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Centennial Care Program

New Mexico State Medicaid Managed Care

2020 External Quality Review

Annual Technical Report

April 2022

Prepared on behalf of:
The New Mexico Human Service Department

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Abbreviations Used in this Report

AHRQ:	Agency for Healthcare Research and Quality
AMM:	Antidepressant Medication Management, NCQA
AOD:	Alcohol and Other Drugs
ART:	Audit Report Table
ARTC:	Accredited Residential Treatment Center
ASAM:	American Society of Addiction Medicine
BCBS:	Blue Cross Blue Shield of New Mexico
BBA:	Balanced Budget Act
BMI:	Body Mass Index
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CFR:	Code of Federal Regulation
CHIP:	Children's Health Insurance Program
CIS:	Childhood Immunization Status, NCQA
CMS:	Centers for Medicare and Medicaid Services
CNA:	Comprehensive Needs Assessment
COVID-19:	Coronavirus Disease
CY:	Calendar Year
DSIPT:	Delivery System Improvement Performance Targets
ED:	Emergency Department
EQR:	External Quality Review
EQRO:	External Quality Review Organization
EVV:	Electronic Visit Verification
FAR:	Final Audit Report, HEDIS

FQHC:	Federally Qualified Health Center
FUH:	Follow-Up After Hospitalization for Mental Illness, NCQA
FUM:	Follow-Up After Emergency Department Visit for Mental Illness, NCQA
HEDIS:	Healthcare Effectiveness Data and Information Set
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HCBS:	Home and Community-Based Services
HSD:	Human Services Department, New Mexico
IET:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, NCQA
IPRO:	Island Peer Review Organization
IS:	Information Systems
ISCA:	Information Systems Capabilities Assessment
I/T/U:	Indian Health Service/Tribal Health Providers/Urban Indian Providers
LTC:	Long-Term Care
LTSS:	Long-Term Services and Supports
MAD:	Medical Assistance Division, HSD
MAT:	Medication-Assisted Treatment
MCO:	Managed Care Organization
MMC:	Medicaid Managed Care
MRSS:	Minimum Required Sample Size
MY:	Measurement Year
NCQA:	National Committee of Quality Assurance
NF LOC:	Nursing Facility Level of Care
NMAC:	New Mexico Administrative Code
OB/GYN:	Obstetrics/Gynecology or Obstetrician/Gynecologist
PAHP:	Prepaid Ambulatory Health Plan

PCCM:	Primary Care Case Management
PCP:	Primary Care Provider
PHP:	Presbyterian Health Plan, Inc.
PHQ-2:	Patient Health Questionnaire-2
PHQ-9:	Patient Health Questionnaire-9
PIHP:	Prepaid Inpatient Health Plan
PIP:	Performance Improvement Project
PM:	Performance Measure
PPC:	Timeliness of Prenatal and Postpartum Care, NCQA
PPO:	Preferred Provider Organization
QC:	Quality Compass, NCQA
RHC:	Rural Health Clinic
SAMHSA:	Substance Abuse and Mental Health Services Administration
SS:	Small Sample
SSD:	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications, NCQA
STCA:	Short-Term Complications Admissions
T-MSIS:	Transformed Medicaid Statistical Information System
TOC:	Transition of Care
WCC:	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, NCQA
WSCC:	Western Sky Community Care, Inc.
W30:	Well-Child Visits in the First 30 Months of Life, NCQA

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I. Executive Summary

Introduction

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

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

To comply with these requirements, the New Mexico Human Services Department (HSD) contracted with Island Peer Review Organization (IPRO), an EQRO, to assess and report the impact of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provides IPRO's independent evaluation of the services provided by Blue Cross Blue Shield of New Mexico (BCBS),[4] Presbyterian Health Plan, Inc. (PHP),[5] and Western Sky Community Care, Inc. (WSCC)[6] in 2020.

Scope of External Quality Review Activities

This report focuses on the four federally mandatory EQR activities (validation of performance improvement projects [PIPs], validation of performance measures [PMs], review of compliance with Medicaid standards, and validation of network adequacy) and one optional EQR activity (validation of quality-of-care surveys) that were conducted. It should be noted that validation of provider network adequacy was conducted at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. These updated protocols did state that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component

[1] Prepaid Inpatient Health Plan.
[2] Prepaid Ambulatory Health Plan.
[3] Primary Care Case Management.
[4] Blue Cross Blue Shield of New Mexico Website: https://www.bcbsnm.com/community-centennial.
[5] Presbyterian Health Plan Website: https://www.phs.org/health-plans/centennial-care-medicaid/Pages/default.aspx.
[6] Western Sky Community Care Website: https://www.westernskycommunitycare.com/.

of the EQR as part of Protocols 1, 2, 3, and 4." CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCOs' HEDIS measurement year (MY) 2020 final audit reports (FARs) are in the **Validation of Performance Measures** section of this report.

As required by 42 *CFR § 438.358 Activities related to external quality review*, the following activities were conducted in for 2020:

(i) **Validation[7] of Performance Improvement Projects (Protocol 1) –** This activity validated that MCO PIPs were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
(ii) **Validation of Performance Measures (Protocol 2) –** This activity assessed the accuracy of PMs reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
(iii) **Review of Compliance with Medicaid and CHIP[8] Standards (Protocol 3) –** This activity determined MCO compliance with its contract and with state and federal regulations.
(iv) **Validation of Network Adequacy (Protocol 4)** – This activity assessed MCO adherence to state distance standards for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population. (CMS has not published an official protocol for this activity.)
(v) **Validation of Quality-of-Care Surveys (Protocol 6) –** This activity validated that the MCOs complied with the state requirement to conduct a member satisfaction survey. Each MCO contracted with an NCQA-certified survey vendor to administer the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) to evaluate member experience with health care services received in 2020.

The aggregate results of these EQR activities are reported in the **High-Level Findings and Recommendations** subsection that immediately follows.

High-Level Findings and Recommendations

Validation of Performance Improvement Projects

IPRO's validation of the MCOs' PIPs conducted in 2020 confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1*); and confirmed the MCOs' compliance with the HSD requirement to conduct a PIP for each of these overarching topics: long-term care (LTC) services and supports, prenatal and postpartum care, adult obesity, diabetes prevention and management, and clinical depression screening and follow-up.

The results of the validation activity determined BCBS and WSCC were fully compliant with the standards of *42 CFR § 438.330(d)(2)* for each of their five PIPs while PHP was fully compliant for four of their five PIPs. Fully compliant PIPs were conducted in a manner consistent with the EQRO PIP process. Concerning PHP's PIP that did not achieve

[7] CMS defines validation at *42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."
[8] Children's Health Insurance Program.

full compliance, validation findings identified issues related to topic selection, data collection, and interpretation of study results.

Concerning the LTC services and supports PIPs, no MCO achieved any performance indicator target as of the MY 2020 remeasurement period. For BCBS and WSCC, performance improvement was not demonstrated from the baseline period (MY 2018 for BCBS, MY 2019 for WSCC) to the MY 2020 remeasurement period. IPRO was unable to evaluate PHP's performance for this PIP as issues related to topic selection, data collection and study results were identified during the validation process.

Concerning the prenatal and postpartum care PIPs, no MCO achieved any performance indicator target as of the MY 2020 remeasurement period. However, from the MY 2018 baseline period to the MY 2020 remeasurement period, BCBS demonstrated improvement in the number of members who received timely postpartum care, and PHP demonstrated improvement in the number of members who received timely prenatal care. WSCC demonstrated improvement from the MY 2019 baseline period to the MY 2020 remeasurement period for the timely initiation of treatment for a substance dependence diagnosis among pregnant members and for timely postpartum care.

Concerning the adult obesity PIPs, MCO performance was mixed from the baseline period to the MY 2020 remeasurement period. BCBS and WSCC demonstrated improvement in the number of adult members with a documented body mass index (BMI) and exceeded their respective target rate. (BCBS exceeded its target rate for documented BMI during the MY 2019 remeasurement period and discontinued use of the measure for MY 2020.) PHP demonstrated improvement in the number of members with controlled hypertension but did not meet the target rate.

Concerning the diabetes prevention and management PIPs, all MCOs were compliant with the Centennial Care contract requirement to evaluate performance for this PIP using the following standardized measures: Comprehensive Diabetes Care – HbA1c Testing (NCQA) and Diabetes, Short-Term Complications Admission Rate (Agency for Healthcare Research and Quality [AHRQ]).

PHP and WSCC demonstrated a reduction in hospital admissions for diabetes-related short-term complications from the baseline period (MY 2018 for BCBS, MY 2019 for WSCC) to the MY 2020 remeasurement period and exceeded their respective target rate. WSCC also reported a higher rate of adult members with a documented HbA1c value and exceeded the target rate.

Concerning the clinical depression screening and follow-up PIPs, all MCOs were compliant with the Centennial Care contract requirement to evaluate performance for this PIP using the following standardized measures: Antidepressant Medication Management (NCQA) and Screening for Clinical Depression and Follow-Up Plan (CMS).

From the baseline period to the MY 2020 remeasurement period, all MCOs demonstrated performance improvement among adult members demonstrating appropriate antidepressant medication management for at least 84 days and for at least 180 days, exceeding their respective target rates. PHP demonstrated improvement in documented follow-up for a positive depression screen among members 65 years and older from the MY 2018 baseline period to the MY 2020 remeasurement period. BCBS and WSCC demonstrated a decline in performance for this area.

Validation of Performance Measures

IPRO's validation of the MCOs' PMs confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that each MCO was compliant with the standards of *42 CFR § 438.330(c)(2)*.

Information Systems Capabilities Assessment

The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCOs' independent auditors.

Based on a review of the FARs issued by each MCO's independent auditor, IPRO found that the MCOs were determined to be *fully compliant* with all seven of the applicable NCQA information system (IS) standards. HEDIS rates produced by the MCOs were reported to NCQA and HSD.

HEDIS Performance

As part of the HSD PM program, the MCOs were required to calculate and report 2020 rates to HSD for ten HEDIS measures. A total of ten points were available for each MCO to achieve based on individual rate performance towards the target rate. No MCO earned all ten of the available points. BCBS earned eight points, PHP earned six points, and WSCC earned two points.

For two PMs, all MCOs reported rates that exceeded the target rates. Every MCO reported a rate that exceeded the respective target rate for Antidepressant Medicaid Management – Continuation Phase, and Follow-Up After Hospitalization for Mental Illness – 30 Day.

Seven Centennial Care PM averages (the aggregate PM rates of all MCOs) exceeded their respective target rates: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Physical Activity Counseling; Timeliness of Prenatal and Postpartum Care – Postpartum Care; Childhood Immunization Status – Combination 3; Antidepressant Medication Management – Continuation Phase; Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation; Follow-Up After Hospitalization for Mental Illness – 30 Day; and Follow-Up After Emergency Department Visit for Mental Illness – 30 Day.

No MCO met the target rates for Well-Child Visits in the First 30 Months of Life – First 15 Months and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications.

Three Centennial Care PM averages (the aggregate PM rates of all MCOs) did not meet their respective target rates: Well-Child Visits in the First 30 Months of Life – First 15 Months; Timeliness of Prenatal and Postpartum Care – Timeliness of Prenatal Care; and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

Compliance with Federal Medicaid Standards

IPRO's conduct of the compliance review activity for the January 1, 2020–April 15, 2021, review period confirmed the state's compliance with evaluating MCO adherence to the standards of *42 CFR Part 438 Subpart D* and *42 CFR § 438.330.* Each MCO achieved full compliance determinations for these standards.

Compliance with State Medicaid Standards

Each MCO achieved full compliance for the January 1, 2020–April 15, 2021, review period. The overall compliance score for each MCO exceeded the 90% threshold. BCBS achieved an overall compliance score of 98.28%, PHP achieved a score of 98.21%, and WSCC achieved an overall score of 98.86%.

All MCOs achieved compliance scores of 100% in the following document review areas: Adverse Benefit Determination; Delegation, Dental, and Transportation; Grievances and Appeals System; Maintenance of Medical Records; Member Services; PCP and Pharmacy Lock-Ins; Program Integrity; Provider Agreements; Provider Services; Quality Assurance; Reporting Requirements; Self-Directed Community Benefit; and Transition of Care (TOC).

All MCOs achieved compliance scores of 100% in the following file review areas: Standard Adverse Benefit Determination and Expedited Adverse Benefit Determination.

There were no areas in which all MCOs performed below the 90% threshold.

Validation of Network Adequacy

Based on the results of the 2020 Compliance Review, it was determined that the MCOs were compliant with adopting the access, distance, and timeliness standards outlined in the Centennial Care Managed Care Agreement. Each MCO exceeded the 90% threshold to achieve a full determination for the Provider Network section of the 2020 Compliance Review.

Regarding MCO compliance with access standards, the MCOs' primary care provider (PCP)-to-member ratio averages did not exceed the maximum threshold of 1:2,000. However, three Centennial Care providers were identified as exceeding the maximum panel. These three providers are in the PHP network. Like the previous year, all MCOs reported low physical health provider counts in gerontology, endocrinology, rheumatology, dermatology, and neurosurgery. All MCOs reported low LTC provider counts in behavior support consultation, community transition service, employment support, nursing respite, nutrition counselling, and occupational therapy. While behavioral health provider types with low counts varied by MCO, low counts for Joint Commission-certified residential treatment centers, accredited adult residential facilities for substance use disorder, and licensed professional art therapists were reported by all MCOs.

The MCOs continued to increase contract provider telemedicine capabilities and increased utilization of these services by their Medicaid members. All three MCOs met the 5% minimum of membership with telemedicine visits for 2020. Approximately 141,357 unique Centennial Care members received telemedicine services in 2020. Physical health care accounted for 65% of telemedicine visits in 2020.

The MCOs met geographic access standards in all regions for the following physical health providers: adult and child PCPs, cardiologists, certified nurse midwives, certified nurse practitioners, dental providers, federally qualified health centers (FQHCs), obstetricians/gynecologists (OBs/GYNs), orthopedists, pharmacies, physician assistants, podiatrists, and surgeons. The MCOs met HSD standards in all regions for the following behavioral health providers: FQHCs providing behavioral health services, other licensed independent behavioral health providers, outpatient provider agencies, psychiatrists, and Suboxone® certified medical providers. Additionally, the MCOs met HSD standards in all regions for the following LTC providers: general hospitals, nursing facilities, personal care service agencies, and transportation.

Geographic access standards were not met by MCOs for any region: Indian Health Service/Tribal Health Providers/Urban Indian Providers (I/T/Us), day treatment services, Indian Health Services and Tribal 638s providing behavioral health services, non-Accredited Residential Treatment Centers (ARTCs) and group homes, partial hospital programs, and treatment foster care I and II.

Timely routine, asymptomatic appointment rates among surveyed providers were reported at approximately 96% for BCBS, 75% for WSCC, and 70% for PHP. Timely urgent appointments among surveyed providers were reported at 83% for WSCC, 33% for PHP, and 34% for BCBS.

Validation of Quality-of-Care Studies

Benchmarks referenced in this section derive from the *2021 Quality Compass* (MY 2020) and represent all lines of business that reported MY 2020 CAHPS data to NCQA.

The MCOs were compliant with state requirements to report on member experience using the NCQA CAHPS tool.

When compared to national Medicaid benchmarks, no MCO achieved an adult CAHPS score for MY 2020 that exceeded the national Medicaid 50th percentile. However, BCBS achieved scores for Rating of Health Plan and How Well Doctors Communicate that exceeded the national Medicaid mean; and WSCC achieved a score for Rating of Personal Doctor that performed at the national Medicaid mean.

Concerning the MY 2020 child CAHPS survey, PHP reported a score for Rating of Personal Doctor that benchmarked at the 75th percentile.

NCQA Accreditation

The MCOs were compliant with state requirements to achieve or maintain NCQA Accreditation in 2020. Out of the available five stars NCQA uses to rate the overall quality of an MCO, BCBS and PHP received three stars while WSCC received 2.5 stars.

Recommendations

Per *42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations for improving the quality of care health care services furnished by the MCOs and recommendations on how HSD can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to New Mexico Medicaid managed care enrollees.

EQR Recommendations for the New Mexico Human Services Department

Recommendations towards achieving the goals of the Medicaid quality strategy are presented in **Section III** of this report.

EQR Recommendations for the Centennial Care Managed Care Plans

MCO-specific recommendations related to the **quality** of, **timeliness** of, and **access** to care are provided in **Section VII** of this report.

II. Introduction

States that provide Medicaid services through contracts with MCOs are required by federal mandate to conduct EQR activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. HSD contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent annual analysis of state and MCO performance related to the **quality** of, **timeliness** of, and **access** to the care and services it provides. This report is the result of IPRO's evaluation of services furnished and quality improvement activities conducted in 2020.

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III. New Mexico Medicaid Managed Care

New Mexico Medicaid Managed Care Program

The State of New Mexico's Centennial Care program is administered through HSD's Medical Assistance Division (MAD). Managed care was implemented to improve the quality of care and access to care for New Mexico's Medicaid clients by providing comprehensive medical and social services in a cost-effective manner. This program has steadily evolved since 1997, from an initial program that provided physical health benefits to the current one that provides a full array of services in an integrated model of care.

The New Mexico Medicaid managed care (MMC) program, formerly referred to as Salud!, was initiated on July 1, 1997. In July 2013, CMS approved the Centennial Care program, a new Medicaid Section 1115 Demonstration[9] waiver. Centennial Care consolidated nine waiver programs into a single, comprehensive managed care delivery system with four MCOs. CMS approved this waiver for an initial 5-year demonstration period from January 1, 2014, through December 31, 2018. The 1115 Demonstration Waiver extension application was approved on December 14, 2018, effective January 1, 2019, through December 31, 2023; and on June 22, 2019, New Mexico State submitted an amendment application that was approved on February 7, 2020, effective February 8, 2020, through December 31, 2023.

In 2020, HSD was contracted with BCBS, PHP, and WSCC to administer health care benefits under the Centennial Care program. As of December 2020, 748,383 New Mexicans were enrolled in the Centennial Care program, 54% with PHP, 36% with BCBS, and 11% with WSCC. **Table 1** displays Centennial Care program enrollment by MCO for 2018, 2019 and 2020.

Table 1: Centennial Care Enrollment, 2018–2020

Reporting Period	BCBS	PHP	WSCC	Centennial Care
December 2018 Enrollment	158,613	305,095	Not Applicable[1]	659,943[2]
% of Centennial Care Enrollment	24%	46.2%	-	100%[2]
December 2019 Enrollment	236,328	373,205	61,164	670,697
% of Centennial Care Enrollment	35%	56%	9%	100%
December 2020 Enrollment	268,223	400,787	79,373	748,383
% of Centennial Care Enrollment	36%	54%	11%	100%
Change +/- between 2019 and 2020	+13.5%	+7.4%	+29.8%	11.6%

Data Sources: Medicaid Enrollment Report-December 2020, Medicaid Enrollment Report-December 2019, and Medicaid Enrollment Report-December 2018.

[1] WSCC joined the Centennial Care program in 2019.

[2] Centennial Care's December 2018 enrollment reflects enrollment for BCBS, PHP, and Molina Healthcare of New Mexico, Inc. (not displayed in this table). Molina Healthcare's December 2018 Medicaid managed care enrollment was 29.7% (196,235) of the total Centennial Care Program enrollment displayed. Molina Healthcare exited the Centennial Care Program in December 2018.

[9] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

Medicaid Quality Strategy, 2021

New Mexico's 2019 Quality Strategy[10] was developed with input from the Medicaid members, public, stakeholders, Medicaid Advisory Committee, tribal leadership, Indian Health Services, tribal health providers, MCOs, EQRO, and the Behavioral Health Collaborative. The 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; PIPs; external independent reviews; TOC; health disparities; intermediate sanctions; long-term services and supports (LTSS); and non-duplication of EQR activities. It also includes an evaluation of the state's PM trends, tracking measures, and member satisfaction measures.

The New Mexico Medicaid Quality Strategy includes the suggested components outlined by CMS.[11]

Goals and Objectives

New Mexico's goals for Centennial Care are to build upon the program's accomplishments to include providing the most effective and efficient health care possible for eligible New Mexicans, as well as continuing the healthcare delivery reforms of Centennial Care. New Mexico's goals for the Centennial Care program are displayed in **Table 2**.

Table 2: New Mexico Medicaid Quality Strategy Goals, 2021

New Mexico Medicaid Goals
1. Assure that Medicaid members in the program receive the right amount of care, delivered at the right time, and in the right setting.
2. Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity.
3. 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.
4. 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.

The state's objectives for Centennial Care track progress toward achieving established goals, as well as identify opportunities for improvement. These objectives include:

- PM monitoring;
- Tracking measure monitoring;
- Hospital quality measure monitoring;
- Annual assessment of member experience (CAHPS);
- Annual assessment of quality, timeliness, and access to care (HEDIS); and
- External Quality Reviews:
  - PIP validation;

[10] At the time of publication of this report, the New Mexico Medicaid Quality Strategy updated in March 2021 was publicly posted in draft form, awaiting CMS approval. New Mexico Medicaid Quality Strategy Managed Care Program, March 2021 Revision website: https://www.hsd.state.nm.us/wp-content/uploads/2021-Quality-Strategy-Draft.pdf.

[11] Medicaid.gov State Quality Strategies website: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html. Accessed January 5, 2022.

- PM validation;
- Compliance review; and
- Network adequacy validation.

Quality Improvement Initiatives

New Mexico's quality improvement approach is executed through the continuation of successful initiatives implemented during the demonstration period, as well as the implementation of new initiatives designed to address gaps in care and to improve healthcare outcomes for Centennial Care members. Key initiatives under the Centennial Care program include:

Performance Measures

New Mexico selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. HSD monitors and utilizes data that evaluate the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying PMs. The selected PMs and performance targets are reasonable, based on industry standards, and consistent with CMS EQR Protocols. HSD conducts quarterly monitoring of the PMs to observe trends and to identify potential risks to meeting performance targets. This information is shared with the MCOs during quarterly quality meetings. The MCOs are required to follow NCQA HEDIS specifications for reporting. The EQRO validates the MCOs' reported performance rates annually.

The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in Section IV of this report.

MCO Accreditation Standards

New Mexico requires Centennial Care 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 HSD. 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 EQRO.

The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in Section V of this report.

Tracking Measures

New Mexico requires Centennial Care 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, HSD 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.

Table 3 displays the tracking measure rates at the MCO and statewide level for each quarter of 2020.

Table 3: Tracking Measure Performance, 2020

Tracking Measure	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	BCBS	PHP	WSCC	Statewide	BCBS	PHP	WSCC	Statewide	BCBS	PHP	WSCC	Statewide	BCBS	PHP	WSCC	Statewide
#1 Fall Risk Management	29%	25%	19%	26%	28%	25%	18%	25%	26%	24%	17%	24%	26%	24%	14%	24%
#2 Diabetes, Short Term Complications Admissions Rate	27.4	16.0	14.8	20.0	26.8	16.4	16.1	20.1	22.7	14.4	15.9	17.6	24.0	14.8	16.2	18.3
#3 Screening for Clinical Depression and Follow-Up Plan	0.7%	0.6%	0.5%	0.6%	0.7%	0.7%	0.5%	0.7%	0.5%	0.8%	0.6%	0.7%	0.6%	0.9%	0.7%	0.8%
#4 Follow-Up after Hospitalization for Mental Illness	47%	84%	37%	66%	49%	85%	36%	65%	48%	83%	37%	64%	48%	57%	36%	52%
#5 Immunizations for Adolescents	54%	81%	70%	64%	55%	81%	71%	68%	57%	80%	74%	71%	56%	79%	72%	72%
#6 Long-Acting Reversible Contraceptive	271	463	66	800	454	747	107	1,308	657	1,070	151	1,878	882	1,411	248	2,541
#7 Smoking Cessation	1,335	2,199	289	3,823	2,114	3,272	456	5,842	2,800	4,467	671	7,938	3,588	5,501	839	9,928
#8 Ambulatory Care	86.4	82.0	80.6	83.4	146.7	142.9	125.3	142.7	223.9	212.2	167.5	213.3	306.7	269.3	210.3	276.8
#9 Annual Dental Visits	15.6%	24.5%	24.1%	21.5%	33.4%	33.9%	32.5%	33.6%	45.1%	43.9%	39.9%	43.9%	55.2%	52.2%	46.6%	52.7%
#10 Controlling High Blood Pressure [1, 2]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	51.1%	50.6%	43.6%	48.4%[3]

Data Source: Centennial Care 2.0 Demonstration Section 1115 Demonstration Quarterly Report Demonstration Year: 8 (1/1/2021-12/31/2021) Quarter 1/2021

[1] The Tracking Measure #10 Controlling High Blood Pressure rate is calculated from a combination of claims data and medical record documentation and is therefore not reported to HSD on a quarterly basis. A single rate is reported to HSD in June of the following year. The final 2020 rate is reflected under Quarter 4 in this table.

[2] MCO Tracking Measure #10 Controlling High Blood Pressure rates presented for Quarter 4 represent MY 2020 and derive from the MCOs' HEDIS MY 2020 files.

[3] The statewide Tracking Measure #10 Controlling High Blood Pressure rate was calculated by IPRO using the MCO HEDIS MY 2020 rates for this measure.

NA: not available.

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, that tracks utilization of outpatient visits and emergency department (ED) 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 PCP.

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; and required MCO 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 PIP on diabetes prevention and management.

HSD selected 2019 aggregate facility rates as the baseline statistic and the MCO aggregate 2019 audited HEDIS rates reported for 2019 as the target. HSD aligned the selected metrics that are associated with the overarching state selected measures to improve outcomes for members. **Table 4** displays aggregate facility rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target.

Table 4: Hospital Quality Monitoring – Not for Profit Hospitals, MY 2019-MY 2020

Metric	Baseline 2019 Rate	Remeasurement 2020 Rate	+/- Difference between 2019 and 2020 Rates	Target Rate	+/- Difference Between 2020 Rate and Target
Not For Profit Hospitals					
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.89%	14.47%	+ 0.58	9.87%	+ 4.60
Comprehensive Diabetes Care: HbA1c Testing	46.59%	43.69%	- 2.90	83.41%	- 39.72
Follow-Up After Hospitalization for Mental Illness – 30 Days	11.92%	14.45%	+ 2.53	40.29%	- 25.84
For Profit Hospitals					
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	17.20%	15.25%	- 1.95	9.87%	+ 5.38
Comprehensive Diabetes Care: HbA1c Testing	62.52%	59.29%	- 3.23	83.41%	- 24.12

Metric	Baseline 2019 Rate	Remeasurement 2020 Rate	+/- Difference between 2019 and 2020 Rates	Target Rate	+/- Difference Between 2020 Rate and Target
Follow-Up After Hospitalization for Mental Illness – 30 Days	13.13%	16.67%	+ 3.54	40.29%	- 23.62
Community Tribal Hospitals					
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.28%	12.91%	- 0.37	9.87%	+ 3.04
Comprehensive Diabetes Care: HbA1c Testing	44.70%	46.87%	+ 2.17	83.41%	- 36.54
Follow-Up After Hospitalization for Mental Illness – 30 Days	5.99%	8.58%	+ 2.59	40.29%	- 31.71

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

HSD selected 2019 facility rates as the baseline statistic and the Hospital Compare National Average 2020 rates as the targets. HSD aligned the selected metrics that are associated with the overarching state selected measures to improve outcomes for members. **Table 5** displays facility rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target.

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Table 5: Hospital Quality Monitoring – Trauma Hospitals, MY 2019-MY 2020

Metric/Facility Name	Baseline 2019 Rate	Remeasurement 2020 Rate	+/- Difference Between 2019 and 2020 Rates	Target Rate	+/- Difference Between 2020 Rate and Target
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	-5	81	-6
Carlsbad Medical Center (level 3)	75	69	-6	81	-12
Christus St. Vincent Regional Medical Center (level 3)	78	75	-3	81	-6
Eastern New Mexico Medical Center (level 3)	76	60	-16	81	-21
Gerald Champion Regional Medical Center (level 3)	75	74	-1	81	-7
Mountain View Regional Medical Center (level 3)	75	72	-3	81	-9
San Juan Regional Medical Center (level 3)	76	66	-10	81	-15
Miners' Colfax Medical Center (level 4)	94	91	-3	81	+10
Nor-Lea General Hospital (level 4)	Not Reported	86	Not Applicable	81	+5
Sierra Vista Hospital (level 4)	Not Reported	100	Not Applicable	81	+19
Union County General Hospital (level 4)	77	77	0	81	-4
Memorial Medical Center (level 4)	76	74	-2	81	-7
Cibola General Hospital (level 4)	Not Reported	95	Not Applicable	81	+14
Gila Regional Hospital (level 4)	Not Reported	78	Not Applicable	81	-3
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	-3	86	0
Carlsbad Medical Center (level 3)	79	84	5	86	-2
Christus St. Vincent Regional Medical Center (level 3)	82	81	-1	86	-5
Eastern New Mexico Medical Center (level 3)	80	73	-7	86	-13
Gerald Champion Regional Medical Center (level 3)	83	88	5	86	+2
Mountain View Regional Medical Center (level 3)	84	81	-3	86	-5
San Juan Regional Medical Center (level 3)	83	86	3	86	0
Miners' Colfax Medical Center (level 4)	82	89	7	86	+3
Nor-Lea General Hospital (level 4)	Not Reported	96	Not Applicable	86	+10
Sierra Vista Hospital (level 4)	Not Reported	72	Not Applicable	86	-14
Union County General Hospital (level 4)	66	88	22	86	+2
Memorial Medical Center (level 4)	86	85	-1	86	-1
Cibola General Hospital (level 4)	Not Reported	92	Not Applicable!	86	+6
Gila Regional Hospital (level 4)	Not Reported	83	Not Applicable	86	-3

Consumer Assessment of Healthcare Providers and Systems

New Mexico incorporates the CAHPS 5.0H survey required by NCQA for MCO accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state-specific questions, which currently focus on the members satisfaction with the care coordination services received from the MCOs. The results of the annual CAHPS survey are reviewed and analyzed by HSD 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 EQRO validated the MCOs' 2021 CAHPS results.

The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in Section IV of this report.

Performance Improvement Projects

New Mexico identifies PIPs by assessing gaps in care with a focus on applying sustainable interventions that will improve the access, quality, or timeliness of care and services provided to the state's Medicaid beneficiaries. The PIPs are included in the MCO contracts and revised and updated based on HSD's review of the positive outcomes or the identification of needed attention to specific gaps in care. Beginning in 2019, the MCOs were required to conduct five PIPs each 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.

HSD requires that each MCO implement work plans and activities consistent with PIPs, as required by federal and state regulations. The EQRO reviews PIP proposals and interim PIP reports and provides technical assistance throughout the life of the PIP. PIP validation activities and results are summarized annually by the EQRO for the state.

The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in Section IV of this report.

IPRO's Assessment of the New Mexico Medicaid Quality Strategy

The 2021 New Mexico Medicaid quality strategy meets the requirements of *42 CFR 438.340 Managed Care State Quality Strategy* based on IPRO's review and it reinforces HSD'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.

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 EQR activities. The strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as PIPs, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

Between MY 2019 and MY 2020 statewide performance met or exceeded targets in areas related to antidepressant medication management, follow-up care after an ED visit or hospitalization for mental illness, postpartum care, and treatment for substance abuse.

Opportunities to improve health outcomes exist statewide. As evidenced by State- and MCO-level MY 2020 performance, increased attention to child and adolescent care, prenatal care, and appropriate screenings for members on antipsychotic medications, is appropriate.

Recommendations to the New Mexico Human Services Department

Per *Title 42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include a description of how HSD 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 enrollees. As such, IPRO recommends the following to HSD:

- Statewide provider shortages continue to be the greatest challenge Centennial Care MCOs face while developing and maintaining their Medicaid provider networks. HSD should implement immediate and practical solutions to decreasing these shortages, which may include contracting with out-of-state providers and increasing its support of advancing telehealth/telemedicine capability and utilization.
- Establish appointment availability thresholds for the MMC program to reinforce MCO accountability for increasing the availability of timely appointments.
- Continue to push for the adoption of telehealth services across the state and identify opportunities to provide support to clinicians who participate in state healthcare programs.
- Consider ways to increase professional clinical resources across the state with a specific focus on regions of the state with network adequacy issues.
- Maximize the patient-centered provisions in the Centennial Care contract to direct the MCOs toward supporting initiatives that prioritize improving quality of care.

IV. EQR Findings and Conclusions Related to Quality, Timeliness, and Access

Introduction

To assess the impact of the Centennial Care program on **access** to, **timeliness** of, and **quality** of care, IPRO reviewed pertinent information from a variety of sources, including state managed care standards, health plan contract requirements, PMs, and state monitoring reports.

This section of the report discusses the results, or findings, from the four required EQR activities (validation of PIPs, validation of PMs, review of compliance with Medicaid standards, and validation of network adequacy) and one optional activity (validation of quality-of-care surveys). For each EQR activity, a summary of the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions and findings are presented.

Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

Section 4.12.4.10 of the Centennial Care Agreement and subsection 18.1 of the Centennial Care Policy Manual require the MCOs to perform one PIP in each of the following areas: LTC services, prenatal and postpartum care, adult obesity, diabetes prevention and management, and depression screening and follow-up. Specific MCO PIP topics are displayed in **Table 6**.

Table 6: MCO PIP Topics, 2020

MCO	PIP Titles
BCBS	▪ LTSS – Diabetic Retinal Eye Exams (MY 2018-MY 2020) ▪ Timeliness of Prenatal Care and Postpartum Care (MY 2018-MY 2020) ▪ Adult Obesity (MY 2018-MY 2020) ▪ Diabetes Management and Short-Term Complications Admissions (STCA) Rate and HbA1c Testing (MY 2018-MY 2020) ▪ Screening and Management for Clinical Depression (MY 2018-MY 2020)
PHP	▪ TOC – Community Reintegration (MY 2018-MY 2020) ▪ Prenatal-Postpartum (MY 2018-MY 2020) ▪ Adult Obesity (MY 2018-MY 2020) ▪ Diabetes Prevention and Management (MY 2018-MY 2020) ▪ Screening and Management for Clinical Depression (MY 2018-MY 2021)
WSCC	▪ Fall Risk and Prevention Program (MY 2019-MY 2020) ▪ Addiction in Pregnancy Program (MY 2019-MY 2020) ▪ Adult Weight Management Program (MY 2019-MY 2020) ▪ Diabetes Prevention and Management (MY 2019-MY 2020) ▪ Management for Clinical Depression (MY 2019-MY 2020)

Title 42 CFR § 438.356(a)(1) and *42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the HSD contracted with IPRO to validate the PIPs that were underway in 2020.

Technical Methods of Data Collection and Analysis

IPRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs IPRO provides technical assistance to each MCO.

CMS's *Protocol 1-Validation of Performance Improvement Projects* was used as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following ten 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 generalizable to 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 PIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. 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 PIP outcomes should be accepted as valid and reliable. Specific to New Mexico, each PIP is then scored based on the MCO's compliance with elements 1–8[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 PIP was eight. Compliance levels are assigned based on the number of points (or percentage score) achieved. **Table 7** displays the compliance levels and their applicable score ranges.

Table 7: Validation Scoring and Compliance Levels

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

IPRO provided PIP 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.

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

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

- There were no validation findings that indicate that the credibility was at risk for the PIP results.
- The validation findings generally indicate that the credibility for the PIP 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 in the PIP results. The concerns that put the conclusion at risk are enumerated.

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

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

Description of Data Obtained

To conduct the 2020 EQR, IPRO utilized PIP reports populated by the MCOs during 2020 and 2021. Information obtained included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for PM calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Conclusions and Findings

BCBS and WSCC achieved full compliance for each of their five PIPs conducted in 2020. PHP achieved full compliance for four of their five PIPs. Fully compliant PIPs were conducted in a manner consistent with the EQRO PIP process. Table 8 displays a summary of the MCOs' PIP validation results.

Table 8: MCO PIP Validation Results, 2020

		PIP 1	PIP 2	PIP 3	PIP 4	PIP 5
MCO		LTC Services and Support	Prenatal and Postpartum Care	Adult Obesity	Diabetes Prevention and Management	Clinical Depression Screening and Follow-Up
BCBS	Compliance Level	Full	Full	Full	Full	Full
PHP	Compliance Level	Non-Compliant	Full	Full	Full	Full
WSCC	Compliance Level	Full	Full	Full	Full	Full

Concerning PHP's PIP that did not achieve full compliance, 2019 validation findings for PHP's PIP 1 remained applicable for the 2020 period. PHP's conduct of the LTC PIP (PIP 1) did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for PHP's PIP 1:

- The PIP topic was not selected through a comprehensive analysis of enrollee needs, care, and services.

- The project indicators did not monitor PHP's performance at a point in time or over time and did not inform the selection and evaluation of quality improvement activities.
- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for PIP reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied.
- The analysis did not include baseline and repeat measures of project outcomes; and the PIP results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the PIP did not assess the extent to which the improvement strategy was successful.

PIP summaries, including aim, interventions, results, and validation findings are reported in Table 9, Table 10, and Table 11 for BCBS, PHP and WSCC, respectively. Table 12 displays a summary of IPRO's improvement assessment for each project indicator by PIP topic by MCO.

Table 9: BCBS PIP Summaries, 2020

BCBS PIP Summaries
PIP 1: LTSS – Diabetic Eye Exams **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim BCBS aimed to increase the proportion of eligible Centennial Care diabetic, low NF LOC, LTC facility resident members who completed a yearly diabetic retinal eye exam during the MY. BCBS also aimed to increase the proportion of eligible Centennial Care diabetic members who completed a yearly diabetic retinal eye exam during the MY. Project Indicators ▪ The percentage of members residing in an LTC facility with a diagnosis of diabetes who met low NF LOC requirements and had a retinal eye exam. ▪ The percentage of adult members with a diagnosis of diabetes who had a retinal eye exam. Interventions in 2020 ▪ BCBS coordinated additional retinopathy screening events in underserved rural areas. ▪ BCBS conducted targeted outreach to members diagnosed with diabetes with educational material on the importance of completing diabetes-related screenings. ▪ BCBS and Davis Vision coordinated telephonic and mail outreach efforts to members with diabetes with educational material on the importance of completing a diabetic retinopathy examination annually. Performance Improvement Summary BCBS did not meet target rates for the two project indicators by the conclusion of this PIP. Improvement made between MY 2018 and MY 2019 for diabetic eye exams among its facility-based LTC membership declined between MY 2019 and MY 2020, with the final performance rate falling below the baseline rate. BCBS's rate of diabetic eye exams among the adult population fluctuated between MY 2018 and MY 2020, with the MY 2020 final rate performing below the MY 2018 baseline rate.

BCBS PIP Summaries
PIP 2: Timeliness of Prenatal and Postpartum Care **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim BCBS aimed to increase the proportion of eligible pregnant Centennial Care members with deliveries who received timely prenatal and postpartum care. Project Indicators ▪ The percentage of members with a live delivery who had prenatal care within the first trimester or with 42 days of enrollment. ▪ The percentage of members with a live delivery who had postpartum care on or between 21 and 56 days after delivery. Interventions in 2020 ▪ BCBS continued the Centennial Care Home Visiting Program with the University of New Mexico's Center of Development and Disability[13] and ENMRSH, Inc.[14] ▪ BCBS continued conducting postpartum outreach calls to 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. ▪ BCBS published articles in the member newsletter on the topics of preconception health and prenatal care. ▪ BCBS continued conducting provider educational sessions to highlight qualifying postpartum services and appropriate timeframes for these services. Performance Improvement Summary BCBS did not meet target rates for the two project indicators during the MY 2020 remeasurement period. Between MY 2018 and MY 2020 BCBS, demonstrated continued performance improvement in the rate of members with a timely postpartum visit. During this same timeframe, however, BCBS's rates of pregnant members with timely prenatal care fluctuated from performance improvement in MY 2019 to performance decline below the MY 2018 baseline rate in MY 2020.
PIP 3: Adult Obesity **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim BCBS aimed to improve Centennial Care member outcomes by: increasing the proportion of members aged 19–74 years who had an outpatient visit and whose BMI was documented during the MY 2020 or during the year prior; increasing the proportion of members aged 18–75 years with diabetes who completed an HbA1c test during the MY 2020 with an HbA1c result of less than 9%; and increasing the proportion of members aged 18–85 years who had a diagnosis of hypertension and whose blood pressure was controlled during the MY 2020. Project Indicators

[13] The University of New Mexico's Center for Development and Disability website: https://hsc.unm.edu/cdd/. Accessed November 9, 2021.
[14] The ENMRSH, Inc. website: https://enmrsh.org/. Accessed November 9, 2021.

- The percentage of adult members with an outpatient visit and a documented BMI (reported by the MCO for MY 2018 and MY 2019 only).
- The percentage of adult members with a diagnosis of diabetes with a documented HbA1c level that is higher than 9% (lower rate indicates better performance).
- The percentage of adult members with a diagnosis of hypertension with a documented blood pressure reading that is lower than 140/90.

Interventions in 2020

- BCBS continued the distribution of personal care trackers to members diagnosed with diabetes and hypertension. The trackers included: reminders about diabetes testing; and areas to document their biannual HbA1c and blood pressure values, annual eye exam results, and blood pressure readings.
- BCBS continued to promote clinical guidelines for addressing adult obesity and metabolic syndrome to providers.
- BCBS distributed member materials to increase the awareness on the importance of controlling blood pressure and committing to exercise and physical activity.

Performance Improvement Summary

BCBS did not meet target rates for the remaining two project indicators by the conclusion of this PIP. From the baseline period to the MY 2020 remeasurement period, BCBS's performance fluctuated. Despite exceeding all targets between MY 2018 and MY 2019, performance improvement declined between MY 2018 and MY 2020. During the final remeasurement period, BCBS demonstrated performance improvement in the rate of members with controlled blood pressure from MY 2018 to MY 2020. During this timeframe, however, BCBS demonstrated performance decline in the rate of members with a documented HbA1c reading greater than 9%, as the final rate performed lower than the MY 2018 baseline rate.

PIP 4: Diabetes Management and Short-Term Complications Admission Rates and HbA1c Testing
Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.

Aim

BCBS aimed to increase HbA1c testing rates for members diagnosed with diabetes to decrease diabetes related STCA rates.

Project Indicators

- The rate of admissions for adult members with a principal diagnosis of diabetes with short-term complications per 100,000 members (lower rate indicates better performance).
- The percentage of adult members with a diagnosis of diabetes with a documented HbA1c level.

Interventions in 2020

- BCBS continued to notify providers of members who had an STCA event. Notified providers were invited to discuss plans of care with the assigned BCBS care coordinator.
- BCBS continued to distribute personal care trackers to members diagnosed with diabetes. The trackers included: reminders about diabetes testing; and areas to document their biannual HbA1c and blood pressure values, annual eye exam results, and blood pressure readings.
- BCBS 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.

BCBS PIP Summaries
Performance Improvement Summary BCBS did not meet target rates for the two project indicators at the conclusion of this PIP. Though performance improvement was demonstrated for both the rate of members with a completed HbA1c test between MY 2018 and MY 2019 and for the rate of hospital admissions for diabetes-related short-term complications between MY 2019 and MY 2020, BCBS's final rates for these indicators performed below the MY 2018 baseline rates.
PIP 5: Screening and Management for Clinical Depression **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim BCBS aimed to increase the proportion of eligible Centennial Care members ages 18–64 years and 65 years and older who have an annual screening for depression with appropriate follow-up if positive for depression; and aimed to increase the proportion of eligible Centennial Care members ages 18–64 years and 65 years and older who remain on antidepressant medication for more than 6 months. Project Indicators ▪ The percentage of adult members (18-64 years) with a positive depression screening and documented follow-up plan. ▪ The percentage of adult members (65 years and older) with a positive depression screening and documented follow-up plan. ▪ The percentage of adult members (18-64 years) with a diagnosis of major depression who remained on antidepressant medication for at least 84 days. ▪ The percentage of adult members (65 years and older) with a diagnosis of major depression who remained on antidepressant medication for at least 84 days. ▪ The percentage of adult members (18-64 years) with a diagnosis of major depression who remained on antidepressant medication for at least 180 days. ▪ The percentage of adult members (65 years and older) with a diagnosis of major depression who remained on antidepressant medication for at least 180 days. Interventions in 2020 ▪ BCBS continued to conduct member engagement telephone calls prior to the member's medication refill date to encourage the member to refill their antidepressant medication prescription. During the call, members were assessed for care coordination and support services. ▪ BCBS continued to conduct general and targeted provider education on effective methods for depression screening and appropriate development of follow-up plans. ▪ For members with a positive depression screen, BCBS care coordinators conducted outreach calls to confirm with the member that a follow-up plan is in place and to offer care coordination services. Performance Improvement Summary BCBS exceeded target rates for two of the six project indicators at the conclusion of this PIP. BCBS's performance between MY 2018 and MY 2019 and between MY 2019 and MY 2020 was consistent. BCBS demonstrated continuous improvement between MY 2018 and MY 2020 on four of the six project indicators. During this timeframe, BCBS exceeded target rates for the percentage of members aged 18–64 years who remained on antidepressant medication for at least 84 days and the percentage of members aged 18–64 years

BCBS PIP Summaries
who remained on antidepressant medication for at least 180 days. BCBS reported higher rates for the percentage of members aged 65 years and older who remained on antidepressant medication for at least 84 days and the percentage of members aged 65 years and older who remained on antidepressant medication for at least 180 days. Despite demonstrating improvement between MY 2019 and MY 2020, BCBS's performance declined from the MY 2018 baseline period to the final remeasurement period for the number of members who positively screened for clinical depression with a documented follow-up plan. Performance decline was observed in both the 18–64 years and 65 years and older groups.

Table 10: PHP PIP Summaries, 2020

PHP PIP Summaries
PIP 1: TOC – Community Reintegration **Validation Summary: There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk are enumerated under the PIP Validation Findings section that preceded this section.**
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. Project Indicators ▪ The percentage of members who successfully reintegrated from a nursing facility to the community and did not experience and avoidable hospitalization within 120 days of discharge from the nursing facility. ▪ The percentage of members who successfully reintegrated from a nursing facility to the community and did not experience an avoidable re-institutionalization within 120 days of discharge from the nursing facility. ▪ The percentage of members identified with potential of failure to thrive characteristics and successfully reintegrated from a nursing facility to the community. Interventions in 2020 ▪ PHP continued to educate and refer members to the appropriate providers and services. ▪ PHP continued collaborating with nursing facility staff to educate members on the importance of establishing a community provider. ▪ PHP continued conducting interdisciplinary care plan meetings for members who refuse services. ▪ PHP continued to monitor for potential self-neglect cases and made referrals when appropriate. ▪ PHP continued to refer members to community health workers when appropriate. ▪ PHP continued to identify and establish wraparound supports. Performance Improvement Summary Continuous methodological changes implemented between MY 2018 and MY 2020 prevent IPRO from evaluating the impact of interventions implemented for this PIP and from assessing improvement.

PHP PIP Summaries
PIP 2: Prenatal-Postpartum **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim PHP aimed to increase the proportion of eligible pregnant Centennial Care members with deliveries who receive timely prenatal and postpartum care. Project Indicators ▪ The percentage of members with a live delivery who had prenatal care within the first trimester or with 42 days of enrollment. ▪ The percentage of members with a live delivery who had postpartum care on or between 21 and 56 days after delivery. Interventions in 2020 ▪ PHP continued telephonic and mail outreach to educate members on prenatal and postpartum care and to provide information about the PHP Baby Benefits program. Performance Improvement Summary PHP did not meet target rates for the two project indicators at the conclusion of this PIP. PHP reported a decline in performance for timely prenatal and postpartum care between the MY 2018 baseline period and MY 2019 remeasurement period; however, performance improvement was reported for both indicators between the MY 2019 and MY 2020 remeasurement periods. PHP's final rate for timely prenatal care exceeded the MY 2018 baseline rate while the final rate for timely postpartum care fell below the MY 2018 baseline rate.
PIP 3: Adult Obesity **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim PHP aimed to increase the proportion of members, aged 18 years and older, who had BMI assessments. PHP also aimed to increase the number of members who met the National Diabetes Prevention[15] criteria and were enrolled in an obesity-related support program. Project Indicators ▪ The percentage of adult members with an outpatient visit and a documented BMI ▪ The percentage of adult members enrolled in an obesity-related support program Interventions in 2020 ▪ PHP continued the statewide diabetes prevention program to deliver obesity-related support for adult members. ▪ PHP continued its member communication campaign to inform members about obesity-related support resources and programs.

[15] 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. Accessed November 3, 2021.

PHP PIP Summaries
Performance Improvement Summary PHP exceeded the target rate for one of the two project indicators at the conclusion of this PIP. PHP increased the number of adult members enrolled in an obesity-related support program between the MY 2019 and MY 2020 remeasurement periods. Between MY 2018 and MY 2020, PHP demonstrated declining performance in the number of members with a documented BMI.
PIP 4: Diabetes Prevention and Management **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim PHP aimed to increase HbA1c testing and decrease hospital admissions due to diabetes-related short-term complications among members diagnosed with diabetes. Project Indicators ▪ The rate of admissions for adult members with a principal diagnosis of diabetes with short-term complications per 100,000 members (lower rate indicates better performance). ▪ The percentage of adult members with a diagnosis of diabetes with a documented HbA1c level. Interventions in 2020 ▪ PHP continued targeted telephonic education and outreach to members identified by the MCO as non-adherent diabetes for diabetes-related screenings and diabetes management. Performance Improvement Summary PHP exceeded the target rate for one of the two project indicators during the MY 2020 remeasurement period. PHP demonstrated continuous performance improvement between MY 2018 and MY 2020 in reducing hospital admissions for diabetic short-term complications. During the same timeframe, however, PHP demonstrated declining performance in the number of members with a completed HbA1c test.
PIP 5: Screening and Management of Clinical Depression **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim PHP aimed to increase member adherence to prescribed antidepressant medications by conducting outreach calls to members. Project Indicators ▪ The percentage of adult members with a diagnosis of major depression who remained on antidepressant medication for at least 84 days. ▪ The percentage of adult members with a diagnosis of major depression who remained on antidepressant medication for at least 180 days. ▪ The percentage of adult members (18-64 years) with a positive depression screening and documented follow-up plan. ▪ The percentage of adult members (65 years and older) with a positive depression screening and documented follow-up plan.

PHP PIP Summaries
Interventions in 2020 ▪ Through its collaboration with Project ECHO[16], PHP continued to offer the 8-week TeleECHO Depression Sessions training to network providers. ▪ PHP continued its education initiative to increase member awareness of depression symptoms and management. ▪ PHP continued to incentivize providers through its Provider Quality Incentive Program for the appropriate documentation of depression screening, diagnosis, and follow-up. Performance Improvement Summary PHP demonstrated continued improvement for all four project indicators and exceeded target rates for three of these indicators between the MY 2018 baseline period and the MY 2020 remeasurement period. PHP reported a higher rate of members who remained on antidepressant medication for at least 84 days and exceeded the target rate. PHP also reported a higher rate of members who remained on antidepressant medication for at least 180 days and higher rates of members who were positively screened for depression with a documented follow-up plan for both the 18–64 years and 65 years and older groups.

Table 11: WSCC PIP Summaries, 2020

WSCC PIP Summaries
PIP 1: Fall Risk and Prevention Program **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim WSCC aimed to decrease the number of fall-related hospitalizations for members, aged 60 years and older, who are living in the community. Project Indicators ▪ The rate of adult LTSS members (60 years and older) who had a fall-related hospitalization per 10,000 members. Interventions in 2020 ▪ WSCC continued to coordinate with the New Mexico Department of Health to refer members to the A Matter of Balance and Otago programs.[17] A Matter of Balance is a community intervention designed to reduce fear of falling and to increase physical activity. Otago is an exercise program facilitated by a physical therapist or physical therapy assistant.

[16] "Project ECHO, developed by Sanjeev Arora, MD, at the University of New Mexico Health Sciences Center, is a collaborative model of medical education and care management that helps clinicians provide expert-level care to patients wherever they live. Using video-conferencing technology to train, advise, and support PCPs, Project ECHO increases access to specialty treatment in rural and underserved areas for a variety of conditions." *Agency for Healthcare Research and Quality (September 2020).*

[17] New Mexico Department of Health Injury and Behavioral Epidemiology Bureau, Older Adults Falls Prevention website: https://www.nmhealth.org/about/erd/ibeb/oafp/. Accessed November 9, 2021.

WSCC PIP Summaries
Performance Improvement Summary WSCC reported a decline in performance improvement from the MY 2019 baseline period to MY 2020 remeasurement period and did not meet the target rate. Between the MY 2019 baseline and MY 2020 remeasurement periods, WSCC reported a higher rate of fall-related hospitalizations among its LTSS members.
PIP 2: Addiction in Pregnancy Program **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim WSCC aimed to increase the proportion of pregnant members with a new episode of alcohol and other drug (AOD) abuse who initiated timely treatment and who had two or more additional AOD services or medication-assisted treatment (MAT). Project Indicators ▪ The percentage of pregnant members (13 years and older) who initiated AOD treatment within 14 days of AOD diagnosis ▪ The percentage of pregnant members (13 years and older) with a new episode of AOD abuse who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initial treatment event. ▪ The percentage of members with a live delivery who had postpartum care on or between 21 and 56 days after delivery. Interventions in 2020 ▪ WSCC high-risk obstetrics care coordinators continued to engage members to develop individual care plans, to conduct health assessments, to conduct motivational interviews, and to provide education on prenatal and postpartum care. ▪ WSCC continued to educate providers on the importance of identifying pregnant members facing addiction and on the appropriate codes for reimbursements. Performance Improvement Summary WSCC did not meet target rates for the three project indicators but demonstrated improvement at the conclusion of this PIP. Between the MY 2019 baseline period and MY 2020 remeasurement period, WSCC demonstrated improvement among pregnant members 13 years and older who initiated dependence treatment within 14 days and 34 days of diagnosis. During the same timeframe, WSCC reported a higher rate of members with timely postpartum care.
PIP 3: Adult Weight Management Program **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim WSCC aimed to increase the proportion of members aged 18 to 74 years who had an outpatient visit and documented BMI or weight assessment. WSCC also aimed to decrease the proportion of members aged 19 years and older who had a documented BMI of greater than 30 kg/m. Project Indicators

- The percentage of adult members (19 years and older) with a documented BMI of greater than 30 kg/m (lower rate indicates better performance).
- The percentage of adult members with an outpatient visit and a documented BMI.

Interventions in 2020

- 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.
- WSCC continued outreach to educate providers on appropriate billing for BMI assessments and the importance on documenting BMI. WSCC also distributed a provider toolkit on the topic of adult BMI.

Performance Improvement Summary

WSCC exceeded target rates for two project indicators at the conclusion of this PIP. Between MY 2019 and MY 2020 WSCC reported a lower rate of members with a documented BMI equal to or greater than 30 kg/m and reported a higher rate of adult members with a documented BMI.

PIP 4: Diabetes Prevention and Management

Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.

Aim

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

Project Indicators

- The percentage of adult members with a diagnosis of diabetes with a documented HbA1c level.
- The rate of admissions for adult members with a principal diagnosis of diabetes with short-term complications per 100,000 members (lower rate indicates better performance).

Interventions in 2020

- WSCC continued to outreach to educate providers on appropriate billing for lab results, medication adherence, diabetes medications, and diabetic screening guidelines.
- WSCC continued to conduct care coordination for members with a hospital admission for a diabetes-related short-term complication.
- WSCC continued efforts to collaborate with community health workers and peer support workers to conduct member coaching for diabetes management.
- WSCC continued to work with behavioral health homes to assist high-performing PCPs with managing care for members with diabetes and a behavioral health diagnosis.

Performance Improvement Summary

WSCC exceeded target rates for two project indicators at the conclusion of this PIP. Between MY 2019 and MY 2020 WSCC reported performance improvement for HbA1c testing among members with diabetes and in the reduction of admissions for diabetes-related short-term complications.

WSCC PIP Summaries
PIP 5: Management for Clinical Depression **Validation Summary: There were no validation findings that indicate that the credibility is at risk for the PIP results.**
Aim WSCC aimed to improve medication adherence among members, aged 18 years and older, who had a diagnosis of depression and were treated with antidepressant medications. Project Indicators ▪ The percentage of adult members with a diagnosis of major depression who remained on antidepressant medication for at least 84 days. ▪ The percentage of adult members with a diagnosis of major depression who remained on antidepressant medication for at least 180 days. ▪ The percentage of adult members with a positive depression screening and documented follow-up plan. Interventions in 2020 ▪ WSCC collaborated with pharmacies to implement 90-day refills and to contact prescribing providers when a request for an updated prescription is needed. ▪ WSCC outreached to members who had a history of mediation non-adherence. ▪ WSCC conducted polypharmacy counseling for members identified as having numerous chronic conditions and who struggle with both medication and disease management. ▪ WSCC conducted outreach to educate providers on appropriate depression screening tools and the requirement to implement a follow-up plan for members diagnosed with depression. Performance Improvement Summary WSCC exceeded the target rate for two of three performance indicators at the conclusion of this PIP. Between MY 2019 and MY 2020 WSCC reported higher rates of members who remained on antidepressant medication for at least 84 days and for at least 180 days. WSCC demonstrated performance decline in appropriate documentation of a follow-up plan for members who were positively screened for depression.

Table 12 displays a summary of IPRO's improvement assessment for each project indicator by PIP topic by MCO. In this table, IPRO's assessment of indicator performance was based on the following 4 categories:

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

Table 12: Assessment of MCO PIP Indicator Performance

MCO	Indicator #	Indicator Description	Assessment of Performance Baseline to MY 2019 Remeasurement	Assessment of Improvement Baseline to MY 2020 Remeasurement
PIP 1: LTC Services and Supports				
BCBS	Indicator 1:	Residential LTC facility members with diabetes who had a retinal eye exam	Performance improvement demonstrated and target exceeded.	Performance decline demonstrated and target not met.
	Indicator 2:	Adult members with diabetes who had a retinal eye exam	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
PHP	Indicator 1:	Members who successfully integrated with no avoidable hospitalizations within 120 days post-discharge	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.
	Indicator 2:	Members who successfully integrated with no avoidable re-institutionalization within 120 days post-discharge	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.
	Indicator 3:	Members who successfully integrated despite potential of failure to thrive	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.
WSCC	Indicator 1:	Fall-related hospital admissions among LTSS members	Not Applicable	Performance decline demonstrated and target not met.
PIP 2: Prenatal and Postpartum Care				
BCBS	Indicator 1:	Members with timely prenatal visits	Performance improvement demonstrated but target not met.	Performance decline demonstrated and target not met.
	Indicator 2:	Members with a timely postpartum visit	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.
PHP	Indicator 1:	Members with timely prenatal visits	Performance decline demonstrated and target not met.	Performance improvement demonstrated but target not met.
	Indicator 2:	Members with a timely postpartum visit	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
WSCC	Indicator 1:	Pregnant members with initiated AOD treatment within 14 days of dependence diagnosis	Not Applicable	Performance improvement demonstrated but target not met.
	Indicator 2:	Pregnant members with initiated AOD treatment within 34 days of initial use or discharge	Not Applicable	Performance improvement demonstrated but target not met.
	Indicator 3:	Members with a timely postpartum visit	Not Applicable	Performance improvement demonstrated but target not met.

MCO	Indicator #	Indicator Description	Assessment of Performance Baseline to MY 2019 Remeasurement	Assessment of Improvement Baseline to MY 2020 Remeasurement
PIP 3: Adult Obesity				
BCBS	Indicator 1:	Adult members with a documented BMI	Performance improvement demonstrated and target exceeded.	Not Applicable
	Indicator 2:	Adult members with a documented HbA1c of less than 9% (controlled diabetes)	Performance improvement demonstrated and target exceeded.	Performance decline demonstrated and target not met.
	Indicator 3:	Adult members with a documented blood pressure reading of less than 140/90 (controlled hypertension)	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated but target not met.
PHP	Indicator 1:	Adult members with a documented BMI	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
	Indicator 2:	Members enrolled in an obesity-related support program	Unable to evaluate performance at this time.	Performance improvement demonstrated and target exceeded.
WSCC	Indicator 1:	Adult members with a documented BMI	Not Applicable	Performance improvement demonstrated and target exceeded.
	Indicator 2:	Adult members with an outpatient visit and a documented BMI	Not Applicable	Performance improvement demonstrated and target exceeded.
PIP 4: Diabetes Prevention and Management				
BCBS	Indicator 1:	Hospital admissions for diabetes-related short-term complications	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
	Indicator 2:	Adult members with a documented HbA1c result	Performance improvement demonstrated but target not met.	Performance decline demonstrated and target not met.
PHP	Indicator 1:	Adult members with a documented HbA1c result	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
	Indicator 2:	Hospital admissions for diabetes-related short-term complications	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.

MCO	Indicator #	Indicator Description	Assessment of Performance Baseline to MY 2019 Remeasurement	Assessment of Improvement Baseline to MY 2020 Remeasurement
WSCC	Indicator 1:	Adult members with a documented HbA1c result	Not Applicable	Performance improvement demonstrated and target exceeded.
	Indicator 2:	Hospital admissions for diabetes-related short-term complications	Not Applicable	Performance improvement demonstrated and target exceeded.
PIP 5: Clinical Depression Screening and Follow-Up				
BCBS	Indicator 1:	Members 18–64 years with documented positive depression screen and follow-up plan	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
	Indicator 2:	Members 65 years and older with documented positive depression screen and follow-up plan	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
	Indicator 3:	Members 18–64 years diagnosed with depression who remained on antidepressant medication for at least 84 days	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.
	Indicator 4:	Members 65 years and older diagnosed with depression who remained on antidepressant medication for at least 84 days	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.
	Indicator 5:	Members 18–64 years diagnosed with depression who remained on antidepressant medication for at least 180 days	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.
	Indicator 6:	Members 65 years and older diagnosed with depression who remained on antidepressant medication for at least 180 days	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.
PHP	Indicator 1:	Members 18 years and older diagnosed with depression who remained on antidepressant medication for at least 84 days	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.
	Indicator 2:	Members 18 years and older diagnosed with depression who remained on antidepressant medication for at least 180 days	Performance improvement demonstrated but target not met.	Performance improvement demonstrated and target exceeded.
	Indicator 3:	Members 18–64 years with a documented positive depression screen and follow-up plan	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.

MCO	Indicator #	Indicator Description	Assessment of Performance Baseline to MY 2019 Remeasurement	Assessment of Improvement Baseline to MY 2020 Remeasurement
	Indicator 4:	Members 65 years and older with a documented positive depression screen and follow-up plan	Performance improvement demonstrated but target not met.	Performance improvement demonstrated and target exceeded.
WSCC	Indicator 1:	Members 18 years and older diagnosed with depression who remained on antidepressant medication for at least 84 days	Not Applicable	Performance improvement demonstrated and target exceeded.
	Indicator 2:	Members 18 years and older diagnosed with depression who remained on antidepressant medication for at least 180 days	Not Applicable	Performance improvement demonstrated and target exceeded.
	Indicator 3:	Members 18 years and older with a documented positive depression screen and follow-up plan	Not Applicable	Performance decline demonstrated and target not met.

Validation of Performance Measures

Information Systems Capabilities Assessment

The ISCA data collection tool allows the state or EQRO to evaluate the strength of each MCO's IS capabilities to meet the regulatory requirements for quality assessment and reporting. *Title 42 CFR § 438.242 Health information systems* and *42 CFR § 457.1233 Structure and operation standards (d) Health information systems* also require the state to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. While certain portions of the ISCA are voluntary, there are specific components that are required to support the execution of the mandatory EQR-related activities protocols.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA.

Each MCO contracted with a NCQA-certified HEDIS compliance auditor for HEDIS MY 2020. Auditors assessed the MCO's compliance with NCQA standards in the following designated IS categories as part of the NCQA HEDIS MY 2020 Compliance Audit:

- IS 1.0 Medicaid Services Data: Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0 Enrollment Data: Data Capture, Transfer and Entry
- IS 3.0 Practitioner Data: Data Capture, Transfer and Entry
- IS 4.0 Medical Record Review Processes: Training, Sampling, Abstraction and Oversight
- IS 5.0 Supplemental Data: Capture, Transfer and Entry
- IS 6.0 Data Production Processing: Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
- IS 7.0 Data Integration and Reporting: Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The term "IS" – Information Systems – included the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation included a review of any manual processes used for HEDIS reporting. The compliance auditor determined the extent to which the MCOs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

An MCO meeting all IS standards required for successful HEDIS reporting and submitting HEDIS data to HSD according to the requirements in the Centennial Care contract were considered strengths during this evaluation. An MCO not meeting an IS standard was considered an opportunity for improvement during this evaluation.

In addition to the HEDIS MY 2020 Compliance Audit, HSD opted for all MCOs to undergo a full ISCA review. The ISCA commenced in 2020 and concluded in 2021.

IPRO conducted the ISCA in accordance with Appendix A of the CMS EQR *Protocols* published in October 2019.

The purpose of the assessment was to pose standard questions used to assess the strength of each MCO with respect to the capabilities outlined above. MCO responses to these questions assisted IPRO in assessing the extent to which each MCO's information system was capable of producing valid encounter data, PMs, tracking encounter data submissions and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.

CMS prescribes that at the conclusion of the ISCA review, the EQRO is to compile and analyze the information gathered through the preliminary ISCA review and from the MCO staff interviews. After completing its analysis, the EQRO writes a statement of findings about the MCO's information system. The assessment levels used by IPRO are displayed in Table 13 while the assessment findings for each MCO are displayed in Table 15.

Table 13: IPRO Assessment Level Definitions

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

HEDIS Performance Measures

Objectives

HSD selects a set of PMs to evaluate the quality of care delivered by the MCOs to Centennial Care members. For 2020, HSD required the MCOs to report a total of 10 PMs, 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 HSD-determined targets outlined in the Centennial Care Medicaid Managed Care agreements.

Title 42 CFR 438.358(a)(1) and *438.358(b)(ii)* require that these PMs be validated by the state, its agent, or an EQRO. IPRO conducted this activity on behalf of HSD for 2020.

Technical Methods of Data Collection and Analysis

All PMs follow NCQA HEDIS technical specifications and were independently audited by NCQA-licensed audit organizations as part of the MCOs' annual HEDIS Compliance Audit.

Table 14 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* (MY 2017) regional averages plus one percentage point. Failure to meet the HSD-assigned target for an individual PM 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 PMs specified for the agreement year.

Table 14: HSD PM Descriptions and Available Points, MY 2020

Performance Measures	Steward	Data Collection Method[2]	Available Points	MY 2020 Target
PM 1 Well-Child Visits in the First 30 Months of Life – First 15 Months (W30)[1]: The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits	NCQA	Administrative	1	62.62%
PM 2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Physical Activity (WCC): The percentage of members ages 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: counseling for physical activity	NCQA	Hybrid	1	48.52%
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	78.67%
PM 4 Timeliness of Prenatal and Postpartum Care – Postpartum Care (PPC): The percentage of deliveries that had a postpartum visit on or between seven and 84 calendar days after delivery	NCQA	Hybrid	1	63.35%
PM 5 Childhood Immunization Status – Combination 3 (CIS): The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella; three Haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (CV) vaccines by their second birthday	NCQA	Hybrid	1	68.01%
PM 6 Antidepressant Medication Management – Continuation Phase (AMM): The percentage of members 18 years and older who were treated with medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 calendar days (or six months)	NCQA	Administrative	1	34.33%
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 AOD dependence who received: initiation of AOD treatment	NCQA	Administrative	1	43.34%

Performance Measures	Steward	Data Collection Method[2]	Available Points	MY 2020 Target
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	48.42%
PM 9 Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM): The percentage of ED 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 ED visit	NCQA	Administrative	1	43.52%
PM 10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age 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	80.63%

[1] Formerly known as Well-Child Visits in the First Fifteen (15) Months of Life (W15).
[2] Administrative rates are calculated from claims data. Hybrid rates are calculated from claims data and medical record documentation.
Note: The following measures were included in the HSD PM program for MY 2019: PM 1 W30, PM 2 WCC, PM 3 PPC, PM 4 PPC, PM 6 AMM, and PM 7 IET.

As part of the MY 2020 PM validation activity, IPRO reviewed MCO quality improvement plans to assess the impact of MCO-directed improvement activities on health outcomes related to the PMs in **Table 14**.

Description of Data Obtained

To conduct the 2020 EQR, IPRO reviewed each MCO's HEDIS MY 2020 FAR and MY 2020 audit review table (ART).

The FAR 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 ART produced by the HEDIS compliance auditor displayed PM-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 ART: administrative rate before exclusions; minimum required sample size (MRSS), and MRSS 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.

Conclusions and Findings

The MCO's independent auditors determined that the HEDIS MY 2020 rates reported by the MCOs were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCOs' independent auditors.

Based on a review of the FARs issued by each MCO's independent auditor, IPRO found that the MCOs were determined to be *fully compliant* with all seven of the applicable NCQA IS standards. HEDIS rates produced by the MCOs were reported to NCQA and HSD. **Table 15** displays the results of IS reviews for each MCO, as well as the name of the independent auditor for HEDIS MY 2020.

Table 15: MCO Compliance with Information System Standards, MY 2020

	BCBS	PHP	WSCC
MCO Contracted Compliance Auditor for HEDIS MY 2020	Attest Health Care Advisors	Healthy People, Inc.	Attest Health Care Advisors
Information System Standard			
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 2020–2021 ISCA, IPRO determined that the MCOs met or exceeded the standards reviewed. **Table 16** displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO.

Table 16: MCO ISCA Findings, 2020-2021

ISCA 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 PMs	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 (T-MSIS) 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.,	Met	Met	Met

ISCA Assessment Topic	BCBS	PHP	WSCC
immunization registries, health information exchanges, vital statistics, public health data)			

Table 17 displays the PM rates for each MCO, points earned, and statewide averages for MY 2020. 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 MY target. BCBS earned eight points. PHP earned six points. WSCC earned two points. For two PMs, all MCOs reported rates that exceeded the HSD-targets. Seven Centennial Care averages calculated by IPRO exceeded their respective targets.

Table 17: MCO PM Rates, MY 2020

Performance Measure	MY 2020 Target Rate	BCBS MY 2020 Rate	PHP MY 2020 Rate	WSCC MY 2020 Rate	Centennial Care MY 2020 Average	Difference Between Centennial Care Average and MY Target
PM 1 W30[1] First 15 Months	62.62%	56.89%	49.63%	42.70%	51.91%	-10.71
PM 2 WCC Physical Activity	48.52%	50.36%	49.88%	43.31%	50.08%	+1.56
PM 3 PPC[1] Prenatal Care	78.67%	79.32%	68.61%	68.37%	73.02%	-5.65
PM 4 PPC[1] Postpartum Care	63.35%	67.40%	69.59%	59.85%	68.69%	+5.34
PM 5 CIS Combo 3	68.01%	70.56%	67.64%	61.56%	68.88%	+0.87
PM 6 AMM[1] Continuation	34.33%	39.81%	42.38%	36.46%	40.88%	+6.55
PM 7 IET[1] Initiation	43.34%	43.77%	54.12%	43.26%	49.30%	+5.96
PM 8 FUH 30 Day	48.42%	51.94%	54.84%	53.85%	53.60%	+5.18
PM 9 FUM 30 Day	43.52%	59.36%	64.83%	42.76%	60.78%	+17.26
PM 10 SSD	80.63%	76.46%	75.14%	73.69%	75.53%	-5.10
Total Points Earned (Max 10)		8	6	2		

[1] The following measures were included in the HSD PM program for MY 2019: PM 1 W30, PM 2 WCC, PM 3 PPC, PM 4 PPC, PM 6 AMM, and PM 7 IET.
Note: Green shading indicates that the displayed rate met or exceeded the MY target.

Observations of performance at the aggregate level include the following:

- PM 1 Well-Child Visits in the First 30 Months of Life – First 15 Months was 10.71 percentage points below the target rate of 62.62%. No MCO reported rate met the target. BCBS had the highest reported rate of 56.89%.

- PM 2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Physical Activity Counseling was 1.56 percentage points above the target rate of 48.52%. BCBS had the highest reported rate of 50.36%.
- PM 3 Timeliness of Prenatal and Postpartum Care – Timeliness of Prenatal Care was 5.65 percentage points below the target rate of 78.67%. BCBS had the highest reported rate of 79.32%.
- PM 4 Timeliness of Prenatal and Postpartum Care – Postpartum Care was 5.34 percentage points above the target rate of 63.35%. PHP had the highest reported rate of 69.59%.
- PM 5 Childhood Immunization Status – Combination 3 was 0.87 percentage points above the target rate of 68.01%. BCBS had the highest reported rate of 70.56%.
- PM 6 Antidepressant Medication Management – Continuation Phase was 6.55 percentage points above the target rate of 34.33%. All MCOs reported a rate that exceeded the target. PHP had the highest reported rate of 42.38%.
- PM 7 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation was 5.96 percentage points above the target rate of 43.34%. PHP had the highest reported rate of 54.12%.
- PM 8 Follow-Up After Hospitalization for Mental Illness – 30 Day was 5.18 percentage points above the target rate of 48.42%. All MCOs reported rates that exceeded the target. PHP had the highest reported rate of 54.84%.
- PM 9 Follow-Up After Emergency Department Visit for Mental Illness – 30 Day was 17.26 percentage points above the target rate of 43.52%. PHP had the highest reported rate of 64.83%.
- PM 10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications was 5.10 percentage points below the target rate of 80.63%. No MCO reported rate met the target. BCBS had the highest reported rate of 76.46%.

MCO PM trends are available in **Appendix B** of this report.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Per *42 CFR §438.358* a review must be conducted within the previous 3-year period that determines a plan's adherence to standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards, as well as applicable elements of the Centennial Care Agreement. HSD contracted with IPRO to conduct the 2020 compliance reviews.

Technical Methods of Data Collection and Analysis

The compliance review was an assessment of MCO compliance with the Medicaid Managed Care Services Agreement, HSD Managed Care Policy Manual, *42 CFR Part 43*8, and the New Mexico Administrative Code (NMAC). Each MCO was assessed for its compliance with contractual requirements related to Adverse Benefit Determinations, Care Coordination, Delegation – Dental and Transportation, Enrollment and Disenrollment, Grievances and Appeals, Maintenance of Medical Records, Member Materials, Member Services, PCP and Pharmacy Lock-ins, Program Integrity, Provider Agreements, Provider Network, Provider Services, Quality Assurance, Reporting Requirements, Self-Directed Community Benefit, and TOC.

Modifications were made to the review process and methodology to mitigate the impact of the coronavirus disease (COVID-19) pandemic. Specifically, onsite reviews were held virtually to avoid potential COVID exposure and

transmission; and partial reviews were conducted to allow MCO staff to continue the MCO's COVID response without disruption.

Partial reviews were conducted for *document* review areas in which IPRO reviewed elements that were considered not met during the 2019 compliance review. New contract requirements were reviewed for all MCOs regardless of the review type (e.g., partial, full). Full reviews were conducted for any *file* review area that was not fully deemed for 2019 or had new requirements for 2020. File review sample sizes were increased to 30 for the review 2020 from 15 for the 2019 review. Review types are described in Table 18.

Partial reviews were based on the "deeming" methodology. Deeming is an option that allows for information obtained from a previous review or related review to be used to demonstrate compliance.

Table 18: Review Type Descriptions

Review Type	Description
Partial Review	Only the elements found to be "not met" during the 2019 review were assessed for compliance during the 2020 review. The MCO was given credit, or deemed compliant, for the elements determined to be "met" during the 2019 review.
Full Review	All elements were assessed for compliance during the 2020 review.

IPRO's assessment was conducted in alignment with the CMS *EQR Protocol 3-Review of Compliance with Medicaid and CHIP Managed Care Regulations* and included reviews of MCO-documented policies and procedures, individual member case files, and interviews with key members of the MCO's staff.

The compliance review included a comprehensive evaluation of MCO policies, procedures, files, and other materials corresponding to the areas in Table 19. 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 19: Compliance Review Areas by Centennial Care Contract Citations

State Contract Citation	Area	Document Review	File Review
4.12.15	Adverse Benefit Determinations	✓	✓
4.4	Care Coordination	✓	✓
7.14.2	Delegation, Dental and Transportation	✓	Not Applicable
4.2 and 4.3	Enrollment and Disenrollment	✓	Not Applicable
4.16	Grievances and Appeals System	✓	✓
7.16.1	Maintenance of Medical Records	✓	✓
4.14	Member Materials	✓	Not Applicable
4.15	Member Services	✓	Not Applicable
4.22.2 and 4.22.3	PCP and Pharmacy Lock-ins	✓	✓
4.17	Program Integrity	✓	Not Applicable
4.9	Provider Agreements	✓	Not Applicable
4.8	Provider Network	✓	✓
4.11	Provider Services	✓	Not Applicable
4.12	Quality Assurance	✓	Not Applicable
4.21	Reporting Requirements	✓	Not Applicable
4.6	Self-Directed Community Benefit	✓	Not Applicable
4.4.16	TOC	✓	✓

The period under review was January 1, 2020, through April 15, 2021.

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 20.

Table 20: Review Determination Definitions

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

The initial pre-virtual onsite documentation review consisted of policies and procedures, member handbooks, provider handbooks, member files, and other documents as needed to demonstrate compliance with specific contractual or regulatory requirements. A team of eight experienced IPRO compliance officers, clinical and non-clinical, convened to review the MCOs' policies, procedures, and materials and assess their concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools, with IPRO's initial findings, were used to guide the onsite review discussion.

The virtual onsite component of the review was composed of a 1-day video conference call, which included a review of elements in each of the review tools that scored less than 100% compliance based upon pre-onsite review.

Staff interviews were used to further explore the written documentation and for the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy and was conducted in accordance with state standards.

Scoring and Point Allocation

Each regulatory element is allocated 1 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.

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 met criteria 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 21 displays the compliance levels, score ranges, and definitions.

Table 21: 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 has 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 2020 EQR, IPRO utilized the *Calendar Year 2020 Compliance Review Report* and the final audit review tools. These sources included detailed descriptions of the review methodology, scoring and final results.

Conclusions and Findings

Compliance with Federal Medicaid Standards

Regarding the federal Medicaid standards, each MCO achieved full compliance with the 11 standards reviewed. Table 22 displays the MCOs' compliance determinations for each federal Medicaid standard.

Table 22: MCO Compliance with Federal Medicaid Standards, 2020

Federal Medicaid Standard	BCBS	PHP	WSCC
438.206: Availability of Services	Full Compliance	Full Compliance	Full Compliance
438.207 Assurance of Adequate Capacity and Services	Full Compliance	Full Compliance	Full Compliance
438.208: Coordination and Continuity of Care	Full Compliance	Full Compliance	Full Compliance
438.210: Coverage and Authorization of Services	Full Compliance	Full Compliance	Full Compliance
438.214: Provider Selection	Full Compliance	Full Compliance	Full Compliance
438.224: Confidentiality	Full Compliance	Full Compliance	Full Compliance
438.228: Grievance and Appeal Systems	Full Compliance	Full Compliance	Full Compliance
438.230: Subcontractual Relationships and Delegation	Full Compliance	Full Compliance	Full Compliance
438.236: Practice Guidelines	Full Compliance	Full Compliance	Full Compliance
438.242: Health Information Systems	Full Compliance	Full Compliance	Full Compliance
438.330: Quality Assessment and Performance Improvement Program	Full Compliance	Full Compliance	Full Compliance

Compliance with State Medicaid Standards

Regarding state Medicaid standards, each MCO achieved full compliance or achieved an overall average of 90% or higher. WSCC achieved an overall compliance score of 98.86%, BCBS achieved an overall score of 98.28%, and PHP achieved an overall score of 98.21%. Table 23 displays the MCOs' compliance determinations for each federal Medicaid standard.

Table 23: MCO Compliance with State Medicaid Standards, 2020

Sate Contract Compliance Domain	Crosswalk to Federal Medicaid Standards	BCBS Score	PHP Score	WSCC Score
		Document Review		
Adverse Benefit Determinations	438.210	100%	100%	100%
Care Coordination	438.208 438.210 438.330	100%	99.39%	100%
Delegation – Dental and Transportation	438.230	100%[1]	100%[1]	100%[1]
Enrollment and Disenrollment	Not Applicable	100%[1]	93.75%	100%
Grievances and Appeals System	438.228	100%	100%	100%
Maintenance of Medical Records	438.224	100%[1]	100%[1]	100%[1]
Member Materials	Not Applicable	100%[1]	99.11%	100%
Member Services	Not Applicable	100%[1]	100%[1]	100%[1]
PCP and Pharmacy Lock-ins	Not Applicable	100%[1]	100%[1]	100%[1]
Program Integrity	Not Applicable	100%[1]	100%[1]	100%
Provider Agreements	438.206 438.224	100%[1]	100%[1]	100%[1]
Provider Network	438.206 438.207 438.208 438.210 438.214 438.330	99.46%	96.77%	100%
Provider Services	438.236	100%[1]	100%[1]	100%[1]
Quality Assurance	438.236 438.330	100%	100%	100%
Reporting Requirements	Not Applicable	100%[1]	100%[1]	100%
Self-Directed Community Benefit	Not Applicable	100%	100%[1]	100%
TOC	438.208 438.330	100%	100%	100%
		File Review		
Adverse Benefit Determinations, Standard	438.210	100%	100%	100%
Adverse Benefit Determinations, Expedited	438.210	100%	100%	100%
Care Coordination, Continuing Members	438.208	99.05%	100%	100%
Care Coordination, New Members	438.208	95.30%	100%	92.69%
Credentialing	438.206 438.214	96.67%	94.46%	93.41%
Recredentialing	438.206 438.214	93.00%	93.21%	98.35%
Member Appeals, Standard	438.228	99.73%	100%	100%
Member Appeals, Expedited	438.228	100%	98.33%	100%
Member Grievances	438.228	93.33%	100%	100%
PCP and Pharmacy Lock-ins	Not Applicable	100%[1]	81.71%	100%[1]
TOC	438.208 438.330	85.47%	100%	90.52%
Overall Compliance Average		**98.28%**	**98.21%**	**98.86%**
Compliance Level Achieved		**Full**	**Full**	**Full**

[1] A 2019 compliance score that has been deemed for the 2020 review.

All MCOs achieved compliance scores of 100% in the following domains:

- Adverse Benefit Determination, Document Review;
- Delegation, Dental and Transportation, Document Review;
- Grievances and Appeals System, Document Review;
- Maintenance of Medical Records, Document Review;
- Member Services, Document Review;
- PCP and Pharmacy Lock-Ins, Document Review;
- Program Integrity, Document Review;
- Provider Agreements, Document Review;
- Provider Services, Document Review;
- Quality Assurance, Document Review;
- Reporting Requirements, Document Review;
- Self-Directed Community Benefit, Document Review;
- Transition of Care, Document Review;
- Adverse Benefit Determination, Standard, File Review; and
- Adverse Benefit Determination, Expedited, File Review.

There were no compliance domains in which all MCOs performed below the 90% threshold. However, BCBS and PHP achieved scores for at least one compliance element that did not meet the 90% threshold. The BCBS score for TOC file review and the PHP score for PCP and Pharmacy Lock-ins file review both qualified for moderate compliance.

Validation of Network Adequacy

Objectives

One of the goals and objectives of the Centennial Care program is to assure that Medicaid recipients receive "the right amount of care, at the right time, and in the right setting." The Medicaid Managed Care Program Quality Strategy[18] (revised January 2019) defines New Mexico's standards for network adequacy and service availability, as well as the accepted evidence-based practice guidelines for the Centennial Care program.

Title *42 CFR § 438.68(a)* requires states that contract with an MCO to deliver services must develop and enforce network adequacy standards consistent with the CFR. At a minimum, states must develop time and distance standards for the following areas of care: adult and pediatric primary care, OB/GYN, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and LTSS per *42 CFR § 438.68(b)*. The State of New Mexico has developed access standards based on the requirements outlined at *42 CFR § 438.68(c)*. These access standards are described in the Centennial Care Managed Care Agreement at 4.8.7 Access to Services and in the NMAC at Standards for Access 8.308.2.11 and Access to Healthcare Service 8.308.2.12. Centennial Care plans are required to meet these standards in achieving network adequacy.

[18] New Mexico Medicaid Managed Care Program Quality Strategy, January 2019 Revision website: https://www.hsd.state.nm.us/wp-content/uploads/Quality-Strategy_FINAL-2019.pdf. Accessed January 5, 2022.

Title 42 CFR § 438.356(a)(1) and *42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, HSD contracted with IPRO as an EQRO to perform the validation of network adequacy for Centennial Care MCOs. However, the most current CMS protocols published in October 2019 did not include network adequacy protocols for the EQRO to follow.

Technical Methods of Data Collection and Analysis

IPRO's validation of network adequacy for 2020 was performed using network data, provider directories, and policies and procedures submitted to HSD by the MCOs. Relevant information collected by IPRO during the 2020 Compliance Review was also utilized during this validation activity and incorporated into this report, when applicable.

The HSD-established access, distance, and time standards are presented by the three New Mexico geographical regions: urban, rural, and frontier. **Table 24** displays the HSD Medicaid provider network standards that were applicable in 2020.

Table 24: Medicaid Network Standards, 2020

HSD Standards
Access Requirements
▪ Member caseload, or panel, of any PCP 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 PCPs
▪ 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 and Specialty 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
▪ 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

HSD Standards
▪ 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 30 each year, then the MCO must maintain that same 5% percentage 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 HSD.

IPRO compared each MCO's calculated distance analysis by specialty and by region to the NMAC standards. A determination of whether the standard was met or not met was made. IPRO's analysis also included a review of MCO network-related documentation to assess MCO consideration and implementation of the network adequacy elements described in *42 CFR § 438.68(c)*.

Description of Data Obtained

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

Conclusions and Findings

Through its agreement with the MCOs, HSD meets the requirements at *42 CFR § 438.68 Network adequacy standards*. HSD's assessment of MCO compliance with these standards is performed during the annual administrative compliance review conducted by the state's EQRO. In July 2021, IPRO concluded the 2020 Compliance Review for the Centennial Care MCOs. Review area results for each MCO are displayed in Table 25.

Table 25: MCO Compliance Review—Provider Network, Results, 2020

Review Area	BCBS Score	PHP Score	WSCC Score
Provider Network Policy and Procedure Review	Full Compliance	Full Compliance	Full Compliance

Note 1: Full Compliance represents an achievement score between 90% and 100%. Moderate Compliance represents an achievement score between 80% and 89%. Minimal Compliance represents an achievement score between 50% and 79%. Non-Compliance represents an achievement score of 50% and below.
Data Source: Calendar Year 2020 Compliance Review Report.

CMS requires state agencies to comply with the network adequacy standards at *42 CFR § 438.68*. To ensure its compliance with these standards, HSD contractually requires the Centennial Care MCOs to adhere to these standards. Table 26 displays a summary of MCO compliance with the standards at *42 CFR § 438.68*.

Table 26: MCO Compliance with 42 CFR § 438.68 Network Adequacy Standards, 2020

42 CFR § 438.68 Network adequacy standards		BCBS	PHP	WSCC
(b) Provider-specific network adequacy standards				
(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) OB/GYN	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) LTSS. States with MCO, Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) contracts which cover LTSS must develop a quantitative network adequacy standard for LTSS provider types		Met	Met	Met
(c) Development of network adequacy standards				
(1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements:	(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, PIHP, and PAHP contract	Met	Met	Met
	(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

As part of the Delivery System Improvement Performance Targets (DSIPT), MCOs focus on increasing telemedicine availability and utilization. As part of its monitoring system, HSD collects quarterly MCO counts of unduplicated members served via telemedicine in rural, frontier, and urban areas. All three MCOs met the minimum 5% total membership with telemedicine visits for 2020. **Table 27** displays the total counts for 2020.

Table 27: MCO Telemedicine Visit Counts, 2020

Measure	BCBS	PHP	WSCC	Centennial Care
Total Unduplicated Members with a Telemedicine Visit	**82,809**	**42,562**	**15,986**	**141,357**
Unduplicated Members with a Physical Health Telemedicine Visit	**69,521**	**11,691**	**10,983**	**92,195**
Urban	38,447	6,077	5,857	50,381
Rural	26,001	4,610	4,461	35,072
Frontier	5,073	1,004	665	6,742
Unduplicated Members with a Behavioral Health Telemedicine Visit	**27,383**	**34,839**	**7,307**	**69,529**
Urban	16,312	20,011	4,150	40,473
Rural	8,980	11,753	2,717	23,450
Frontier	2,091	3,075	440	5,606
5% Membership Threshold	**Met**	**Met**	**Met**	

Data Source: Centennial Care 2.0 Demonstration Section 1115 Annual Report Demonstration Year: 6(1/1/2020–12/31/2020) Annual Report.

Each quarter, the MCOs are required to calculate and report the PCP-member ratio to HSD. IPRO validated the MCO-calculated ratios for the fourth quarter of 2020. **Table 28** displays the validated MCO ratios for 2018, 2019, and 2020. All MCOs met the provider-member ratio standard for 2020.

Table 28: MCO Provider to Member Ratios, 2018–2020

Year	BCBS	PHP[1]	WSCC
CY 2018	1:79	1:100	Not Applicable
CY 2019	1:113	1:110	1:28
CY 2020	1:139	1:105	1:27

[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 PCPs impacted the 2018 ratio.

Data Sources: BCBS HSD Report #3 Calendar Year (CY) 2018, PHP HSD Report #3 CY 2018, BCBS HSD Report #3 Q4 CY 2019, PHP HSD Report #3 Q4 CY 2019, WSCC HSD Report #3 Q4 CY 2019, BCBS HSD Report #3 Q4 CY 2020, PHP HSD Report #3 Q4 CY 2020, and WSCC HSD Report #3 Q4 CY 2020.

HSD requires that at least 90% of an MCO's membership has access to providers within the established distance standards. IPRO analyzed Report #55 produced for the fourth quarter of 2020 by the MCOs to determine if the MCOs were compliant with the HSD distance requirements. IPRO's review focused on the specialties listed at *42 CFR § 438.68(b)*. **Table 29** displays MCO performance in meeting the 90% threshold for distance.

Table 29: Summary of MCO Adherence to HSD Provider Network Distance Standards, Fourth Quarter 2020

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	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	Met	Met
	Frontier	1 in 90 Miles	Not Met	Met	Met
Ear, Nose, and Throat	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Not Met	Met	Met
	Frontier	1 in 90 Miles	Met	Not Met	Met
FQHCs	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
FQHCs, PCP Only	Urban	1 in 30 Miles	Met	Met	Met
	Rural	1 in 45 Miles	Met	Not Met	Met
	Frontier	1 in 60 Miles	Met	Not 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
I/T/U	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	Not Met
	Frontier	1 in 90 Miles	Met	Met	Not Met
Neurosurgery	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
OB/GYN	Urban	1 in 35 Miles	Met	Met	Met
	Rural	1 in 60 Miles	Met	Met	Met

Specialty	Region	Standard	BCBS	PHP	WSCC
	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 (RHCs)	Urban	1 in 30 Miles	Not Met	Not Met	Met
	Rural	1 in 60 Miles	Not Met	Not Met	Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not Met
Surgeons	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	Met	Not Met
	Frontier	1 in 90 Miles	Met	Met	Met
Behavioral Health					
ARTCs	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	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 Centers	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
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

Specialty	Region	Standard	BCBS	PHP	WSCC
	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
FQHCs 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 Services 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	Not Met
	Rural	1 in 60 Miles	Not Met	Not Met	Met
	Frontier	1 in 90 Miles	Not Met	Not Met	Not 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-ARTCs 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	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
	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	Met	Not Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met
RHCs 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

Specialty	Region	Standard	BCBS	PHP	WSCC
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
LTC					
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	Met	Met	Met
	Frontier	1 in 90 Miles	Met	Met	Met

Data Sources: BCBS HSD Report #55 Q4 CY 2020, PHP HSD Report #55 Q4 CY 2020, and WSCC HSD Report #55 Q4 CY 2020.
Note 1: Red shading indicates that the distance standard was not met.

HSD requires the Centennial Care MCOs to conduct semiannual "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 in 2020.

BCBS conducted two secret shopper surveys in 2020. The combined results of these two surveys are displayed in Table 30.

Table 30: BCBS Appointment Availability Results, 2020

Appointment Type	Total Providers Surveyed	Total Timely Appointments Made	MY 2020 Timely Appointment Rates Among Surveyed Providers
Primary Care			
Routine, Asymptomatic	84	81	96.4%
Routine, Symptomatic	44	32	72.7%
Urgent	38	13	34.2%
Behavioral Health Care			
Routine, Substance Use Disorder	91	82	90.1%
Urgent, Substance Use Disorder	168	110	65.5%
Routine, Community Mental Health Centers	45	43	95.6%
Urgent, Community Mental Health Centers	58	29	50.0%

Data Source: Blue Cross Blue Shield New Mexico; Centennial Care Secret Shopper Report, November 2020, and March 2021.

PHP conducted two secret shopper surveys in 2020. The combined results of these two surveys are displayed in Table 31.

Table 31: PHP Appointment Availability Results, 2020

Appointment Type	Total Providers Surveyed	Total Timely Appointments Made	MY 2020 Timely Appointment Rates Among Surveyed Providers
Routine, Asymptomatic	43	30	69.6%
Routine, Symptomatic	44	25	56.7%
Urgent	23	10	43.9%
Specialists	111	50	45.1%

Data Source: Presbyterian Health Plan & Presbyterian Insurance Company, Inc. Practitioner Services/Patient Access, February 2020, and August 2020.

WSCC conducted two secret shopper surveys in 2020. The results of these two surveys are displayed in Table 32.

Table 32: WSCC Appointment Availability Results, 2020

Appointment Type	Total Providers Surveyed	Total Timely Appointments Made	MY 2020 Timely Appointment Rates Among Surveyed Providers
Primary Care			
Routine, Asymptomatic	168	126	75.0%
Urgent	168	139	82.7%
Behavioral Health Care			
Routine, Substance Use Disorder	234	76	32.5%
Urgent, Substance Use Disorder	194	84	43.3%
Routine, Community Mental Health Centers	16	9	56.3%
Urgent, Community Mental Health Centers	16	2	12.5%

Data Source: Western Sky Community Care 2020 Physical Health Secret Shopper Survey Report and Western Sky Community Care 2020 Behavioral Health Secret Shopper Survey Report.

Validation of Quality-of-Care Surveys – Member Experience

Objectives

Section 4.12.5 of the Centennial Care Agreement requires contracted MCOs to evaluate and report on member experience annually using the CAHPS tool. The CAHPS tool is a standardized questionnaire that asks enrollees to report on their satisfaction with care and services from the MCO, the providers, and their staff.

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 provided care.

Each MCO independently contracted with a certified CAHPS vendor to administer the adult and child surveys for MY 2020.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for New Mexico's Centennial Care 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, 2019, continuously enrolled for at least five of the last six months of 2019, and currently enrolled in the MCO.

Table 33 provides a summary of the technical methods of data collection by MCO.

Table 33: CAHPS Technical Methods of Data Collection by MCO, MY 2020

	BCBS	PHP	WSCC
Adult CAHPS Survey			
Survey Vendor	SPH, Inc.	SPH, Inc.	SPH, Inc.
Survey Tool	5.1H	5.1H	5.1H
Survey Timeframe	2/26/2021-5/19/2021	3/5/2021-5/19/2021	3/5/2021-5/19/2021
Method of Collection	Mail and Telephone	Mail and Telephone	Mail and Telephone
Sample Size	1,350	2,025	1,350
Response Rate	15.5%	12.3%	10.0%
Child CAHPS Survey			
Survey Vendor	SPH, Inc.	SPH, Inc.	SPH, Inc.
Survey Tool	5.1H	5.1H	5.1H
Survey Timeframe	2/26/2021-5/19/2021	3/5/2021-5/19/2021	3/5/2021-5/19/2021
Method of Collection	Mail and Telephone	Mail and Telephone	Mail and Telephone
Sample Size - General	1,650	2,310	1,650
Response Rate	12.5%	10.8%	10.0%

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 34 displays these categories and the measures which these response categories are used.

Table 34: CAHPS Response Categories, MY 2020

Measures	Response Categories
Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist	0 to 4 (Dissatisfied) 5 to 7 (Neutral) 8 to 10 (Satisfied)
Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures and items; and the Coordination of Care individual item measure	Never (Dissatisfied) Sometimes (Neutral) Usually/Always (Satisfied)

To assess MCO performance, IPRO compared MCO scores to national Medicaid performance reported in the *2021 Quality Compass* (MY 2020) for all lines of business that reported MY 2020 CAHPS data to NCQA.

Description of Data Obtained

For each MCO, IPRO received a copy of the final MY 2020 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.

Findings and Conclusions

When compared to the available national Medicaid benchmarks, no MCO achieved an adult CAHPS score for MY 2020 that exceeded the national Medicaid 50th percentile. However, BCBS achieved two adult CAHPS scores that exceeded the national Medicaid MY 2020 mean and WSCC achieved one adult CAHPS score that met the mean.

PHP achieved three child CAHPS scores that exceeded the national Medicaid MY 2020 mean, with one of these scores benchmarking at the national Medicaid 75th percentile.

Table 35 displays the results of the 2021 CAHPS Adult Medicaid Survey for MY 2020 and Table 36 displays the results of the 2021 CAHPS Child Medicaid Survey for MY 2020.

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Table 35: Adult Member CAHPS Results, MY 2020

Measures	BCBS 2021 CAHPS MY 2020	*QC* MY 2020 National Benchmark Met/Exceeded	PHP 2021 CAHPS MY 2020	*QC* MY 2020 National Benchmark Met/Exceeded	WSCC 2021 CAHPS MY 2020	*QC* MY 2020 National Benchmark Met/Exceeded	*QC* MY 2020 National Medicaid Mean
Rating of Health Plan[1]	79.0%	50th	73.2%	10th	76.7%	33.33rd	78.32%
Rating of All Health Care	75.8%	25th	76.5%	33.33rd	SS	Not Applicable	77.63%
Rating of Personal Doctor[1]	82.5%	33.33rd	81.4%	25th	83.2%	50th	83.23%
Rating of Specialist Seen Most Often[1]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	83.56%
Getting Care Quickly[2]	SS	Not Applicable	81.4%	33.33rd	SS	Not Applicable	81.83%
Getting Needed Care[2]	81.1%	25th	81.4%	25th	SS	Not Applicable	83.58%
Customer Service[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	88.94%
How Well Doctors Communicate[2]	93.0%	50th	88.7%	<10th	SS	Not Applicable	92.17%
Coordination of Care[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	Not Available

[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."
QC: Quality Compass, NCQA; SS: small sample (less than 100 members).

Table 36: General Population-Child Member CAHPS Results, MY 2020

Measures	BCBS 2021 CAHPS MY 2020	*QC* MY 2020 National Benchmark Met/Exceeded	PHP 2021 CAHPS MY 2020)	*QC* MY 2020 National Benchmark Met/Exceeded	WSCC 2021 CAHPS MY 2020	*QC* MY 2020 National Benchmark Met/Exceeded	*QC* MY 2020 National Medicaid Mean
Rating of Health Plan[1]	85.4%	33.33rd	88.2%	50th	84.3%%	25th	86.65%
Rating of All Health Care	86.1%	10th	85.5%	10th	SS	Not Applicable	88.94%
Rating of Personal Doctor[1]	90.7%	33.33rd	92.3%	75th	91.5%	50th	90.56%
Rating of Specialist Seen Most Often[1]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	87.42%
Getting Care Quickly[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	86.90%
Getting Needed Care[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	85.65%
Customer Service[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	88.32%
How Well Doctors Communicate[2]	SS	Not Applicable	94.9%	50th	SS	Not Applicable	94.39%
Coordination of Care[2]	SS	Not Applicable	SS	Not Applicable	SS	Not Applicable	Not Available

[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."
QC: Quality Compass, NCQA; SS: small sample (less than 100 members).

V. NCQA Accreditation

Objectives

Section 3.1.1.1 of the Centennial Care 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 PMs.

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. MCOs achieve 1 of 3 accreditation levels based on how they score on each standards category. Table 37 displays the accreditation determination levels and points needed to achieve each level.

Table 37: 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. However, in response to COVID-19's impact on health plans and the changes to HEDIS and CAHPS for MY 2019, NCQA did not publish the *Health Plan Ratings 2020* report.

The *Health Insurance Plan Ratings 2021* 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 38.

Table 38: 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.

For 2021 only, NCQA implemented a special Overall Rating Policy for NCQA-accredited plans. The *Health Plan Ratings 2021* displays the better of the overall rating score between the *Health Plan Ratings 2019* and *Health Plan Ratings 2021*, for plans with accredited, provisional, and interim status as of June 30, 2021. Individual measures, sub-composites, and composites continued to be scored and displayed using *Health Plan Rating 2021* performance (i.e., MY 2020 data) for all plans.

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website[19] to review the *Health Plan Report Cards 2021* 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, 2021.

Conclusions and Findings

BCBS, PHP, and WSCC were compliant with the state's requirement to achieve and maintain NCQA accreditation. Table 39 displays each MCO's accreditation level achieved and the effective dates for the accreditation.

Table 39: MCO Medicaid Accreditation Status

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

BCBS and PHP achieved overall health plan star ratings of three out of 5 for the *Health Plan Ratings 2021* report, while WSCC achieved a star rating of 2.5. Table 40 displays the MCOs' overall health plan star ratings as well as the ratings for the three overarching categories and their subcategories under review.

Table 40: MCO NCQA Rating by Category, 2021

MCO	BCBS	PHP	WSCC
Highest Possible Star Rating	★★★★★ 5 Stars	★★★★★ 5 Stars	★★★★★ 5 Stars
Overall Rating	**3 Stars**	**3 Stars**	**2.5 Stars**
Patient Experience	Insufficient Data	Insufficient Data	Insufficient Data
Getting Care	Insufficient Data	Insufficient Data	Insufficient Data
Satisfaction with Plan Physicians	2.5 Stars	2.5 Stars	Insufficient Data
Satisfaction with Plan Services	3 stars	3 stars	3 Stars
Prevention	2.5 Stars	2.0 Stars	2.0 Stars
Children and Adolescent Well Care	2.5 Stars	2.5 Stars	2.5 Stars
Women's Reproductive Health	2 Stars	1.5 Stars	1 Star
Cancer Screening	1.5 Stars	1.5 Stars	0.5 Star
Other Preventive Services	2 Stars	2 Stars	No Data Available
Treatment	2.5 Stars	2.5 Stars	2.0 Stars
Asthma	3 Stars	2 Stars	1 Star
Diabetes	2 Stars	2 Stars	1.5 Stars
Heart Disease	2 Stars	2 Stars	1 Star
Mental and Behavioral Health	3 Stars	3 Stars	2.5 Stars

Note: Getting Need Care includes 2 measures; Satisfaction with Plan Physicians includes 4 measures; Satisfaction with Plan Services includes 1 measure; Children and Adolescent Well-Care includes 4 measures; Women's Reproductive Health includes 2 measures; Cancer Screening includes 2 measures; Other Preventive Services includes 2 measures; Asthma includes 1 measure; Diabetes includes 5 measures; Heart Disease includes 4 measures; and Mental and Behavioral Health includes 10 measures; and Other Treatment Measures, which is not included in the table, includes 9 measures.

[19] NCQA Health Plan Report Cards Website: https://reportcards.ncqa.org/health-plans. Accessed December 8, 2021.

VI. MCOs Responses to the 2019 EQR Recommendations

Title 42 CFR § 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 EQRO during the previous year's EQR." **Table 41** displays the assessment categories used by IPRO to describe MCO progress towards addressing the to the 2019 EQR recommendations. **Table 42**, **Table 43**, and **Table 44** 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 2019*, as well as IPRO's assessment of the MCO's response.

Table 41: 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 42: IPRO's Assessment of BCBS's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCO Response
Consider the recommendations in the *Centennial Care Validation of Performance Improvement Projects, Calendar Year 2019 Report*. (Specific recommendations are in the referenced report.)	Addressed.
Address PMs that did not meet the established targets or demonstrate improvement by: ▪ Continuing quality assurance activities related to child and adolescent care, perinatal care, and behavioral health as related PMs have demonstrated continuous improvement. ▪ Identifying causes for declines in retinal eye exams and nephropathy screening tests for kidney disease and leveraging quality improvement activities of related successful PMs such as HbA1c testing. IPRO also recommends that BCBS consider implementing telemedicine applications and services to facilitate communication and clinical support. ▪ Adopting clinical guidelines related to alcohol and substance abuse and distributing these guidelines to network providers. IPRO also recommends that BCBS actively identify members who have initiated treatment for substance abuse and enroll these members into disease case management to ensure the continuation of treatment services.	Partially addressed.

2019 EQR Recommendation	IPRO's Assessment of MCO Response
Address the findings in the *Centennial Care 2019 Compliance Review Report* and develop an internal action plan to improve deficient areas. (Specific recommendations are in the referenced report.)	Addressed.
Continue to identify opportunities to establish in-network contracts with providers in the following specialty areas and geographic regions: Dermatology – urban and rural; Endocrinology – rural and frontier; Assisted Living Facilities – urban, rural, and frontier.	Partially addressed.

Table 43: IPRO's Assessment of PHP's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCO Response
Consider the recommendations in the *Centennial Care Validation of Performance Improvement Projects, Calendar Year 2019 Report*. (Specific recommendations are in the referenced report.)	Partially addressed.
Address PMs that did not meet the established targets or demonstrate improvement by: ▪ Reviewing outpatient encounter data to determine if decline in PM 3 can be assigned to provider practice, or improper billing, or both, and devising a quality improvement plan to encourage the appropriate documentation of adult BMI in medical records and billing systems. ▪ Identifying providers with patterns of non-compliance with the PM 4 specifications using claims data; and upon identification of these providers with gaps, educating them on appropriate care, claim submissions, and medical record documentation. ▪ Leveraging the positive trend of the PM 8 initiation phase to improve the engagement phase. IPRO also recommends that PHP actively identify members who have initiated treatment for substance abuse and enroll these members into disease case management to ensure the continuation of treatment services.	Partially addressed.
Address the findings from the *Centennial Care 2019 Compliance Review Report* and develop an internal action plan to improve deficient areas. (Specific recommendations are in the referenced report.)	Partially addressed.
Continue to identify opportunities to establish in-network contracts with providers in the following specialty areas and geographic regions: Psychology – rural; Dermatology – rural and frontier; ENT – frontier; Dental – rural and frontier; Assisted Living Facilities – urban and rural.	Partially addressed.

Table 44: IPRO's Assessment of WSCC's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCO Response
Consider the recommendations in the *Centennial Care Validation of Performance Improvement Projects, Calendar Year 2019 Report*. (Specific recommendations are in the referenced report.)	Addressed.
Address PMs that did not meet the established targets or demonstrate improvement by identifying overarching areas needing improvement and implementing a targeted quality assurance strategy to improve the quality of timeliness of and access to care.	Partially addressed.
Address the findings from the *Centennial Care 2019 Compliance Review Report* and develop an internal action plan to improve deficient areas. (Specific recommendations are in the referenced report.)	Addressed.
Identify opportunities to establish in-network contracts with providers in the following specialty areas and geographic regions: Psychiatry – urban, rural, and frontier; Dermatology – rural; Endocrinology – rural and frontier; Pharmacy – rural; Dental, Adult and Pediatric – rural; Assisted Living Facility – urban, rural, and frontier.	Partially addressed.

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VII. Strengths, Opportunities and 2020 Recommendations Related to Quality, Timeliness, and Access

The MCO strengths and opportunities for improvement identified during IPRO's EQR 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' 2020 performance, as well recommendations for improving **quality**, **timeliness,** and **access** to care are presented in **Table 45**, **Table 46**, and **Table 47**. 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 45: BCBS Strengths, Opportunities and Recommendations for Improvement, 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	In 2020, BCBS was NCQA accredited.	X	X	X
ISCA	BCBS met all standards evaluated during the 2020–2021 ISCA.			
PIP - General	Five of five PIPs conducted in 2020 passed PIP validation.			
PIP 2 – Prenatal and Postpartum Care	Although BCBS did not meet the target goal for postpartum visits, the MCO demonstrated improvement in this area.		X	X
PIP 3 – Adult Obesity	BCBS exceeded the target goal for one of the PIP indicators and demonstrated improvement in the number of adult members with a documented BMI.	X		
PIP 3 – Adult Obesity	Although BCBS did not meet the target goal for increasing the number of members with controlled hypertension, the MCO demonstrated improvement in this area.	X		
PIP 5 – Depression	BCBS met the target for two of the PIP indicators and demonstrated improvement among members aged 18–64 years for medication adherence for the effective and	X		

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Screening and Management	continuation phases. BCBS demonstrated improvement in the same areas for members aged 65 years and older but did not meet the target goals.			
Performance Measures	BCBS met all IS and validation requirements to successfully report HEDIS data to HSD and NCQA.			
	Rates for eight of 10 measures exceeded their targets.	X	X	X
	Rates trended upward for six measures between MY 2019 and MY 2020.	X	X	X
	BCBS demonstrated notable improvement in provider follow-up with a patient after a mental health hospitalization.	X	X	X
Compliance with Medicaid Standards	BCBS achieved an overall compliance determination of full and is compliant with state and federal Medicaid standards.	X	X	X
Network Adequacy	BCBS met all standards at *42 CFR § 438.68(b)* and *(c)* and achieved full compliance for its provider network policies and procedures reviewed during the 2020 Compliance Review.		X	X
	BCBS did not exceed the provider-to-member ratio standard.		X	X
	Approximately 82,909 BCBS members completed a telemedicine visit in 2020, which accounts for 59% of all telemedicine visits covered by Centennial Care.		X	X
	In the fourth quarter of 2020, BCBS met HSD distance standards in all regions for the following provider types: adult and child PCPs, cardiologists, certified nurse midwives, certified nurse practitioners, dental providers, FQHCs, FQHCs with PCPs only, hematologists/oncologists, neurologists, OBs/GYNs, orthopedics, pharmacies, physician assistants, podiatrists, surgeons, community mental health centers, core service agencies, FQHCs 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.		X	X
	Of the primary care providers surveyed in 2020, 96% reported timely routine asymptomatic appointments. Of the substance use disorder providers surveyed, 90% reported timely routine appointments. Of the community mental health centers surveyed, 96% reported timely routine appointments		X	X
Quality of Care Survey –	BCBS achieved two adult CAHPS scores for Rating of Health Plan and How Well Doctors Communicate that exceeded the national MY 2020 Medicaid mean.	X		

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Member Experience				
Opportunities for Improvement				
NCQA Health Plan Rating	BCBS was awarded three of five stars for its overall rating in the 2021 Health Plan Ratings and did not achieve five stars in any subcategory.	X	X	X
PIP 1 – LTSS	BCBS did not meet target goals for two indicators and demonstrated performance decline in diabetic eye care for the LTC population or the general population.	X	X	X
PIP 2 – Prenatal and Postpartum Care	BCBS did not meet target goals for two indicators and demonstrated performance decline in the timeliness of prenatal visits.		X	X
PIP 3 – Adult Obesity	BCBS did not meet target goals for two indicators and demonstrated performance decline in the number of members with controlled diabetes.	X		
PIP 4 – Diabetes Prevention and Management	BCBS did not meet target goals for two indicators and demonstrated performance decline in reducing the hospital admissions for diabetic short-term complications and increasing the number of members with a documented HbA1c value.	X	X	X
PIP 5 – Depression Screening and Management	BCBS did not meet target goals for four indicators and demonstrated performance decline in documented positive depression screen and follow-up plan for members aged 18–64 years and 65 years and older.	X		
Performance Measures	Rates for two measures related to well-child visits and diabetes did not meet their targets.	X	X	X
	Rates trended downward for four measures related to child and adolescent care and appropriate diabetic screening for members on antipsychotic medication between MY 2019 and MY 2020.	X	X	X
Compliance with Medicaid Standards	BCBS did not achieve full compliance in the TOC File Review domain.	X	X	
Network Adequacy	BCBS did not meet HSD distance standards for the following provider types in any region: I/T/Us, rheumatologists, RHCs, assertive community treatment, day treatment services, Indian Health Services and Tribal 638s providing behavioral health services, non-ARTCs and group homes, partial hospital programs, RHCs providing behavioral health services, treatment foster care I and II, and assisted living facilities.		X	X
	Of the primary care providers surveyed in 2020, 73% reported timely routine symptomatic appointments, and 34% reported timely urgent appointments. Of the substance use disorder providers surveyed, 66% reported timely urgent appointments. Of the		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	community mental health centers surveyed, 50% reported timely urgent appointments.			
Quality of Care Survey – Member Experience	BCBS achieved three adult CAHPS scores and three child CAHPS scores that performed below the national MY 2020 Medicaid 50th percentile.	X	X	X
Recommendations to BCBS to Address Quality, Timeliness, and Access				
PIP - General	Request technical assistance related to the selection of performance indicators and the development of interventions and tracking measures.			
	Refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.			
PIP 1 – LTSS	BCBS should continue to 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.	X	X	X
	BCBS should investigate the reason(s) why the rate for retinal eye exams among members residing in an LTC facility declined.	X	X	X
PIP 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.	X	X	X
	BCBS should identify the reason(s) why the rate for indicator one declined.	X	X	X
PIP 3 – Adult Obesity	BCBS should continue to 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.	X		
	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 trials failed, the next step is anti-obesity pharmacotherapy trials).	X	X	X
PIP 4 – Diabetes Prevention and Management	BCBS should continue to 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.	X		
	BCBS should investigate the reason(s) why the rate for indicator one increased and why the rate for indicator #2 decreased.	X		

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
PIP 5 – Depression Screening and Management	BCBS should investigate the reasons why the rates for indicator one and indicator #2 continue to perform below their respective baseline rates.	X		
	BCBS should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this PIP.	X		
Performance Measures	Attach tracking measures to key quality improvement activities to support continuous monitoring for intervention effectiveness.	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.	X		
Network Adequacy	BCBS should update the online provider directory to reflect accurate and current cultural competency training information for each provider.	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 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.		X	X
	In the absence of an HSD appointment timeliness threshold, BCBS should identify a threshold to work toward. Although not required by HSD, 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, telephone number, etc., to reduce barriers members face when attempting to obtain appointments.		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.	X	X	X

Table 46: PHP Strengths, Opportunities and Recommendations for Improvement, 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	In 2020, PHP was NCQA accredited.	X	X	X
ISCA	PHP met all standards evaluated during the 2020–2021 ISCA.			
PIP – General	Four of five PIPs passed PIP validation.			
PIP 2 – Prenatal/ Postpartum	Although PHP did not meet the target goal, the MCO demonstrated improvement in timely prenatal visits.		X	X
PIP 3 – Adult Obesity	PHP met one target goal and demonstrated improvement in the number of members enrolled in an obesity-related support program.	X		
PIP 4 – Diabetes	PHP met the target for one indicator and demonstrated improvement in hospital admissions for diabetic short-term complications.	X	X	X
PIP 5 – Depression Screening and Management	PHP met the target for three PIP indicators and demonstrated performance improvement among members aged 18–64 years for medication adherence for the effective and continuation phases and documented positive depression screen with follow-up plan for members aged 65 years and older. PHP demonstrated improvement documented positive depression screen and follow-up plan for members aged 18–64 years but did not meet the target goal.	X		
Performance Measures	PHP met all IS and validation requirements to successfully report HEDIS data to HSD and NCQA.			
	Rates for six measures related to child and adolescent care, postpartum care, and behavioral health care exceeded their targets.	X	X	X
	Rates trended upward for five measures between MY 2019 and MY 2020.	X	X	X
	PHP demonstrated notable improvement in the initiation of alcohol/substance dependence treatment and provider follow-up with a patient after a mental health hospitalization.	X	X	X
Compliance with Medicaid Standards	PHP achieved an overall compliance determination of full and is compliant with state and federal Medicaid standards.	X	X	X
Network Adequacy	PHP met all standards at *42 CFR § 438.68(b)* and *(c)* with one exception. PHP achieved full compliance for its provider network policies and procedures reviewed during the 2020 Compliance Review.		X	X
	PHP did not exceed the provider-to-member ratio standard.		X	X
	Approximately 42,562 PHP members completed a telemedicine visit in 2020, which accounts for 30% of all telemedicine visits covered by Centennial Care.		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	In the fourth quarter of 2020, PHP met HSD distance standards in all regions for the following provider types: adult and child PCPs, cardiologists, certified nurse midwives, certified nurse practitioners, dental providers, endocrinologists, FQHCs, hematologists/oncologists, neurologists, OBs/GYNs, orthopedists, pharmacies, physician assistants, podiatrists, surgeons, urologists, community mental health centers, core service agencies, FQHCs providing behavioral health services, intensive outpatient services, other licensed independent behavioral health providers, outpatient provider agencies, psychiatrists, Suboxone certified medical doctors, general hospitals, nursing facilities, personal care service agencies, and transportation.		X	X
Quality of Care Survey – Member Experience	PHP achieved a child CAHPS score for How Well Doctors Communicate that performed better than the national MY 2020 Medicaid mean.	X		
Opportunities for Improvement				
NCQA Health Plan Rating	PHP was awarded three of five stars for its overall rating in the 2021 Health Plan Ratings and did not achieve five stars in any subcategory.	X	X	X
PIP 1 – TOC	PHP's conduct of this PIP did not meet all standards related to topic selection, data collection, and interpretation of study results.	X	X	X
PIP 2 – Prenatal and Postpartum Care	PHP did not meet target goals for two indicators and demonstrated performance decline in the timelines of prenatal visits.		X	X
PIP 3 – Adult Obesity	PHP did not meet the target goal for one indicator and demonstrated performance decline in the number of members with a documented BMI.	X		
PIP 4 – Diabetes	PHP did not meet the target goal for one indicator and demonstrated performance decline in documented HbA1c values.	X		
PIP 5 – Depression Screening and Management	PHP did not meet the target goal for one indicator.	X		
Performance Measures	Rates for four of 10 measures did not meet their targets.	X	X	X
	Rates trended downward for five measures between MY 2019 and MY 2020.	X	X	X
Compliance with Medicaid Standards	PHP did not achieve full compliance in the PCP and Pharmacy Lock-in domain.	X		
Network Adequacy	PHP partially met one standard at *42 CFR § 438.68*. The PHP online provider directory and hardcopy directory		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	did not include cultural competency information or accessibility information on providers.			
	Three providers in the PHP network reported a panel that exceeded the maximum threshold of 2,000 patients.		X	X
	PHP did not meet HSD distance standards for the following provider types in any region: I/T/Us, RHCs, day treatment centers, freestanding psychiatric hospitals, Indian Health Services and Tribal 638s providing behavioral health services, non-ARTCs and group homes, partial hospital programs, RHCs providing behavioral health services, and treatment foster care I and II.		X	X
	Of the providers surveyed in 2020, 70% reported timely routine, asymptomatic appointments; 57% reported timely routine, symptomatic appointments; 44% reported timely urgent appointments; and 45% reported timely specialty appointments.		X	X
Quality of Care Survey – Member Experience	PHP achieved six adult CAHPS scores and one child CAHPS score that performed below the national MY 2020 Medicaid 50th percentile.	X	X	X
Recommendations to PHP to Address Quality, Timeliness and Access				
PIP – General	PHP should request EQRO technical assistance to support the selection of appropriate performance indicators and the development of interventions and tracking measures.			
	PHP should refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.			
	To ensure future PIP methodologies are effectively designed and managed, PHP staff should complete PIP refresher trainings, consult the CMS protocol to ensure the PIP meets all validation requirements, and fully address issues identified by the EQRO during the proposal phase, interim reporting phase, and final reporting phase.			
PIP 1 – TOC	PHP should identify alternative performance indicators to evaluate PIP performance as the MY 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.	X	X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
PIP 2 – Prenatal and Postpartum Care	PHP should continue to 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.		X	X
PIP 3 – Adult Obesity	PHP should investigate the reason(s) why the rate for documented BMI decreased.	X		
	As the Obesity-Related Support Program was developed as part of the PIP 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.			
	PHP should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this PIP.	X	X	X
PIP 4 – Diabetes	PHP should continue to its efforts to increase HbA1c screenings as the target was not met.	X	X	X
	PHP should investigate the reason(s) why the rate for HbA1c testing continues to perform below the target rate.	X	X	X
	PHP should continue effective interventions and increase target rates for improvement that were exceeded through the conduct of this PIP.	X	X	X
PIP 5 – Depression Screening and Management	PHP should continue effective interventions and increase target rates that were exceeded through the conduct of this PIP.	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 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.		X	X
	PHP should augment its Medicaid quality strategy to include more member educational activities.	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.	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,		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	distance, and timeliness standards until the panel size is reduced.			
	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.	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 MCOs and state agencies to recruit providers to the State of New Mexico.		X	X
	In the absence of an HSD 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.		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.	X	X	X

Table 47: WSCC Strengths, Opportunities and Recommendations for Improvement, 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	In 2020, WSCC was NCQA accredited.	X	X	X
ISCA	WSCC met all standards evaluated during the 2020–2021 ISCA.			
PIP – General	Five of five PIPs conducted in 2020 passed PIP validation.			
PIP 3 – Adult Obesity	WSCC met all target rates and demonstrated improvement in the reduction of members with a BMI of greater than 30 kg/m and the number of members with a documented BMI.	X		
PIP 4 – Diabetes	WSCC exceeded all target rates and demonstrated improvement HbA1c screenings and the reduction of hospital admissions for short-term complications related to diabetes.	X		
PIP 5 – Depression Screening and Management	WSCC exceeded the target rate for two of three indicators and demonstrated improvement in member medication adherence.	X		
Performance Measures	WSCC met all IS and validation requirements to successfully report HEDIS data to HSD and NCQA.			
	Rates for two of 10 measures exceeded their targets.	X	X	X
	Rates trended upward for six measures between MY 2019 and MY 2020.	X	X	X
	WSCC demonstrated notable improvement in provider follow-up with a patient after a mental health hospitalization.	X	X	X
Compliance with Medicaid Standards	WSCC achieved an overall compliance determination of full and is compliant with state and federal Medicaid standards. All compliance domain scores exceeded the 90% threshold.	X	X	X
Network Adequacy	WSCC met all standards at *42 CFR § 438.68(b)* and *(c)* and achieved full compliance for its provider network policies and procedures reviewed during the 2020 Compliance Review.		X	X
	WSCC did not exceed the provider-to-member ratio standard.		X	X
	Approximately 15,986 WSCC members completed a telemedicine visit in 2020, which accounts for 11% of all telemedicine visits covered by Centennial Care.		X	X
	In the fourth quarter of 2020, WSCC met HSD distance standards in all regions for the following provider types: adult and child PCPs, cardiologists, certified nurse midwives, certified nurse practitioners, dental providers, ENTs, FQHCs, FQHCs with PCPs only, OBs/GYNs, orthopedists, pharmacies, physician assistants, podiatrists,		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	surgeons, behavioral health management services, FQHCs 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.			
	Of the primary care providers surveyed in 2020, 83% reported timely urgent appointments.		X	X
Quality of Care Survey – Member Experience	WSCC achieved an adult CAHPS score for Rating of Personal Doctor that was at the national MY 2020 Medicaid mean.	X		
Opportunities for Improvement				
NCQA Health Plan Rating	WSCC was awarded two and a half of five stars for its overall rating in the 2021 Health Plan Ratings and did not achieve five stars in any subcategory.	X	X	X
PIP 1- Fall Risk	WSCC did not meet the target goal for the project indicator and did not reduce the rate of members who had a fall-related hospitalization.	X		
PIP 2 – Prenatal and Postpartum Care	Although WSCC demonstrated performance improvement in the number of pregnant members seeking AOD treatment and in the number of members with timely postpartum care, WSCC did not meet target goals for the three project indicators.	X	X	X
PIP 5 – Depression Screening and Management	WSCC demonstrated performance decline in documented follow-up plans for adult members with a positive depression screening. WSCC did not meet the target rate for this indicator.	X	X	X
Performance Measures	Rates for four of 10 measures did not meet their targets.	X	X	X
	Rates trended downward for three measures between MY 2019 and MY 2020.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	WSCC did not meet HSD distance standards for the following provider types in any region: I/T/Us, rheumatologists, ARTCs, assertive community treatment, community mental health centers, core services agencies, day treatment services, general hospitals with psychiatric units, Indian Health Services and Tribal 638s providing behavioral health services, non-ARTCs and group homes, partial hospital programs, RHCs providing behavioral health services, treatment foster care I and II, and assisted living facilities.		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	Of the primary care providers surveyed in 2020, 75% reported timely routine asymptomatic appointments. Of the substance use disorder providers surveyed, 33% reported timely routine appointments, while 43% reported timely urgent appointments. Of the community mental health centers surveyed, 56% reported timely routine appointments, while 13% reported timely urgent appointments.		X	X
Quality of Care Survey – Member Experience	WSCC achieved one adult CAHPS score and one child CAHPS score that performed below the national MY 2020 Medicaid 50th percentile.	X	X	X
Recommendations to WSCC to Address Quality, Timeliness, and Access				
PIP-General	Refrain from maintaining the same interventions year-over-year, especially if performance improvement has declined, stalled, been inconsistent, or simply not achieved.	X	X	X
PIP 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.	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).	X		
PIP 2 – Prenatal and Postpartum Care	The Substance Abuse and Mental Health Services Administration (SAMHSA) has reported the importance of family-centered MAT programs for persons with AOD. WSCC should explore family-centered care options to increase engagement rates among pregnant members[20]. WSCC should also evaluate its role in the integration of behavioral health, obstetric, and primary care.[21]	X	X	X
	The American Society of Addiction Medicine (ASAM) guidelines state that AOD treatment services must be able to meet the specific needs of women, 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.	X	X	X

[20] 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.

[21] 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.

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	WSCC should consider the recommendations for improvement published in the *New Mexico Substance Use Disorder Treatment Gap Analysis* report in January 2020.[22]	X	X	X
	The American Society of Addiction Medicine (ASAM) guidelines state that AOD treatment services must be able to meet the specific needs of women, 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.	X	X	X
PIP 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.	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.	X	X	X
	To increase PCP awareness of available behavioral health screening tools and their confidence in administering these tools, WSCC should sponsor CME training on the use of the Patient Health Questionnaire (PHQ)-2 and PHQ-9 in the primary care setting.	X	X	X
	WSCC should enhance its intervention strategy to include culturally responsive services, specifically for its Native American population.[23]	X	X	X
	WSCC should identify opportunities within the healthcare delivery system for the MCO to facilitate coordination between PCPs 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.	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	X	X	X

[22] 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/. Accessed November 3, 2021.
[23] 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. Accessed: November 11, 2021.

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	descriptions of interventions planned/implemented and attach tracking measures to support routine monitoring of the effectiveness of active interventions.			
	WSCC should Identify additional opportunities to utilize services provided through its vendor, Teledoc.		X	X
Compliance with Medicaid Standards	None.			
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 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.		X	X
	In the absence of an HSD 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 HSD, 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 the 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.		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.	X	X	X

Appendix A: HSD Tracking Measures Program

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description	Measure Steward/Data Collection Method
#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 aged 18 and older.	
# 3	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid members aged 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	Measure Steward/Data Collection Method
		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 six 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 six 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.	NCQA/HEDIS
# 6	Long-Acting Reversible Contraceptive	The MCO shall measure the use of long-acting reversible contraceptives among members ages 15 to 19.	
# 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	Utilization of outpatient visits and emergency department visits reported by all member months for the measurement year.	NCQA/HEDIS
# 9	Annual Dental Visit	The percentage of enrolled members ages two to 20 who had at least one dental visit during the measurement year.	NCQA/HEDIS
# 10	Controlling High Blood Pressure	The percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	NCQA/HEDIS Hybrid

Appendix B: MCO Performance Measure Tables, MY 2019 and MY 2020

BCBS PM Rates for MY 2019 and MY 2020

Performance Measure	BCBS MY 2019 Rate	BCBS MY 2020 Rate	Difference Between BCBS MY 2019 and MY 2020 Rates	MY 2020 Target Rate
PM 1 W30 First 15 Months	65.94%	56.89%	-9.05	62.62%
PM 2 WCC Physical Activity	45.50%	50.36%	+4.86	48.52%
PM 3 PPC Prenatal Care	84.43%	79.32%	-5.11	78.67%
PM 4 PPC Postpartum Care	64.48%	67.40%	+2.92	63.35%
PM 5 CIS Combo 3	70.80%	70.56%	-0.24	68.01%
PM 6 AMM Continuation	37.35%	39.81%	+2.46	34.33%
PM 7 IET Initiation	41.05%	43.77%	+2.72	43.34%
PM 8 FUH 30 Day	41.62%	51.94%	+10.32	48.42%
PM 9 FUM 30 Day	56.27%	59.36%	+3.09	43.52%
PM 10 SSD	79.02%	76.46%	-2.56	80.63%
Available Points	19	10		
Points Earned	12	8		

Note: The following measures were included in the HSD PM program for MY 2019: PM 1 W30, PM 2 WCC, PM 3 PPC, PM 4 PPC, PM 6 AMM, and PM 7 IET.

PHP PM Rates for MY 2019 and MY 2020

Performance Measure	PHP MY 2019 Rate	PHP MY 2020 Rate	Difference Between PHP MY 2019 and MY 2020 Rates	MY 2020 Target Rate
PM 1 W30 First 15 Months	66.67%	49.63%	-17.04	62.62%
PM 2 WCC Physical Activity	49.15%	49.88%	+0.73	48.52%
PM 3 PPC Prenatal Care	90.51%	68.61%	-21.90	78.67%
PM 4 PPC Postpartum Care	75.43%	69.59%	-5.84	63.35%
PM 5 CIS Combo 3	69.83%	67.64%	-2.19	68.01%
PM 6 AMM Continuation	39.31%	42.38%	+3.07	34.33%
PM 7 IET Initiation	42.79%	54.12%	+11.33	43.34%
PM 8 FUH 30 Day	40.22%	54.84%	+14.62	48.42%
PM 9 FUM 30 Day	61.01%	64.83%	+3.82	43.52%
PM 10 SSD	79.51%	75.14%	-4.37	80.63%
Available Points	19	10		
Points Earned	11	6		

Note: The following measures were included in the HSD PM program for MY 2019: PM 1 W30, PM 2 WCC, PM 3 PPC, PM 4 PPC, PM 6 AMM, and PM 7 IET.

WSCC PM Rates for MY 2019 and MY 2020

Performance Measure	WSCC MY 2019 Rate	WSCC MY 2020 Rate	Difference Between WSCC MY 2019 and MY 2020 Rates	MY 2020 Target Rate
PM 1 W30 First 15 Months	Small Denominator	42.70%	-	62.62%
PM 2 WCC Physical Activity	50.36%	43.31%	-7.05	48.52%
PM 3 PPC Prenatal Care	70.80%	68.37%	-2.43	78.67%
PM 4 PPC Postpartum Care	59.12%	59.85%	+0.73	63.35%
PM 5 CIS Combo 3	58.33%	61.56%	+3.23	68.01%
PM 6 AMM Continuation	32.85%	36.46%	+3.61	34.33%
PM 7 IET Initiation	41.89%	43.26%	+1.37	43.34%
PM 8 FUH 30 Day	35.36%	53.85%	+18.49	48.42%
PM 9 FUM 30 Day	45.70%	42.76%	-2.94	43.52%
PM 10 SSD	70.79%	73.69%	+2.90	80.63%
Available Points	19	10		
Points Earned	Not Applicable	2		

Small Denominator = less than 30 eligible members.
Note 1: The following measures were included in the HSD PM program for MY 2019: PM 1 W30, PM 2 WCC, PM 3 PPC, PM 4 PPC, PM 6 AMM, and PM 7 IET.
Note 2: MY 2019 was WSCC's baseline period and therefore, there was no contractual requirement for WSCC's rates to meet any targets.

Appendix C: MCO CAHPS Tables, MY 2018-MY 2020

BCBS Adult CAHPS Results, MY 2018–MY 2020

Adult CAHPS Measures	BCBS			*2021 Quality Compass* (MY 2020)	
	2019 CAHPS MY 2018	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	74.7%	79.0%	79.0%	50th	78.32%
Rating of All Health Care	73.8%	78.8%	75.8%	25th	77.63%
Rating of Personal Doctor[1]	83.8%	88.1%	82.5%	33.33rd	83.23%
Rating of Specialist[1]	84.2%	SS	SS	Not Applicable	83.56%
Getting Care Quickly[2]	80.1%	SS	SS	Not Applicable	81.83%
Getting Needed Care[2]	81.6%	SS	81.1%	25th	83.58%
Customer Service[2]	SS	SS	SS	Not Applicable	88.94%
How Well Doctors Communicate[2]	93.5%	96.0%	93.0%	50th	92.17%
Coordination of Care[2]	SS	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

BCBS General Population-Child CAHPS Results, MY 2018–MY 2020

General Population Child CAHPS Measures	BCBS			*2021 Quality Compass* (MY 2020)	
	2019 CAHPS MY 2018	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	87.2%	88.9%	85.4%	33.33rd	86.65%
Rating of All Health Care	87.7%	86.0%	86.1%	10th	88.94%
Rating of Personal Doctor[1]	92.9%	90.8%	90.7%	33.33rd	90.56%
Rating of Specialist[1]	SS	SS	SS	Not Applicable	87.42%
Getting Care Quickly[2]	92.1%	SS	SS	Not Applicable	86.9%
Getting Needed Care[2]	83.4%	SS	SS	Not Applicable	85.65%
Customer Service[2]	SS	SS	SS	Not Applicable	88.32%
How Well Doctors Communicate[2]	96.4%	93.8%	SS	Not Applicable	94.39%
Coordination of Care[2]	SS	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

PHP Adult CAHPS Results, MY 2018–MY 2020

Adult CAHPS Measures	PHP			*2021 Quality Compass* (MY 2020)	
	2019 CAHPS MY 2018	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	78.4%	78.7%	73.2%	10th	78.32%
Rating of All Health Care	69.4%	78.7%	76.5%	33.33rd	77.63%
Rating of Personal Doctor[1]	79.3%	82.1%	81.4%	25th	83.23%
Rating of Specialist Seen Most Often[1]	74.8%	89.4%	SS	Not Applicable	83.56%
Getting Care Quickly[2]	81.4%	80.8%	81.4%	33.33rd	81.83%
Getting Needed Care[2]	78.7%	81.6%	81.4%	25th	83.58%
Customer Service[2]	92.8%	92.6%	SS	Not Applicable	88.94%
How Well Doctors Communicate[2]	89.5%	93.2%	88.7%	<10th	92.17%
Coordination of Care[2]	77.1%	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

PHP General Population-Child CAHPS Results, MY 2018–MY 2020

General Population Child CAHPS Measures	PHP			*2021 Quality Compass* (MY 2020)	
	2019 CAHPS MY 2018	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	86.9%	87.3%	88.2%	50th	86.65%
Rating of All Health Care	83.5%	87.8%	85.5%	10th	88.94%
Rating of Personal Doctor[1]	87.7%	91.1%	92.3%	75th	90.56%
Rating of Specialist Seen Most Often[1]	SS	SS	SS	Not Applicable	87.42%
Getting Care Quickly[2]	84.8%	87.9%	SS	Not Applicable	86.90%
Getting Needed Care[2]	85.3%	85.2%	SS	Not Applicable	85.65%
Customer Service[2]	94.5%	SS	SS	Not Applicable	88.32%
How Well Doctors Communicate[2]	92.9%	95.5%	94.9%	50th	94.39%
Coordination of Care[2]	82.6%	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

WSCC Adult CAHPS Results, MY 2018–MY 2020

Adult CAHPS Measures	WSCC		*2021 Quality Compass* (MY 2020)	
	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	SS	76.7%	33.33rd	78.32%
Rating of All Health Care	SS	SS	Not Applicable	77.63%
Rating of Personal Doctor[1]	SS	83.2%	50th	83.23%
Rating of Specialist Seen Most Often[1]	SS	SS	Not Applicable	83.56%
Getting Care Quickly[2]	SS	SS	Not Applicable	81.83%
Getting Needed Care[2]	SS	SS	Not Applicable	83.58%
Customer Service[2]	SS	SS	Not Applicable	88.94%
How Well Doctors Communicate[2]	SS	SS	Not Applicable	92.17%
Coordination of Care[2]	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

WSCC General Population-Child CAHPS Results, MY 2018–MY 2020

General Population Child CAHPS Measures	WSCC		*2021 Quality Compass* (MY 2020)	
	2020 CAHPS MY 2019	2021 CAHPS MY 2020	National Medicaid Benchmark (Met/Exceeded)	National Medicaid Mean
Rating of Health Plan[1]	SS	84.3%%	25th	86.65%
Rating of All Health Care	SS	SS	Not Applicable	88.94%
Rating of Personal Doctor[1]	SS	91.5%	50th	90.56%
Rating of Specialist Seen Most Often[1]	SS	SS	Not Applicable	87.42%
Getting Care Quickly[2]	SS	SS	Not Applicable	86.90%
Getting Needed Care[2]	SS	SS	Not Applicable	85.65%
Customer Service[2]	SS	SS	Not Applicable	88.32%
How Well Doctors Communicate[2]	SS	SS	Not Applicable	94.39%
Coordination of Care[2]	SS	SS	Not Applicable	Not Available

[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."
SS: small sample (less than 100 members).

Appendix D: MCO PIP Indicator Tables

BCBS PIP 1 – LTSS Diabetic Eye Exam Indicators, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - Members residing in a LTC facility with a diagnosis of diabetes who met low NF LOC requirements during the MY and had a retinal eye exam during the MY or the year prior to the MY	27.91%	43.75%	25.76%	31.91%	Performance improvement demonstrated and target exceeded.	Performance decline demonstrated and target not met.
Indicator 2 - Adult members aged 18–75 years with a diagnosis of diabetes who had a retinal eye exam during the MY or the year prior to the MY	53.77%	48.66%	48.91%	57.77%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.

BCBS PIP 2 – Timeliness of Prenatal and Postpartum Care Indicators, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
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	80.78%	84.43%	79.32%	84.78%	Performance improvement demonstrated but target not met.	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.	63.50%	64.48%	67.40%	67.50%	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.

BCBS PIP 3 – Adult Obesity Indicators, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - The percentage of members 18–74 years of age who had an outpatient visit and whose BMI was documented during the MY or the year prior to the MY	77.86%	83.45%	Retired	81.86%	Performance improvement demonstrated and target exceeded.	Not Applicable
Indicator 2 - The percentage of members ages 18–75 years with diabetes who complete an HbA1c test during the MY that is > 9% *(lower rate indicates better performance)*	50.61%	43.07%	52.31%	46.61%	Performance improvement demonstrated and target exceeded.	Performance decline demonstrated and target not met.
Indicator 3 - The number of members 18–85 years who had a diagnosis of hypertension with blood pressure control (< 140/90) in the most recent blood pressure reading in a medical chart in the MY	48.66%	54.50%	51.09%	52.66%	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated but target not met.

BCBS PIP 4 – Diabetes Management and STCA Rate HbA1c Testing Indicators, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
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)*	14.56	25.24	24.06	8.56	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
Indicator 2 - The number of members ages 18–75 years with diabetes during the MY who complete an HbA1c test	82.97%	85.89%	78.83%	86.97%	Performance improvement demonstrated but target not met.	Performance decline demonstrated and target not met.

BCBS PIP 5 – Screening and Management for Clinical Depression Indicators, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018 (Q1–Q3)	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - Percentage of patients aged 18–64 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	1.58%	0.39%	0.55%	≥ 11.58%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
Indicator 2 - Percentage of patients aged 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	4.22%	1.18%	1.39%	≥ 14.22%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
Indicator 3 - The percentage of members 18–64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	43.99%	51.11%	52.73%	≥ 47.80%	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.
Indicator 4 - The percentage of members 65 years of age 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)	64.29%	70.00%	80.00%	≥ 85.71%	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.
Indicator 5 - The percentage of members 18–64 years of age 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)	24.46%	35.01%	35.42%	≥ 30.46%	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.

Performance Indicator Description	Baseline Period MY 2018 (Q1–Q3)	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 6 - The percentage of members 65 years of age 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)	50.00%	60.00%	60.00%	≥ 71.43	Performance improvement demonstrated but target not met.	Performance improvement demonstrated but target not met.

PHP PIP 1 – TOC Community Reintegration Indicators, MY 2018–MY 2019

Performance Indicator Description	Original Baseline Period MY 2018	Revised Baseline Period MY 2019	Interim Period MY 2020	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
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%	93.0%	85.0%	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.
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%	96.5%	85.0%	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.
Indicator 3 - Members who were identified with the potential of failure to thrive yet successfully reintegrated with care coordination support	58.0%	100%	91.2%	91.2%	85.0%	Unable to evaluate performance at this time.	Unable to evaluate performance at this time.

PHP PIP 2 – Prenatal-Postpartum Indicators, MY 2019–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
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%	81.13%	Performance decline demonstrated and target not met.	Performance improvement demonstrated but 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.	59.30%	42.63%	56.75%	64.53%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.

PHP PIP 3 – Adult Obesity Indicators, MY 2018–MY 2019

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2019	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - The percentage of members 18–74 years who had an outpatient visit and whose BMI was documented during the MY or the year prior to the MY	87.34%	84.82%	58.12%	89.34%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
Indicator 2 - The percent of members 18 years and older that are enrolled in an obesity-related support program	No data to report	9.62%	20.76%	20.00%	Unable to evaluate performance at this time.	Performance improvement demonstrated and target exceeded.

PHP PIP 4 – Diabetes Prevention and Management, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - The percentage of members 18–74 years with diabetes (type 1 and type 2) who had HbA1c testing	84.85%	76.91%	70.88%	87.54%	Performance decline demonstrated and target not met.	Performance decline demonstrated and target not met.
Indicator 2 - Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members 18 years and older *(lower rate indicates better performance)*	23.11	18.35	14.80	21.11	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.

PHP PIP 5 – Screening and Management of Clinical Depression, MY 2018–MY 2020

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Interim Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
Indicator 1 - The percentage of members 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%	54.79%	Performance improvement demonstrated and target exceeded.	Performance improvement demonstrated and target exceeded.
Indicator 2 - The percentage of members 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%	39.66%	Performance improvement demonstrated but target not met.	Performance improvement demonstrated and target exceeded.
Indicator 3 - The percentage of members 18–64 years with an outpatient visit in the MY that are	0.32%	0.58%	0.84%	1.32%	Performance improvement	Performance improvement

Performance Indicator Description	Baseline Period MY 2018	Interim Period MY 2019	Interim Period MY 2020	Target Rate	Assessment of Improvement MY 2018–MY 2019	Assessment of Improvement MY 2018–MY 2020
screened for clinical depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen					demonstrated but target not met.	demonstrated but target not met.
Indicator 4 - Medicaid members aged 65 years and older with an outpatient visit in the MY 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%	1.63%	Performance improvement demonstrated but target not met.	Performance improvement demonstrated and target exceeded.

WSCC PIP 1 – Fall Risk Prevention Program Indicator, MY 2019-MY 2020

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
Indicator 1 – Rate of LTSS members 60 years and older, who had a fall-related hospitalization (per 10,000 members) *(lower rate indicates better performance)*	545.57	882.35	152	Performance decline demonstrated and target not met.

WSCC PIP 2 – Addiction in Pregnancy Program Indicators, MY 2019-MY 2020

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
Indicator 1 – Percentage of pregnant members 13 years and older who have experienced a new episode of AOD abuse or dependence as of December 31 of the MY who were initiated for treatment for alcohol and other substances 14 days within diagnosis	46.2%	46.5%	49.7%	Performance improvement demonstrated but target not met.
Indicator 2 - Percentage of pregnant members 13 years and older who have experienced a new episode of AOD abuse or dependence as of December 31 of the measurement year who engaged in treatment for	14.4%	14.9%	19.8%	Performance improvement demonstrated but target not met.

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
alcohol and other substances within 34 days of initial treatment				
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%	47.43%	Performance improvement demonstrated but target not met.

WSCC PIP 3 – Adult Weight Management Program Indicators, MY 2019-MY 2020

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
Indicator 1 – The percentage of members 19 years and older with a documented BMI of greater than 30 kg/m *(lower rate indicates better performance)*	63.7%	34.9%	49.4%	Performance improvement demonstrated and target exceeded.
Indicator 2 - The percentage of members 18–74 years who had an outpatient visit and whose BMI was documented during the MY or the year prior to the MY	17.2%	36.7%	20.2%	Performance improvement demonstrated and target exceeded.

WSCC PIP 4 – Diabetes Prevention and Management Indicators, MY 2019-MY 2020

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
Indicator 1 – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a HbA1c screening	52.6%	63.66%	50.93%	Performance improvement demonstrated and target exceeded.
Indicator 2 – 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)*	23.53	16.94	19.35	Performance improvement demonstrated and target exceeded.

WSCC PIP 5 – Management for Clinical Depression Indicators, MY 2019-MY 2020

Performance Indicator Description	Baseline Period MY 2019	Final Period MY 2020	Target Rate	Assessment of Improvement from MY 2019 to MY 2020
Indicator 1 - The percentage of members 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)	36.2%	53.17%	37.34%	Performance improvement demonstrated and target exceeded.
Indicator 2 - The percentage of members 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)	18.9%	36.46%	34.76%	Performance improvement demonstrated and target exceeded.
Indicator 3 - The percentage of members 18 years and older with an outpatient visit in the MY 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%	0.37%	4.08%	Performance decline demonstrated and target not met.