PHP	Accredited	8/28/2020	8/28/2023	8/6/2024
WSCC	Accredited	3/26/2021	3/26/2024	1/9/2024

PHP achieved an overall health plan star rating of 3.0 out of 5.0 for *Health Plan Ratings 2022*, while BCBS and WSCC achieved star ratings of 2.5. Further, PHP and WSCC achieved 5.0 stars for the Risk-Adjusted Utilization subcategory. (The Risk-Adjusted Utilization subcategory performance is based on a single measure: *Plan All-cause Readmissions*.) **Table 50** displays the MCOs' overall health plan star ratings as well as the ratings for the three overarching categories and their subcategories under review.

Table 50: MCO NCQA Rating by Category, Measurement Year 2021

Overarching and Subcategories *(Number of Measures Included in Subcategory)*	MCO and Star Rating Achieved *(out of 5 stars)*		
	BCBS	PHP	WSCC
	2.5 Stars Overall	3.0 Stars Overall	2.5 Stars Overall
Patient Experience	**2.0 Stars**	**1.5 Stars**	**Insufficient Data**
Getting Care *(2)*	Insufficient Data	Insufficient Data	Not Applicable
Satisfaction with Plan Physicians *(1)*	3.0 Stars	1.0 Star	Not Applicable
Satisfaction with Plan and Plan Services *(2)*	1.5 Stars	2.0 Stars	2.0 Stars
Prevention	**2.5 Stars**	**2.5 Stars**	**2.0 Stars**
Children and Adolescent Well Care *(4)*	3.0 Stars	3.0 Stars	2.5 Stars
Women's Reproductive Health *(3)*	1.5 Stars	2.0 Stars	1.5 Stars
Cancer Screening *(2)*	2.0 Stars	1.0 Star	1.0 Star
Other Preventive Services *(3)*	2.0 Stars	2.0 Stars	2.0 Stars
Treatment	**2.0 Stars**	**2.5 Stars**	**2.0 Stars**
Respiratory *(6)*	2.5 Stars	2.0 Stars	1.5 Stars
Diabetes *(5)*	1.5 Stars	2.0 Stars	1.0 Star
Heart Disease *(3)*	1.0 Star	2.5 Stars	1.0 Star
Behavioral Health-Care Coordination *(4)*	3.0 Stars	3.0 Stars	2.5 Stars
Behavioral Health-Medication Adherence *(3)*	2.5 Stars	2.5 Stars	2.5 Stars
Behavioral Health-Access, Monitoring and Safety *(5)*	3.0 Stars	3.0 Stars	3.0 Stars
Risk-Adjusted Utilization *(1)*	3.0 Stars	5.0 Stars	5.0 Stars
Overuse of Opioids *(3)*	3.5 Stars	3.0 Stars	4.5 Stars
Other Treatment Measures *(1)*	3.0 Stars	3.0 Stars	3.0 Stars

Table 51: Other NCQA Programs and MCO Participation

NCQA Program	Program Description	MCO Status
Health Equity Accreditation	This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.	▪ BCBS – Scheduled for 11/14/2023 ▪ WSCC – Scheduled for 12/05/2023
Long Term Services and Support	NCQA awards Long Term Services and Support Distinction to organizations that deliver efficient, effective person-centered care that meets people's needs, helps keep people in their preferred setting and aligns with state requirements.	▪ PHP – Distinction ▪ WSCC – Distinction
Multicultural Health Care	This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.	▪ WSCC – Distinction

Distinction means that the MCO met or exceeded the NCQA standard(s).

Managed Care Organization Response to the 2020 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the external quality review organization during the previous year's external quality review." Table 52 displays the assessment categories used by IPRO to describe MCO progress towards addressing the 2020 external quality review recommendations. Table 53, Table 54, and Table 55 display BCBS's, PHP's, and WSCC's progress related to the recommendations made in the *Centennial Care External Quality Review Technical Report, Calendar Year 2020*, as well as IPRO's assessment of the MCO's response. In these tables, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Table 52: MCO Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
MCO's quality improvement response resulted in demonstrated improvement.
Partially Addressed
MCO's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
MCO's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Table 53: IPRO's Assessment of BCBS's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of BCBS's Response to the 2020 Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Request technical assistance related to the selection of performance indicators and the development of interventions and tracking measures.	Addressed			
	Refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.	Addressed			
Performance Improvement Project 1 – Long-Term Services and Supports	BCBS should continue its efforts to improve diabetic eye care as targets were not met. However, BCBS should evaluate the effectiveness of its improvement strategy and modify it as needed. BCBS should also investigate the reason(s) why the rate for retinal eye exams among members residing in a long-term care facility declined.	Addressed	X	X	X
Performance Improvement Project 2 – Prenatal and Postpartum Care	BCBS should continue its efforts to improve prenatal and postpartum care as targets were not met. However, BCBS should evaluate the effectiveness of its improvement strategy and modify it as needed.	Addressed	X	X	X
	BCBS should identify the reason(s) why the rate of retinal eye exams for members residing in a long-term care facility with a diagnosis of diabetes declined.	Addressed	X	X	X
Performance Improvement Project 3 – Adult Obesity	BCBS should continue its efforts to address adult obesity as targets were not met. However, BCBS should evaluate the effectiveness of its improvement strategy and modify it as needed. BCBS should consider empowering providers to treat obesity as a true chronic disease by incentivizing and sponsoring obesity medicine trainings; ensuring coverage of anti-obesity pharmacotherapy; and emphasizing motivational interviewing and obesity treatment procedures (for example, if diet and exercise	Addressed	X	X	X

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of BCBS's Response to the 2020 Recommendation	Quality	Timeliness	Access
	trials failed, the next step is anti-obesity pharmacotherapy trials).				
Performance Improvement Project 4 – Diabetes Prevention and Management	BCBS should continue its efforts to improve member diabetes management as targets were not met. However, BCBS should evaluate the effectiveness of its improvement strategy and modify it as needed.	Addressed	X		
	BCBS should investigate the reason(s) why the rate of admissions related diabetes short-term complications increased and why the rate for indicator HbA1c screenings decreased.	Addressed	X		
Performance Improvement Project 5 – Depression Screening and Management	BCBS should investigate the reasons why the rate of clinical depression screenings and follow-up for positive screens for the two adult age cohorts fell below their respective baseline rates.	Addressed	X		
	BCBS should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this performance improvement project.	Addressed	X		
Performance Measures	Attach tracking measures to key quality improvement activities to support continuous monitoring for intervention effectiveness.	Addressed	X	X	X
Compliance with Medicaid Standards	BCBS should provide ongoing training to staff involved in transition of care followed by routine monitoring. BCBS should also identify work aids to support staff documentation of evidence of appropriate care.	Addressed	X		
Network Adequacy	BCBS should update the online provider directory to reflect accurate and current cultural competency training information for each provider.	Addressed	X		X

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of BCBS's Response to the 2020 Recommendation	Quality	Timeliness	Access
	BCBS should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but BCBS was not, for example, for dermatology in the urban region and intensive outpatient services in the rural region, BCBS should compare networks to identify opportunities to contract with new providers. BCBS should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.	Partially Addressed		X	X
	In the absence of a Human Services Department appointment timeliness threshold, BCBS should identify a threshold to work toward. Although not required by Human Services Department, BCBS should also expand its secret shopper survey to include additional appointment types and other specialties. Based on BCBS's reasons for no appointment, BCBS should work to improve the accuracy of its provider data, specifically participation status, panel status, and telephone number to reduce barriers members face when attempting to obtain appointments.	Partially Addressed		X	X
Quality-of-Care Survey – Member Experience	BCBS should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. BCBS should also utilize complaints and grievances to identify and address trends that may impact the member-health plan experience.	Addressed	X	X	X

Table 54: IPRO's Assessment of PHP's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2020 Recommendation	Quality	Timeliness	Access
Performance Improvement Project – General	PHP should request external quality review organization technical assistance to support the selection of appropriate performance indicators and the development of interventions and tracking measures.	Addressed			
	PHP should refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.	Partially Addressed			
	To ensure future performance improvement project methodologies are effectively designed and managed, PHP staff should complete performance improvement project refresher trainings, consult the Centers for Medicare & Medicaid Services' protocol to ensure the performance improvement project meets all validation requirements, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase.	Partially Addressed			
Performance Improvement Project 1 – Transitions of Care	PHP should identify alternative performance indicators to evaluate performance improvement project performance as the measurement year 2019 baseline rates exceeded the target rates and were exceptionally high pre-intervention phase. It is not possible to evaluate the success of the current intervention strategy without the appropriate measures tied to them.	Not Addressed	X	X	X
Performance Improvement Project 2 – Prenatal and Postpartum Care	PHP should continue its efforts to improve prenatal and postpartum care as targets were not met. However, PHP should enhance its quality improvement strategy beyond promoting the PHP Baby Benefits program to members.	Not Addressed		X	X

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2020 Recommendation	Quality	Timeliness	Access
Performance Improvement Project 3 – Adult Obesity	PHP should investigate the reason(s) why the rate for documented body mass index decreased.	Addressed	X		
	As the Obesity-Related Support Program was developed as part of the performance improvement project intervention strategy, IPRO suggests that the related indicator (#2) be used as a tracking measure instead of an indicator. Further, IPRO recommends that PHP evaluate the health outcomes of members who enrolled in an obesity-related support program.	Not Addressed			
	PHP should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this performance improvement project.	Addressed	X	X	X
Performance Improvement Project 4 – Diabetes	PHP should continue to its efforts to increase HbA1c screenings as the target was not met.	Partially Addressed	X	X	X
	PHP should investigate the reason(s) why the rate for HbA1c testing continues to perform below the target rate.	Addressed	X	X	X
	PHP should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this performance improvement project.	Addressed	X	X	X
Performance Improvement Project 5 – Depression Screening and Management	PHP should continue effective interventions and increase target rates that were exceeded through the conduct of this performance improvement project.	Addressed	X	X	X
Performance Measures	In its *Quality Improvement Program Evaluation Report, January 1, 2020-December 31, 2020,* PHP identified transportation, appointment availability, and health	Partially Addressed		X	X

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2020 Recommendation	Quality	Timeliness	Access
	literacy as barriers to improving care for its pregnant members. PHP should consider implementing interventions that address these specific barriers, such as transportation services to appointments, identification of practices that are open outside of business hours, etc.				
	PHP should augment its Medicaid quality strategy to include more member educational activities.	Partially Addressed	X		
Compliance with Medicaid Standards	PHP staff should be reeducated on the lock-in policies and procedures and be routinely monitored to ensure adherence to the policies.	Addressed	X		
Network Adequacy	Concerning the provider who exceeded the maximum panel size, PHP should implement steps to reduce the provider's panel size, and routinely monitor the provider's ability to meet the established access, distance, and timeliness standards until the panel size is reduced.	Not Addressed		X	X
	PHP should update the online provider directory and hardcopy directories to include accessibility information on each provider. PHP should develop a method for communicating provider cultural competency information, which is current and accurate, with members.	Not Addressed	X	X	X
	PHP should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but PHP was not, for example, for psychologists in the rural region and dermatologists in the frontier region, PHP should compare networks to identify opportunities to contract with new providers. PHP should also consider collaborating with the other	Partially Addressed		X	X

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2020 Recommendation	Quality	Timeliness	Access
	MCOs and state agencies to recruit providers to the State of New Mexico.				
	In the absence of a Human Services Department appointment timeliness threshold, PHP should identify a threshold to work toward. PHP should continue to reeducate network providers on the appointment wait time standards. PHP should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action.	Partially Addressed		X	X
Quality-of-Care Survey – Member Experience	PHP should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. PHP should also utilize complaints and grievances to identify and address trends that may impact the member-health plan experience.	Addressed	X	X	X

Table 55: IPRO's Assessment of WSCC's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2020 Recommendation	Quality	Timeliness	Access
Performance Improvement Project – General	Refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.	Addressed	X	X	X
Performance Improvement Project 1 – Fall Risk	WSCC should consider evaluating the uptake and persistence in programs following referrals, as the number of referrals is not necessarily indicative of impactful change if members are not engaged in programs.	Partially Addressed	X		
	WSCC should consider the role of family members and caregivers in the community in educating members on fall prevention prior to their hospitalizations (being more proactive in prevention through culturally sensitive anticipatory guidance).	Not Addressed	X		
Performance Improvement Project 2 – Prenatal and Postpartum Care	The Substance Abuse and Mental Health Services Administration has reported the importance of family-centered medication assisted treatment programs for persons with alcohol and other drug abuse. WSCC should explore family-centered care options to increase engagement rates among pregnant members.[24] WSCC should also evaluate its role in the integration of behavioral health, obstetric, and primary care.[25]	Addressed	X	X	X
	The American Society of Addiction Medicine guidelines state that alcohol and other drug treatment services must be able to meet the specific needs of women,	Addressed	X	X	X

[24] Seibert J, Stockdale H, Feinberg R, Dobbins E, Theis E, Karon SL. *State policy levers for expanding family-centered medication-assisted treatment.* Washington, DC: Office of the Assistance Secretary for Planning and Evaluation; 2019. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//187076/ExpandFCMAT.pdf. Accessed November 3, 2021.

[25] Johnson E. Models of care for opioid dependent pregnant women. *Semin Perinatol.* 2019;43(3):132-140. doi: 10.1053/j.semperi.2019.01.002.

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2020 Recommendation	Quality	Timeliness	Access
	including pregnant and parenting women, and their families. WSCC should consider services that include the management of co-occurring disorders (including post-traumatic stress disorder), childcare, transportation, reproductive health, nutrition, and parenting.				
	WSCC should consider the recommendations for improvement published in the *New Mexico Substance Use Disorder Treatment Gap Analysis*[26] report in January 2020.	Addressed	X	X	X
Performance Improvement Project 5 – Depression Screening and Management	WSCC should consider addressing barriers in treatment adherence for those members who have a history of medication non-compliance. Potential barriers could include cultural barriers to treatment, problems in a therapeutic relationship with a provider, overall fear associated with the side effects of medications used to manage symptoms of depression, etc.	Addressed	X	X	X
	For members identified as having numerous chronic conditions and struggling with both medication and disease management, WSCC should provide targeted education on the maintenance phase of depression treatment with an emphasis on what this treatment looks like for members who are also managing chronic conditions.	Addressed	X	X	X
	To increase primary care provider awareness of available behavioral health screening tools and their confidence in administering these tools, WSCC should sponsor continuing medical education training on the use of the	Addressed	X	X	X

[26] New Mexico Department of Health. *New Mexico substance use disorder treatment gap analysis*. Santa Fe, NM: New Mexico Department of Health; 2020. https://www.nmhealth.org/publication/view/marketing/5596/.

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2020 Recommendation	Quality	Timeliness	Access
	Patient Health Questionnaire (PHQ)-2 and PHQ-9 in the primary care setting.				
	WSCC should enhance its intervention strategy to include culturally responsive services, specifically for its Native American population.[27]	Addressed	X	X	X
	WSCC should identify opportunities within the healthcare delivery system for the MCO to facilitate coordination between primary care providers and behavioral health specialists. In the event of a member who has a positive depression screen, WSCC should assist in the referral to a practitioner or program for further evaluation for depression.	Addressed	X	X	X
Performance Measures	In future versions of the quality strategy and quality strategy evaluation reports, WSCC should consider enhancing the performance measure section with detailed descriptions of interventions planned/implemented and attach tracking measures to support routine monitoring of the effectiveness of active interventions.	Addressed	X	X	X
	WSCC should identify additional opportunities to utilize services provided through its vendor, Teladoc.	Addressed		X	X
Network Adequacy	WSCC should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but WSCC was not, for example, for hematologists/oncologists in the frontier region and	Partially Addressed		X	X

[27] Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for American Indians and Alaska Natives, Treatment Improvement Protocol 61.* HHS Publication No (SMA) 18-5070, Printed 2018. https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf.

External Quality Review Activity	2020 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2020 Recommendation	Quality	Timeliness	Access
	rheumatologists in the urban region, WSCC should compare networks to identify opportunities to contract with new providers. WSCC should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.				
	In the absence of a Human Services Department appointment timeliness threshold, WSCC should identify a threshold to work toward. WSCC should continue to reeducate network providers on the appointment wait time standards. Although not required by Human Services Department, WSCC should also expand its secret shopper survey to include additional appointment types and other specialties. WSCC should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action. Based on WSCC's reasons for no appointment, WSCC should work to improve the accuracy of its provider data, specifically participation status, specialty, panel status, telephone number, etc., to reduce barriers members face when attempting to obtain appointments.	Partially Addressed		X	X
Quality-of-Care Survey – Member Experience	WSCC should utilize the results of the adult and child CAHPS surveys to drive performance improvement as it relates to member experience. WSCC should also utilize complaints and grievances to identify and address trends that may impact the member-health plan experience.	Partially Addressed	X	X	X

Strengths, Opportunities, and 2021 Recommendations Related to Quality, Timeliness, and Access

The MCOs' strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of and **access** to care are presented. These three elements are defined as:

- **Quality** is the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCO's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by MCOs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

The strengths and opportunities for improvement based on the MCOs' 2021 performance, as well recommendations for improving **quality**, **timeliness,** and **access** to care are presented in **Table 56**, **Table 57**, and **Table 58**. In these tables, links between strengths, opportunities, and recommendations to **quality**, **timeliness** and **access** are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Table 56: BCBS's Strengths, Opportunities and Recommendations for Improvement, 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	BCBS met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Project	Five of five performance improvement projects conducted in 2021 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	Between 2020 and 2021, the single indicator demonstrated performance improvement.	X		
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, one of two indicators demonstrated performance improvement.	X	X	X
Performance Improvement	Between 2020 and 2021, two of three indicators demonstrated performance improvement.	X		

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Project – Adult Obesity				
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, five of six indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2021, four of six indicators demonstrated performance improvement.	X	X	X
Performance Measures	BCBS met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			
	BCBS exceeded target rates for seven of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	BCBS achieved an overall compliance determination of full and is compliant with all state and federal Medicaid standards reviewed.	X	X	X
Network Adequacy	BCBS achieved full compliance for its provider network policies and procedures reviewed during the compliance review of 2021.	X	X	X
	BCBS demonstrated full compliance with the requirements at *42 Code of Federal Regulations 438.68 (b)* and *(c)*.	X	X	X
	As of December 2021, approximately 57% of BCBS's membership was assigned to a patient-centered medical home provider.	X		
	Approximately 80,147 unique BCBS members completed a telemedicine visit in 2021, which accounted for 37% of Centennial Care 2.0 members with a telemedicine service in 2021.		X	X
	In the 4th quarter of 2021, BCBS met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse practitioners, ▪ dental providers, otolaryngologists, ▪ federally qualified health centers,		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ federally qualified health centers with primary care providers only, ▪ hematologists/oncologists, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ community mental health centers, ▪ core service agencies, ▪ federally qualified health centers providing behavioral health services, ▪ other licensed independent behavioral health providers, ▪ psychiatrists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, and ▪ personal care service agencies.			
	Of the primary care providers surveyed in 2021 who accepted new patients, 77% reported timely routine asymptomatic appointments.		X	X
Quality-of-Care Survey	BCBS achieved an adult CAHPS score for *Rating of Health Plan* that exceeded the 90th percentile.	X	X	X
NCQA Accreditation	In 2021, BCBS was NCQA accredited.	X	X	X
Opportunities for Improvement				
Performance Improvement Project – Long-Term Care Services and Supports	None.			
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, one of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Adult Obesity	Between 2020 and 2021, one of three indicators demonstrated a decline in performance.	X		

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, one of six indicators demonstrated a performance decline.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2021, two of six indicators demonstrated performance declines.	X	X	X
Performance Measures	BCBS did not meet target rates for three of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	One provider in the BCBS network reported a panel that exceeded the maximum threshold of 2,000 patients.	X	X	X
	BCBS reported low counts for 7 physical health providers, 16 behavioral health providers, and 13 long-term care providers.		X	X
	BCBS did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ rheumatologists, ▪ rural health clinics, ▪ assertive community treatment providers, ▪ day treatment service providers, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ rural health clinics providing behavioral health services, ▪ treatment foster care I and II, and ▪ assisted living facilities.		X	X
	Of the primary care providers surveyed in 2021 who accepted new patients, ▪ 59% reported timely routine symptomatic appointments, and		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ 20% reported timely urgent appointments. Of the substance use disorder providers surveyed who accepted new patients, ▪ 68% reported timely routine appointments, and ▪ 49% reported timely urgent appointments. Of the community mental health centers surveyed that accepted new patients, ▪ 68% reported timely routine appointments, and ▪ 50% reported timely urgent appointments. Of the behavioral health clinics and agencies surveyed that accepted new patients, ▪ 58% reported timely routine appointments, and ▪ 10% reported timely urgent appointments. Of the behavioral health facilities surveyed, ▪ no providers accepted new patients. Of the behavioral health practitioners surveyed who accepted new patients, ▪ 48% reported timely routine appointments, and ▪ 17% reported timely urgent appointments.			
Quality-of-Care Survey	BCBS achieved three adult CAHPS scores and two child CAHPS scores that did not meet the national Medicaid average.	X	X	X
NCQA Accreditation	Although BCBS achieved NCQA accreditation status, BCBS only achieved 2.5 of the possible five stars under NCQA's Star Rating program. Further, BCBS did not achieve the full five stars in any of three overarching categories or subcategories of measurement.	X	X	X
Recommendations				
Performance Improvement Project	As all performance improvement projects were initiated in 2021, BCBS should plan to continue these projects until targets are met and sustainable improvement is realized. BCBS should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
Performance Measures	BCBS should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, BCBS should focus on the areas of care in which its rates did not meet the target.			
Compliance with Medicaid Standards	BCBS should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Network Adequacy	Concerning the provider who exceeded the maximum panel size, BCBS should implement steps to reduce the provider's panel size, and routinely monitor the provider's ability to meet the established access, distance, and timeliness standards until the panel size is reduced.		X	X
	BCBS should continue its efforts to address "low count" provider types.		X	X
	BCBS should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but BCBS was not, for example, for certified nurse midwifery and psychology in the rural region, BCBS should compare networks to identify opportunities to contract with new providers. BCBS should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.		X	X
	In the absence of a state-established threshold for timely appointments, BCBS should identify a threshold to work toward. Although not required by the Human Services Department, BCBS should also expand its secret shopper survey to include additional physical health specialties. Based on BCBS's reasons for no appointment, BCBS should work to improve the accuracy of its provider data, specifically telephone number, participation status and panel status to reduce barriers members face when attempting to obtain appointments. BCBS should also educate its provider network on unintended barriers to care such as requests for previous medical records before an appointment will be given.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	BCBS should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

Table 57: PHP's Strengths, Opportunities and Recommendations for Improvement, 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	PHP met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Project	Four of five performance improvement projects conducted in 2021 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	None.			
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, one of two indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Adult Obesity	Between 2020 and 2021, two of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, one of two indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2021, four of four indicators demonstrated performance improvement.	X	X	X
Performance Measures	PHP met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	PHP exceeded target rates for six of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	PHP achieved an overall compliance determination of full and is compliant with all state and federal Medicaid standards reviewed.	X	X	X
Network Adequacy	PHP achieved full compliance for its provider network policies and procedures reviewed during the compliance review of 2021.	X	X	X
	PHP demonstrated full compliance with the requirements at *42 Code of Federal Regulations 438.68 (b).*	X	X	X
	As of December 2021, approximately 65% of PHP's membership was assigned to a patient-centered medical home provider.	X	X	X
	Approximately 119,316 PHP members completed a telemedicine visit in 2021, which accounted for 55% of Centennial Care 2.0 members with a telemedicine service in 2021.		X	X
	In the 4th quarter of 2021, PHP met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse midwives, ▪ certified nurse practitioners, ▪ dental providers, ▪ federally qualified health centers, ▪ federally qualified health centers with primary care providers only, ▪ hematologists/oncologists, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, ▪ pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ core service agencies, ▪ federally qualified health centers providing behavioral health services, ▪ intensive outpatient service providers, ▪ other licensed independent behavioral health providers, ▪ outpatient provider agencies,		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ psychiatrists, ▪ psychologists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, ▪ personal care service agencies, and ▪ transportation providers.			
	Of the behavioral health providers surveyed in 2021 that gave an appointment, ▪ 75% of routine adult alcohol use appointments were timely, ▪ 100% of child/adolescent substance abuse appointments were timely, ▪ 75% of community mental health center/core service agencies/behavioral health appointments were timely, and ▪ 100% of routine child Suboxone use appointments were timely.		X	X
Quality-of-Care Survey	None.			
NCQA Accreditation	In 2021, PHP was NCQA accredited.	X	X	X
	PHP achieved five full stars for the Risk Adjusted Utilization subcategory which is related to the reduction of all-cause readmissions.	X	X	X
	PHP was awarded NCQA Long Term Services and Support distinction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project – Long-Term Care Services and Supports	This performance improvement project did not pass validation and did not fully meet the requirements of Protocol 1. Additionally, assessment of PHP's performance on the three indicators could not be conducted because target rates for improvement were lower than the reported baseline rates.	X	X	X
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, one of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Adult Obesity	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, one of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	None.			
Performance Measures	PHP did not meet target rates for four of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	PHP was not compliant with the requirements at *42 Code of Federal Regulation 438.68 (c)(1)(viii),* which calls for "physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities." Specifically, the PHP online provider directory and hardcopy directory did not include cultural competency information or accessibility information on providers.	X	X	X
	PHP reported low counts for six physical health providers, four behavioral health providers, and seven long-term care providers.		X	X
	PHP did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ neurosurgeons, ▪ accredited residential treatment centers, ▪ day treatment service providers, ▪ freestanding psychiatric hospitals, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ residential health centers providing behavioral health services, and		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ treatment foster care I and II.			
	Of the physical health providers surveyed in 2021 that gave an appointment, ▪ 63% of routine appointments were timely, ▪ 61% of preventive appointments were timely, ▪ 28% of urgent appointments were timely, and ▪ 46% of specialty care appointments were timely. Of the behavioral health providers surveyed in 2021 that gave an appointment, ▪ 70% of routine adult mental health appointments were timely, ▪ 29% of routine child mental health appointments were timely, ▪ 12% of urgent adult mental health appointments were timely, ▪ 10% of urgent child mental health appointments were timely, and ▪ 50% of mental health appointments for schizophrenia were timely. Of the providers surveyed for Suboxone use routine adult and urgent child appointments, ▪ no appointments were given.		X	X
Quality-of-Care Survey	PHP achieved six adult CAHPS scores and four child CAHPS scores that did not the national Medicaid average.	X	X	X
NCQA Accreditation	Although PHP achieved NCQA accreditation status, PHP only achieved three of the possible five stars under NCQA's Star Rating program.	X	X	X
Recommendations				
Performance Improvement Project	To ensure future performance improvement project methodologies are effectively designed and managed, PHP staff should continue to utilize the report template issued by the external quality review organization, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase. Lastly, PHP should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
Performance Measures	PHP should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, PHP should focus on the areas of care in which its rates did not meet the target.			
	PHP should enhance its quality improvement strategy, by tailoring broad interventions to address the specific barriers members and providers face when engaging the health care system; and consider conducting personalized appointment reminder calls to pregnant members and members with newborns and use the live contact opportunity to provide support for barriers attending scheduled appointments.	X	X	X
Compliance with Medicaid Standards	PHP should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Network Adequacy	Concerning the provider who exceeded the maximum panel size, PHP should implement steps to reduce the provider's panel size, and routinely monitor the provider's ability to meet the established access, distance, and timeliness standards until the panel size is reduced.		X	X
	PHP should update the online provider directory and hardcopy directories with accessibility information on each provider to comply with state and federal requirements.		X	X
	PHP should develop a method for communicating provider cultural competency information, which is current and accurate, with members.	X		
	PHP should continue its efforts to address "low count" provider types.		X	X
	PHP should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but PHP was not, for example, for otolaryngology in the rural and frontier regions, PHP should compare networks to identify opportunities to contract with new providers. PHP should also consider collaborating		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	with the other MCOs and state agencies to recruit providers to the State of New Mexico.			
	In the absence of a state-established threshold for timely appointments, PHP should identify a threshold to work toward. PHP should increase Centennial Care 2.0 sample sizes for the semi-annual secret shopper surveys to produce results that are reliable. PHP should continue to re-educate network providers on the appointment wait time standards and unintended barriers to care such as requests for previous medical records before an appointment will be given. PHP should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action.		X	X
Quality-of-Care Survey	PHP should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

Table 58: WSCC's Strengths, Opportunities and Recommendations for Improvement, 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	WSCC met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Project	Five of five performance improvement projects conducted in 2021 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	Between 2020 and 2021, the single indicator demonstrated performance improvement.	X		
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, two of three indicators demonstrated performance improvement.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project – Adult Obesity	None.			
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, one of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2021, two of three indicators demonstrated performance improvement. The remaining indicator exceeded the target rate despite demonstrating a decline in performance.	X	X	X
Performance Measures	WSCC met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			
	WSCC exceeded target rates for four of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	WSCC achieved an overall compliance determination of full and is compliant with all federal Medicaid standards reviewed.	X	X	X
Network Adequacy	WSCC achieved full compliance for its provider network policies and procedures reviewed during the compliance review of 2021.		X	X
	WSCC demonstrated full compliance with the requirements at *42 Code of Federal Regulations 438.68 (b)* and *(c).*	X	X	X
	As of December 2021, approximately 46% of WSCC's membership was assigned to a patient-centered medical home provider.	X	X	X
	Approximately 16,957 WSCC members completed a telemedicine visit in 2021, which accounted for 8% of Centennial Care 2.0 members with a telemedicine service in 2021.		X	X
	In the 4th quarter of 2021, WSCC met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse midwives, ▪ certified nurse practitioners,		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ dental providers, ▪ otolaryngologists, ▪ federally qualified health centers, ▪ federally qualified health centers with primary care providers only, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, ▪ pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ urologists, ▪ behavioral health management services, federally qualified health centers providing behavioral health services, ▪ other licensed independent behavioral health providers, ▪ outpatient provider agencies, ▪ psychiatrists, ▪ psychologists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, ▪ personal care service agencies, and ▪ transportation providers.			
Quality-of-Care Survey	None.			
NCQA Accreditation	In 2021, WSCC was NCQA accredited.	X	X	X
	WSCC achieved five full stars for the Risk Adjusted Utilization subcategory which is related to the reduction of all-cause readmissions.	X	X	X
	WSCC was awarded NCQA Long Term Services and Supports distinction and Multicultural Health Care distinction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project – Long-Term Care Services and Supports	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2021, one of three indicators demonstrated a decline in performance.		X	X
Performance Improvement Project – Adult Obesity	Between 2020 and 2021, two of two indicators demonstrated performance declines.	X		
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2021, one of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	None.			
Performance Measures	WSCC did not meet target rates for six of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	WSCC achieved moderate compliance in one subject area under review. Specifically, WSCC achieved moderate compliance for Transitions of Care file review due to the following findings: ▪ Three files did not demonstrate compliance with *Medicaid Managed Care Services Agreement* citation 4.4.15.2 – For those Members who are candidates for transition to the community, the care coordinator, with the member and/or member's representative, shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the transition has occurred and a new comprehensive care plan is in place. ▪ Two files did not demonstrate compliance with *Medicaid Managed Care Services Agreement* citation 4.4.15.3 – The MCO shall conduct an additional assessment within 75 calendar days of transition to determine if the transition was successful and identify any remaining needs.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ Three files did not demonstrate compliance with *Medicaid Managed Care Services Agreement* citation 4.4.16.1.4 – The MCO shall perform an in-home assessment for members who are transitioning from an inpatient hospital or nursing facility stay to home and/or community and may be in need of community benefits within three calendar days upon notification of the transition. ▪ Two files did not demonstrate compliance with *Medicaid Managed Care Services Agreement* citation 4.4.16.1.5 – The MCO shall contact the member monthly for 3 months to ensure continuity of care has occurred and the member's needs are met.			
Network Adequacy	WSCC reported low provider counts for six physical health specialties, nine behavioral health specialties, and eight long-term care specialties.		X	X
	WSCC did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ rheumatologists, ▪ accredited residential treatment centers, assertive community treatment, ▪ community mental health centers, ▪ core service agencies, ▪ day treatment service providers, ▪ general hospitals with psychiatric units, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ treatment foster care I and II, and ▪ assisted living facilities.		X	X
	Of the physical health providers surveyed in 2021, ▪ 43% reported timely routine asymptomatic appointments, and ▪ 54% reported timely urgent appointments. Of the behavioral health providers surveyed in 2021, ▪ 51% reported timely routine substance use and mental health center appointments for adults and children, and		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ 56% reported urgent substance use and mental health center appointments for adults and children.			
Quality-of-Care Survey	WSCC achieved one adult CAHPS score and one child CAHPS score that did not meet the national Medicaid average.	X		
NCQA Accreditation	Although WSCC achieved NCQA accreditation status, WSCC only achieved 2.5 of the possible five stars under NCQA's Star Rating program.	X	X	X
Recommendations				
Performance Improvement Project	WSCC should extend the duration of the current performance improvement projects to allow itself a reasonable amount of time to achieve goals and sustained improvement. WSCC should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
Performance Measures	WSCC should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, WSCC should focus on the areas of care in which its rates did not meet the target.	X	X	X
	To enhance its quality improvement strategy, WSCC should include member, program, and provider-level interventions for each focus area to adequately address a comprehensive set of factors that contribute to members not receiving the services and supports that are clinically indicated.	X	X	X
Compliance with Medicaid Standards	WSCC should reeducate staff on supporting care coordination policies and procedures; identify automated solutions for alerting care coordination staff of time sensitive required action; and enhance current internal monitoring of care coordination procedures with a focused review of staff compliance to the citations noted in this table.	X	X	X
	WSCC should conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Network Adequacy	WSCC should continue its efforts to address "low count" provider types.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	WSCC should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but WSCC was not, for example, for general hospitals with psychiatric units in the urban region and hematology/oncology in the frontier region, WSCC should compare networks to identify opportunities to contract with new providers. WSCC should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.		X	X
	In the semi-annual secret shopper reports, WSCC should include data tables displaying reasons why contact with the provider was not made and reasons why an appointment was not given. WSCC should continue to re-educate network providers on the appointment wait time standards, and although not required by the Human Services Department, WSCC should expand its secret shopper survey to include additional physical health specialties. WSCC should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action.		X	X
Quality-of-Care Survey	WSCC should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

Appendix A: Centennial Care 2.0 Tracking Measures Program

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description
#1	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, who were seen by a practitioner in the past 12 months, and who received fall risk intervention from their current practitioner.
# 2	Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with principal diagnosis codes for diabetes short-term complications for Medicaid members ages 18 and older. (A lower rate indicates improvement for this measure.)
# 3	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid members ages 18 and older 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.
#4	Follow-Up After Hospitalization for Mental Illness	Percent of seven-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days.
	Inpatient Psychiatric Facility/Unit	Discharges for members six years of age or older at the time of discharge who were hospitalized for treatment of mental health disorders for a continuous period of four days or more (i.e., discharge date more than three days after admission date). Includes only psychiatric units in general hospitals and freestanding psychiatric hospitals. For the purposes of tracking discharges and follow-ups, claims data should be used.
	Follow-Up After Hospitalization for Mental Illness	Discharges for members six years of age or older at the time of discharge who were hospitalized for treatment of mental health disorders for a continuous period of four days or more and who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within seven calendar days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description
		Members who are enrolled with the MCO at the time of the member's discharge and are eligible for Medicaid services under New Mexico's State Plan. For purposes of this calculation, use age at time of discharge. Measure should be sorted by two categories and in two member groups: ▪ Number of inpatient facility discharges of members 6 to 17 years of age during the quarter; ▪ Number of inpatient facility discharges of members 18 years of age and older during the quarter; ▪ Number of members 6 to 17 years of age who had a follow-up visit within seven days after an inpatient facility discharge during the quarter; and ▪ Number of members 18 years of age and older who had a follow-up visit within seven days after an inpatient facility discharge during the quarter.
# 5	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Report rates for each vaccine and one combination rate.
# 6	Long-Acting Reversible Contraceptive	The MCO shall measure the use of long-acting reversible contraceptives among members ages 15 to 19 years.
# 7	Smoking Cessation	The MCO shall monitor and report quarterly, the use of smoking cessation products and counseling utilization within a calendar year.
# 8	Ambulatory Care Outpatient Visits	Utilization of outpatient visits reported as a rate per 1,000 member months. An increase in rate indicates improvement for this measure.
	Ambulatory Care Emergency Department Visits	Utilization of emergency department visits reported as a rate per 1,000 member months. (A lower rate indicates improvement for this measure.)
# 9	Annual Dental Visit	The percentage of enrolled members ages 2 to 20 years of age who had at least one dental visit during the measurement year.
# 10	Controlling High Blood Pressure	The percentage of members ages 18 to 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.
#11	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	The percentage of members ages 6 to 12 years newly prescribed attention-deficit/hyperactivity disorder medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description
		least two follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure.
#12	Child and Adolescent Well-Care Visits	The percentage of members ages 3 to 21 years who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year. An increase in percentage indicates improvement for this measure.

Appendix B: Managed Care Organization Performance Improvement Project Indicator Tables

BCBS Performance Improvement Project 1 – Long-Term Care Services – Urinary Tract Infection Indicators, Measurement Years 2020 to 2021

BCBS's Performance Improvement Project 1 – Long-Term Care Services and Support			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – Rate of urinary tract infection events per 1,000 days for the total long-term care resident population *(lower rate indicates better performance)*	4.78	4.70	4.30

BCBS Performance Improvement Project 2 – Timeliness of Prenatal and Postpartum Care Indicators, Measurement Years 2020 to 2021

BCBS's Performance Improvement Project 2 – Prenatal and Postpartum Care			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	58.98%	57.38%	82.73%
Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	51.21%	54.30%	65.95%

BCBS Performance Improvement Project 3 – Adult Obesity Indicators, Measurement Years 2020 to 2021

BCBS's Performance Improvement Project 3 – Adult Obesity			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had at least one claim with an obesity diagnosis during the measurement year *(lower rate indicates better performance)*	4.79%	3.92%	4.69%
Indicator 2 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control	51.09%	46.47%	55.09%

BCBS's Performance Improvement Project 3 – Adult Obesity			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
(< 140/90) in the most recent blood pressure reading during the measurement year[1]			
Indicator 3 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (< 140/90) in the most recent blood pressure reading during the measurement year[2]	7.52%	20.83%	25.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

BCBS Performance Improvement Project 4 – Diabetes Management and STCA Rate HbA1c Testing Indicators, Measurement Years 2020 to 2021

BCBS's Performance Improvement Project 4 – Diabetes Prevention and Management			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 18 to 64 years and older *(lower rate indicates better performance)*	24.06%	21.68%	20.06%
Indicator 2 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 65 years and older *(lower rate indicates better performance)*	22.81%	20.82%	18.81%
Indicator 3 – The percentage of members ages 18 to 75 years with diabetes during the measurement year who complete an HbA1c test	78.83%	80.05%	82.83%
Indicator 4 – The percentage of providers satisfied with the timeliness of discharge information received	35.10%	58.62%	39.00%
Indicator 5 – The percentage of providers indicating having received adequate information about medication at discharge	43.07%	67.24%	47.00%
Indicator 6 – The percentage of members indicating ease of getting necessary care, tests or treatment needed (Always or Usually)	86.29%	79.07%	85.50%

BCBS Performance Improvement Project 5 – Screening and Management for Clinical Depression Indicators, Measurement Years 2020 to 2021

BCBS's Performance Improvement Project 5 – Clinical Depression Screening and Follow-Up			
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of members ages 18 to 84 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	52.68%	55.98%	≥56.7%
Indicator 2 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	80.00%	73.97%	≥84.0%
Indicator 3 – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	35.38%	35.85%	≥39.4%
Indicator 4 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	60.00%	53.42%	≥64.0%
Indicator 5 – Percentage of patients ages 18 to 64 years screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen	0.55%	1.37%	≥10.6%
Indicator 6 – Percentage of patients ages 65 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen	1.39%	1.83%	≥11.4%

PHP Performance Improvement Project 1 – Transitions Of Care-Community Reintegration Indicators, Measurement Years 2018 to 2021

PHP's Performance Improvement Project 1 – Long-Term Care Services and Support					
Performance Indicator Description	Original Baseline Period Measurement Year 2018	Revised Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Final Period Measurement Year 2021	Target Rate
Indicator 1 – Volume of members who have successfully reintegrated and did not experience an avoidable hospitalization within 120 calendar days post discharge	58.0%	91.3%	93.0%	100.0%	85.0%
Indicator 2 – Volume of members who have successfully reintegrated and did not experience an avoidable re-institutionalization within 120 calendar days post-discharge	58.0%	97.1%	96.5%	98.2%	85.0%
Indicator 3 – Members who were identified with the potential of failure to thrive yet successfully reintegrated with care coordination support	58.0%	100.0%	91.2%	100.0%	85.0%

PHP Performance Improvement Project 2 – Prenatal-Postpartum Indicators, Measurement Years 2018 to 2021

PHP's Performance Improvement Project 2 – Prenatal and Postpartum Care					
Performance Indicator Description	Baseline Period Measurement Year 2018	Interim Period Measurement Year 2019	Interim Period Measurement Year 2020	Final Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	71.36%	57.94%	77.48%	67.22%	81.13%
Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery.	59.30%	42.63%	56.75%	68.33%	64.53%

PHP Performance Improvement Project 3 – Adult Obesity Indicators, Measurement Years 2018 to 2021

PHP's Performance Improvement Project 3 – Adult Obesity					
Performance Indicator Description	Baseline Period Measurement Year 2018	Interim Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	87.34%	84.82%	58.12%	60.13%	89.34%
Indicator 2 – The percent of members ages 18 years and older that are enrolled in an obesity-related support program	No data to report	9.62%	20.76%	25.32%	20.00%

PHP Performance Improvement Project 4 – Diabetes Prevention and Management Indicators, Measurement Years 2018 to 2021

PHP's Performance Improvement Project 4 – Diabetes Prevention and Management					
Performance Indicator Description	Baseline Period Measurement Year 2018	Interim Period Measurement Year 2019	Interim Period Measurement Year 2020	Final Period Measurement Year 2021	Target Rate
Indicator 1 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	23.11	18.35	14.80	15.91	21.11
Indicator 2 – The percentage of members ages 18 to 74 years with diabetes (type 1 and type 2) who had HbA1c testing	84.85%	76.91%	70.88%	65.35%	87.54%

PHP Performance Improvement Project 5 – Screening and Management of Clinical Depression Indicators, Measurement Years 2018 to 2021

PHP's Performance Improvement Project 5 – Clinical Depression Screening and Follow-Up					
Performance Indicator Description	Baseline Period Measurement Year 2018	Interim Period Measurement Year 2019	Interim Period Measurement Year 2020	Final Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of members ages 18 years older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	50.59%	58.14%	60.24%	63.45%	54.79%
Indicator 2 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	34.31%	39.31%	42.00%	44.22%	39.66%
Indicator 3 – The percentage of members ages 18 to 64 years with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen	0.32%	0.58%	0.84%	1.72%	1.32%
Indicator 4 – Medicaid members ages 65 years and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen	0.63%	1.15%	1.90%	3.03%	1.63%

WSCC Performance Improvement Project 1 – Fall Risk and Prevention Program Indicators, Measurement Years 2019 to 2021

Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – Rate of members who experienced a fall-related hospitalization via claims in the population of long-term services and supports members ages 60 years and older living in the community during the measurement year *(lower rate indicates better performance)*	190.78	882.35	565.22	152.00

WSCC Performance Improvement Project 2 – Addiction in Pregnancy Program Indicators, Measurement Years 2018 to 2021

Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who were initiated for treatment for alcohol and other substances 14 days within diagnosis	46.21%	46.49%	44.91%	48.5%
Indicator 2 - Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who engaged in treatment for alcohol and other substances within 34 days of initial treatment	14.39%	14.91%	16.11%	16.9%
Indicator 3 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	42.43%	46.91%	60.10%	48.9%

WSCC Performance Improvement Project 3 – Adult Obesity Indicators, Measurement Years 2020 to 2021

Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	17.2%	36.7%	6.7%[1]	41.7%
Indicator 2 – The percentage of members ages 19 years and older with a documented body mass index of greater than 30 kg/m *(lower rate indicates better performance)*	63.7%	34.9%	25.1%[2]	54.4%

[1] There was a significant increase in the denominator in measurement year 2021. The denominator for measurement year 2020 was 14,529, and the denominator in measurement year 2021 was 54,736.

[2] Rate reflects measurement year 2021 and 2022 data. Starting with measurement year 2021, the data collection methodology for this measure was modified to include two-year reporting period.

WSCC Performance Improvement Project 4 – Diabetes Prevention and Management, Measurement Years 2020 to 2021

Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 – Rate of admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	7.42	16.94	23.94	19.35
Indicator 2 – The percentage of members ages 18 to 75 years of age with diabetes (type 1 and type 2) who had a HbA1c screening	52.59%	66.84%	75.43%	66.66%

WSCC Performance Improvement Project 5 – Screening and Management of Clinical Depression Indicators, Measurement Years 2020 to 2021

Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Target Rate
Indicator 1 - The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	36.23%	53.17%	60.60%	37.34%
Indicator 2 - The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	18.85%	36.46%	43.67%	34.76%
Indicator 3 - The percentage of members ages 18 years and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen	0.42%	2.03%	1.13%	1.08%

Appendix C: Managed Care Organization Performance Measure Tables, Measurement Years 2019 to 2021

BCBS Performance Measure Rates for Measurement Years 2019 to 2021

Performance Measure (PM)	BCBS Measurement Year 2019 Rate	BCBS Measurement Year 2020 Rate	BCBS Measurement Year 2021 Rate	Difference Between BCBS's Measurement Years 2020 and 2021 Rates (Percentage Points)	Measurement Year 2021 Target Rate
PM 1 W30 First 15 Months	65.94%	56.89%	58.54%	+1.65	63.72%
PM 2 WCC Physical Activity	45.50%	50.36%	55.72%	+5.36	53.33%
PM 3 PPC Prenatal Care	84.43%	79.32%	82.00%	+2.68	80.70%
PM 4 PPC Postpartum Care	64.48%	67.40%	69.10%	+1.70	64.65%
PM 5 CIS Combo 3	70.80%	70.56%	69.59%	-0.97	69.27%
PM 6 AMM Continuation	37.35%	39.81%	40.63%	+0.82	34.76%
PM 7 IET Initiation	41.05%	43.77%	42.91%	-0.86	44.74%
PM 8 FUH 30 Day	41.62%	51.94%	56.60%	+4.66	50.22%
PM 9 FUM 30 Day	56.27%	59.36%	56.57%	-2.79	45.01%
PM 10 SSD	79.02%	76.46%	77.59%	+1.13	81.35%
Available Points	19	10	10		
Points Earned	12	8	7		

PHP Performance Measure Rates for Measurement Years 2019 to 2021

Performance Measure (PM)	PHP Measurement Year 2019 Rate	PHP Measurement Year 2020 Rate	PHP Measurement Year 2021 Rate	Difference Between PHP's Measurement Years 2020 and 2021 Rates (Percentage Points)	Measurement Year 2021 Target Rate
PM 1 W30 First 15 Months	66.67%	49.63%	44.37%	-5.26	63.72%
PM 2 WCC Physical Activity	49.15%	49.88%	58.15%	+8.27	53.33%
PM 3 PPC Prenatal Care	90.51%	68.61%	67.22%	-1.39	80.70%
PM 4 PPC Postpartum Care	75.43%	69.59%	68.33%	-1.26	64.65%
PM 5 CIS Combo 3	69.83%	67.64%	63.02%	-4.62	69.27%
PM 6 AMM Continuation	39.31%	42.38%	44.80%	+2.42	34.76%
PM 7 IET Initiation	42.79%	54.12%	54.25%	+0.13	44.74%
PM 8 FUH 30 Day	40.22%	54.84%	53.84%	-1.00	50.22%
PM 9 FUM 30 Day	61.01%	64.83%	63.40%	-1.43	45.01%
PM 10 SSD	79.51%	75.14%	78.48%	+3.34	81.35%
Available Points	19	10	10		
Points Earned	11	6	6		

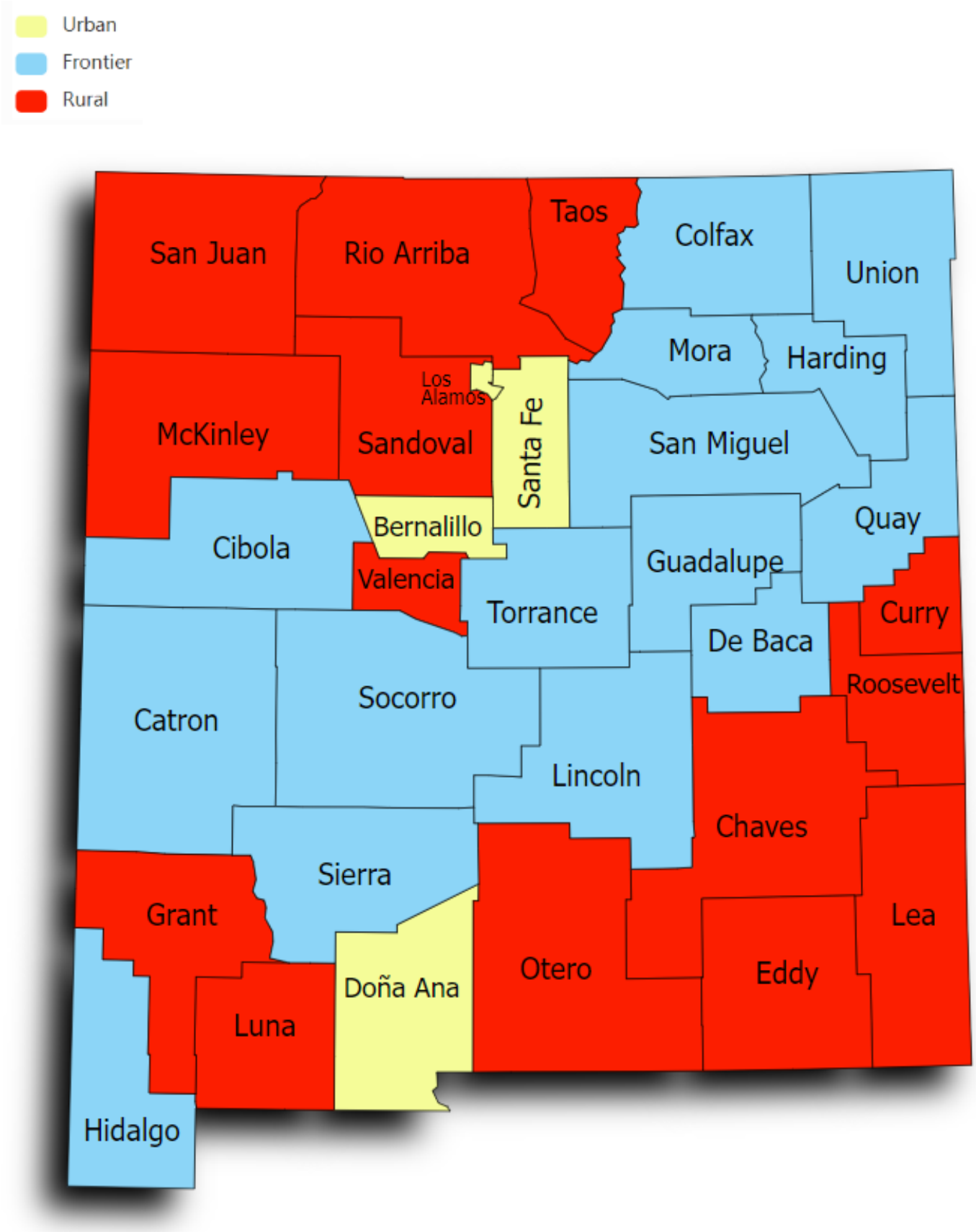
WSCC Performance Measure Rates for Measurement Years 2019 to 2021

Performance Measure (PM)	WSCC Measurement Year 2019 Rate	WSCC Measurement Year 2020 Rate	WSCC Measurement Year 2020 Rate	Difference Between WSCC's Measurement Years 2020 and 2021 Rates (Percentage Points)	Measurement Year 2021 Target Rate
PM 1 W30 First 15 Months	Small Denominator	42.70%	51.18%	+8.51	63.72%
PM 2 WCC Physical Activity	50.36%	43.31%	51.82%	-7.06	53.33%
PM 3 PPC Prenatal Care	70.80%	68.37%	61.31%	+0.25	80.70%
PM 4 PPC Postpartum Care	59.12%	59.85%	60.10%	-2.68	64.65%
PM 5 CIS Combo 3	58.33%	61.56%	58.88%	+7.21	69.27%
PM 6 AMM Continuation	32.85%	36.46%	43.67%	+1.65	34.76%
PM 7 IET Initiation	41.89%	43.26%	44.91%	+0.09	44.74%
PM 8 FUH 30 Day	35.36%	53.85%	53.94%	+3.86	50.22%
PM 9 FUM 30 Day	45.70%	42.76%	46.62%	+3.85	45.01%
PM 10 SSD	70.79%	73.69%	77.54%	+8.51	81.35%
Available Points	19	10	10		
Points Earned	Not Applicable[1]	2	4		

[1] Measurement year 2019 was WSCC's baseline period and therefore, there was no contractual requirement for WSCC's rates to meet any targets.

Small Denominator means that there were less than 30 eligible members.

Appendix D: Map of New Mexico with Urban, Rural, and Frontier Designations


Urban
Frontier
Rural
San Juan
Rio Arriba
Taos
Colfax
Union
Mora
Harding
Los Alamos
McKinley
Sandoval
Santa Fe
San Miguel
Quay
Bernalillo
Cibola
Valencia
Guadalupe
Torrance
Curry
De Baca
Roosevelt
Catron
Socorro
Lincoln
Chaves
Sierra
Grant
Lea
Otero
Eddy
Doña Ana
Luna
Hidalgo

Appendix E: Managed Care Organization CAHPS Tables, Measurement Years 2018 to 2021

BCBS Adult CAHPS Results, Measurement Years 2018 to 2021

Adult CAHPS Measures	BCBS			
	2019 CAHPS Measurement Year 2018	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	74.7%	79.0%	79.0%	84.5%
Rating of All Health Care	73.8%	78.8%	75.8%	76.0%
Rating of Personal Doctor[1]	83.8%	88.1%	82.5%	80.7%
Rating of Specialist[1]	84.2%	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	80.1%	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	81.6%	Small Sample	81.1%	76.9%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	93.5%	96.0%	93.0%	88.1%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.

BCBS General Population-Child CAHPS Results, Measurement Years 2018 to 2021

General Population Child CAHPS Measures	BCBS			
	2019 CAHPS Measurement Year 2018	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	87.2%	88.9%	85.4%	83.1%
Rating of All Health Care	87.7%	86.0%	86.1%	88.0%
Rating of Personal Doctor[1]	92.9%	90.8%	90.7%	89.4%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	92.1%	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	83.4%	Small Sample	Small Sample	Small Sample
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	96.4%	93.8%	Small Sample	Small Sample
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.

PHP Adult CAHPS Results, Measurement Years 2018 to 2021

Adult CAHPS Measures	PHP			
	2019 CAHPS Measurement Year 2018	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	78.4%	78.7%	73.2%	78.2%
Rating of All Health Care	69.4%	78.7%	76.5%	68.7%
Rating of Personal Doctor[1]	79.3%	82.1%	81.4%	79.9%
Rating of Specialist Seen Most Often[1]	74.8%	89.4%	Small Sample	Small Sample
Getting Care Quickly[2]	81.4%	80.8%	81.4%	74.5%
Getting Needed Care[2]	78.7%	81.6%	81.4%	76.4%
Customer Service[2]	92.8%	92.6%	Small Sample	Small Sample
How Well Doctors Communicate[2]	89.5%	93.2%	88.7%	90.2%
Coordination of Care[2]	77.1%	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.

PHP General Population-Child CAHPS Results, Measurement Years 2018 to 2021

General Population Child CAHPS Measures	PHP			
	2019 CAHPS Measurement Year 2018	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	86.9%	87.3%	88.2%	86.8%
Rating of All Health Care	83.5%	87.8%	85.5%	81.5%
Rating of Personal Doctor[1]	87.7%	91.1%	92.3%	90.4%
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	84.8%	87.9%	Small Sample	Small Sample
Getting Needed Care[2]	85.3%	85.2%	Small Sample	Small Sample
Customer Service[2]	94.5%	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	92.9%	95.5%	94.9%	91.4%
Coordination of Care[2]	82.6%	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.

WSCC Adult CAHPS Results, Measurement Years 2019 to 2021

Adult CAHPS Measures	WSCC		
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	Small Sample	76.7%	77.7%
Rating of All Health Care	Small Sample	Small Sample	Small Sample
Rating of Personal Doctor[1]	Small Sample	83.2%	Small Sample
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample
Customer Service[2]	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample
Coordination of Care[2]	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.

WSCC General Population-Child CAHPS Results, Measurement Years 2019 to 2021

General Population Child CAHPS Measures	WSCC		
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021
Rating of Health Plan[1]	Small Sample	84.3%	87.8%
Rating of All Health Care	Small Sample	Small Sample	Small Sample
Rating of Personal Doctor[1]	Small Sample	91.5%	87.6%
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample
Customer Service[2]	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample
Coordination of Care[2]	Small Sample	Small Sample	Small Sample

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").

[2] Rates reflect responses of "always" or "usually."

Small sample means that the denominator included less than less than 100 members.