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New Mexico Medicaid Managed Care Centennial Care 2.0 Program

2022 External Quality Review Annual Technical Report

April 2024

Prepared on behalf of:

The New Mexico Human Services Department

ipro.org

Per *Title 42 Code of Federal Regulations 438.362*, this *2022 External Quality Review Annual Technical Report* does not include Highly Integrated Dual Eligible Special Needs Plans offered by Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, Inc., or Centene Corporation (parent company of Western Sky Community Care).

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About This Report

External Quality Review and Annual Technical Report Requirements

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

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

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the New Mexico Human Services Department (hereafter referred to as Human Services Department) contracted with Island Peer Review Organization, Inc. (doing business as IPRO), an external quality review organization, to conduct the 2022 external quality review of the MCOs that comprised New Mexico's Centennial Care 2.0. Specifically, this report provides IPRO's independent evaluation of the services provided by Blue Cross and Blue Shield of New Mexico (hereafter referred to as BCBS), Presbyterian Health Plan, Inc. (hereafter referred to as PHP), and Western Sky Community Care, Inc. (hereafter referred to has WSCC).

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

2022 External Quality Review

This external quality review technical report focuses on four federally mandatory external quality review activities (validation of performance improvement projects, validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional external quality review activity (validation of quality-of-care surveys) that were conducted for measurement year 2022. IPRO's external quality

[1] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.

[2] prepaid inpatient health plan.

[3] prepaid ambulatory health plan.

[4] primary care case management.

review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[5] published in February 2023. The external quality review activities and corresponding protocols are described in Table 1.

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

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

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

[5] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf.

[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[7] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

New Mexico State Medicaid Managed Care Program and Medicaid Quality Strategy

History of the New Mexico Medicaid Managed Care Program

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

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

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

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

In 2022, the Human Services Department contracted with three MCOs to administer health care benefits under the Centennial Care 2.0 program: BCBS, PHP, and WSCC. Profiles on these MCOs are available in the Medicaid Managed Care Organization Profiles section of this report.

New Mexico State Medicaid Quality Strategy

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

New Mexico's 2021 Medicaid Quality Strategy focuses on driving quality through targeted initiatives, comprehensive monitoring, and ongoing assessment of outcome-based performance improvement. The quality strategy is designed to ensure that services provided to Medicaid members meet or exceed the established standards for access to care, clinical quality of care, and quality of services to achieve the delivery of high-quality and high-value healthcare. New Mexico's quality strategy goals are:

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

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

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

Performance Improvement Projects

New Mexico identifies performance improvement projects by assessing gaps in care with a focus on applying sustainable interventions that will improve the access, quality, or timeliness of care and services provided to the state's Medicaid beneficiaries. The performance improvement projects are included in the MCO contracts and revised and updated based on the Human Services Department's review of the positive outcomes or the identification of needed attention to specific gaps in care. Beginning in 2019, each MCO is required to conduct five performance improvement projects annually on the following topics: long-term care services, prenatal and postpartum care, adult obesity, diabetes prevention and management, and screening for and management of clinical depression.

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

The objectives, technical methods of data collection and analysis, description of data obtained, and comparative results are presented in the External Quality Review Activity 1. Validation of Performance Improvement Projects - Technical Summary section of this report.

Performance Measures

New Mexico selects quality metrics and performance targets by assessing gaps in care within the state's Medicaid population. The Human Services Department monitors and utilizes data that evaluate the MCOs' strengths and opportunities for improvement in serving the Medicaid population by specifying performance measures. The selected performance measures and performance targets are reasonable, based on industry standards, and consistent with the Centers for Medicare & Medicaid Services' External Quality Review Protocols. The MCOs are required to follow NCQA HEDIS technical specifications for reporting. Annually, the external quality review organization validates the MCOs' reported performance rates.

The Human Services Department conducts routine monitoring of the performance measures to observe trends and to identify potential risks to meeting performance targets. A measure at risk of not meeting the performance target is added to the Human Services Department's Monthly Monitoring Plan. The Monthly Monitoring Plan is a framework where MCOs are required to regularly report on interventions, strategies, and barriers associated with improving performance outcomes for specific measures. This information is shared with the MCOs during quarterly quality meetings.

A monthly monitoring plan was initiated by the Human Services Department in 2019 for all MCOs in response to declines in performance between measurement years 2017 and 2018 for two HEDIS measures: *Follow-Up After Hospitalization for Mental Illness – 30 Days* and *Follow-Up After Emergency Visit for Mental Illness – 30 Days*. The Human Services Department ended its monthly monitoring of these two measures in the first quarter of 2022, noting performance improvement across the three MCOs. Subsequently, in the third quarter of 2022, the Human

Services Department incorporated three new HEDIS measures into the Monthly Monitoring Plan: *Well-Child Visits Within the First 15 Months of Life*, *Prenatal and Postpartum Care – Timeliness of Prenatal Care*, and *Childhood Immunizations – Combination 3*.

The objectives, technical methods of data collection and analysis, description of data obtained, and comparative analyses are presented in the External Quality Review Activity 2. Validation of Performance Measures – Technical Summary section of this report.

Consumer Assessment of Healthcare Providers and Systems

New Mexico incorporates the CAHPS 5.1H survey required by NCQA for MCO accreditation as part of the required Centennial Care 2.0 annual report submissions. CAHPS 5.1H allows for inclusion of state-specific questions, which currently focus on member satisfaction with care coordination services received from the MCOs. The results of the annual CAHPS survey are reviewed and analyzed by the Human Services Department to determine gaps in member satisfaction. Results are discussed with the MCOs during the quarterly quality meetings to identify interventions and strategies that the MCOs are applying to improve member satisfaction. The external quality review organization validated the MCOs' 2022 CAHPS results.

The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in the External Quality Review Activity 6. Validation of Quality-of-Care Surveys – Technical Summary section of this report.

Managed Care Organization Accreditation Standards

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

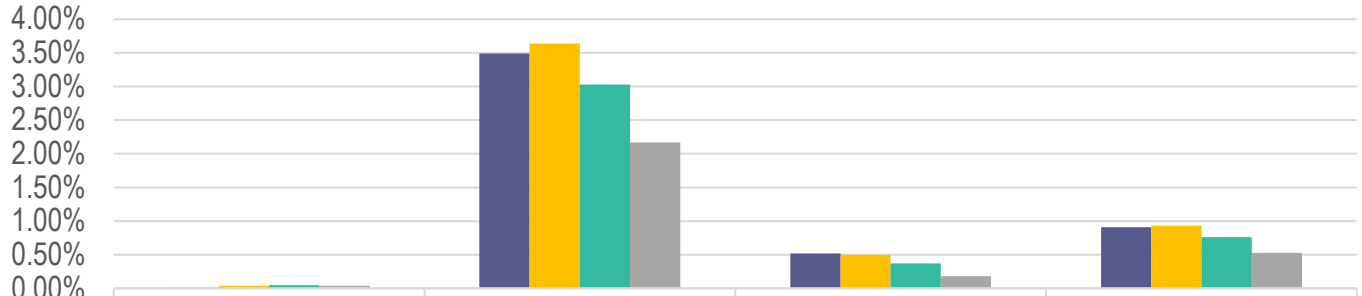
The objectives, technical methods of data collection and analysis, description of data obtained, and conclusions are presented in the NCQA Accreditation – Technical Summary section of this report.

Tracking Measures

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

Figure 1 through Figure 14 display the tracking measure rates at the MCO and statewide level for each quarter of 2022. Figures are not presented for the discharge measures of tracking measure #4 *Follow-Up After Hospitalization for Mental Illness*; however, technical specifications for the discharge measures are in Appendix A of this report.

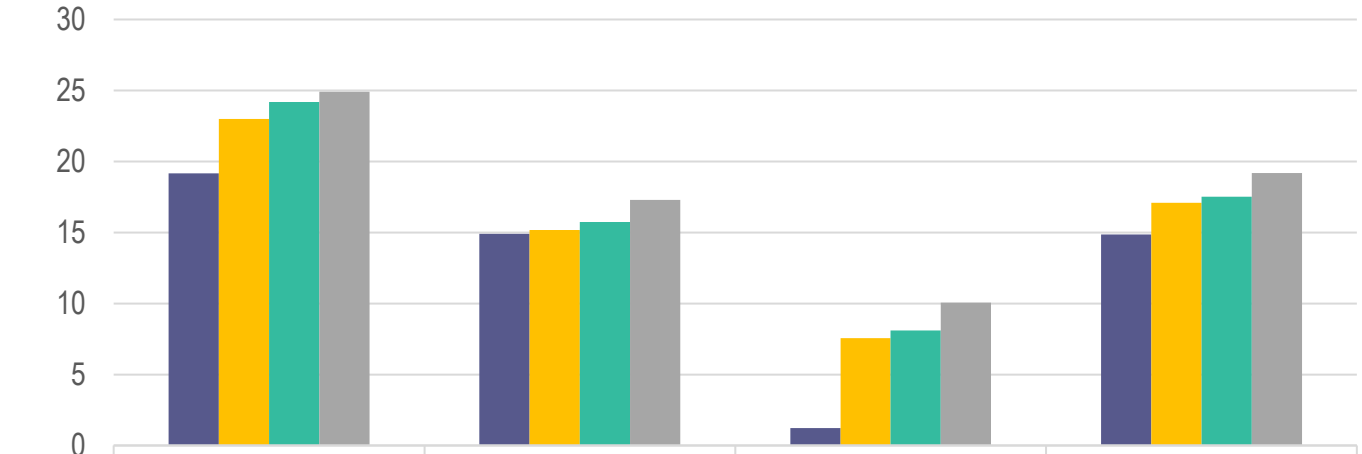
Figure 1. Tracking Measure #1 Fall Risk Management
(Lower Rate Indicates Better Performance)



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	0.01%	3.49%	0.52%	0.91%
Q2 2022	0.04%	3.64%	0.50%	0.93%
Q3 2022	0.05%	3.03%	0.37%	0.76%
Q4 2022	0.04%	2.17%	0.18%	0.53%

Measure Description: 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.
Note: MCO and aggregate rates are not accumulative.

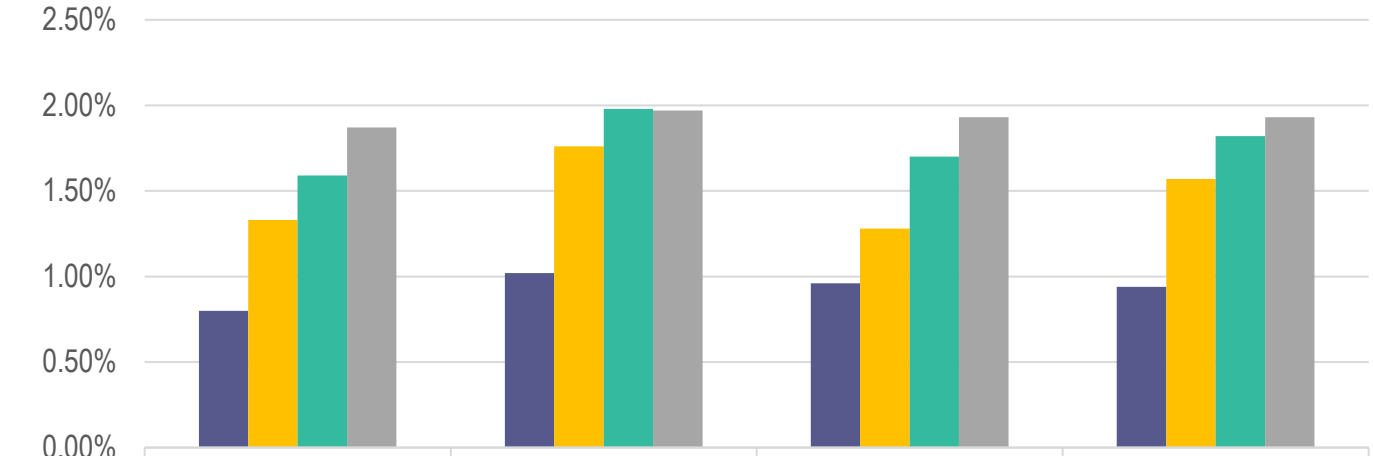
Figure 2. Tracking Measure #2 Diabetes Short-Term Complications Admission Rate *(Lower Rate Indicates Better Performance)*



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	19.17	14.9	1.22	14.87
Q2 2022	23	15.17	7.56	17.1
Q3 2022	24.18	15.73	8.1	17.53
Q4 2022	24.92	17.29	10.07	19.19

Measure Description: The number of inpatient discharges with principal diagnosis codes for diabetes short-term complications for Medicaid members ages 18 and older.
Note: MCO and aggregate rates are accumulative.

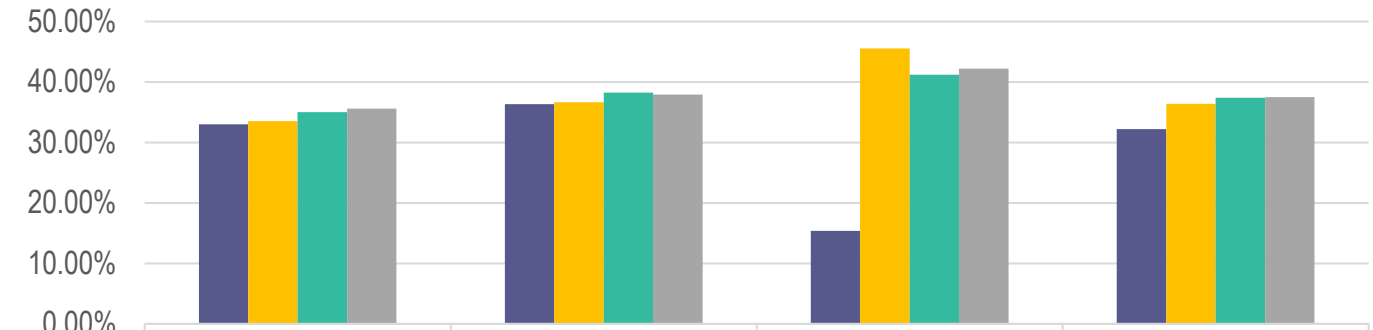
Figure 3. Tracking Measure #3 Screening for Clinical Depression



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	0.80%	1.02%	0.96%	0.94%
Q2 2022	1.33%	1.76%	1.28%	1.57%
Q3 2022	1.59%	1.98%	1.70%	1.82%
Q4 2022	1.87%	1.97%	1.93%	1.93%

Measure Description: The percentage of Medicaid members ages 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
Note: MCO and aggregate rates are accumulative.

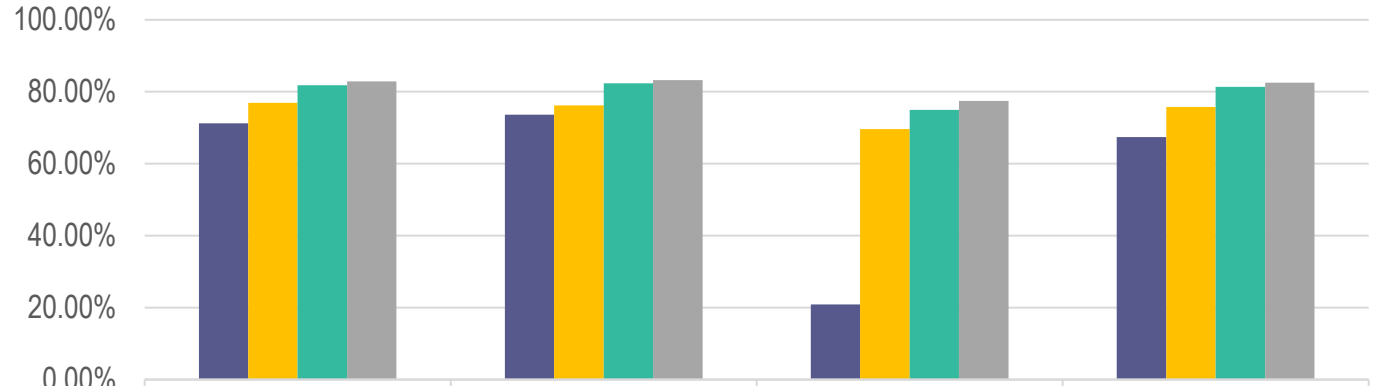
Tracking Measure #4 Follow-Up After Hospitalization for Mental Illness - 7 Day



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	32.99%	36.33%	15.38%	32.22%
Q2 2022	33.53%	36.63%	45.55%	36.39%
Q3 2022	35.02%	38.26%	41.18%	37.38%
Q4 2022	35.61%	37.94%	42.18%	37.52%

Measure Description: Percent of 7-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of 4 or more days.
Note: MCO and aggregate rates are not accumulative.

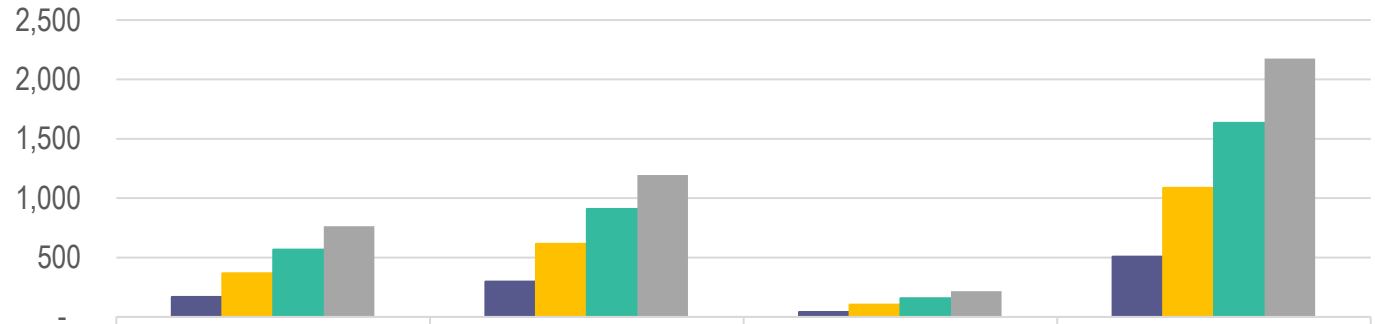
Figure 5. Tracking Measure #5 Immunizations for Adolescents



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	71.25%	73.61%	20.92%	67.43%
Q2 2022	76.89%	76.23%	69.61%	75.77%
Q3 2022	81.80%	82.34%	74.97%	81.41%
Q4 2022	82.87%	83.26%	77.44%	82.54%

Measure Description: 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.
Note 1: MCO and aggregate rates are accumulative.
Note 2: Rates in this figure were calculated using administrative data only, whereas the final audited rates in the MCOs' HEDIS submissions were calculated using hybrid data.

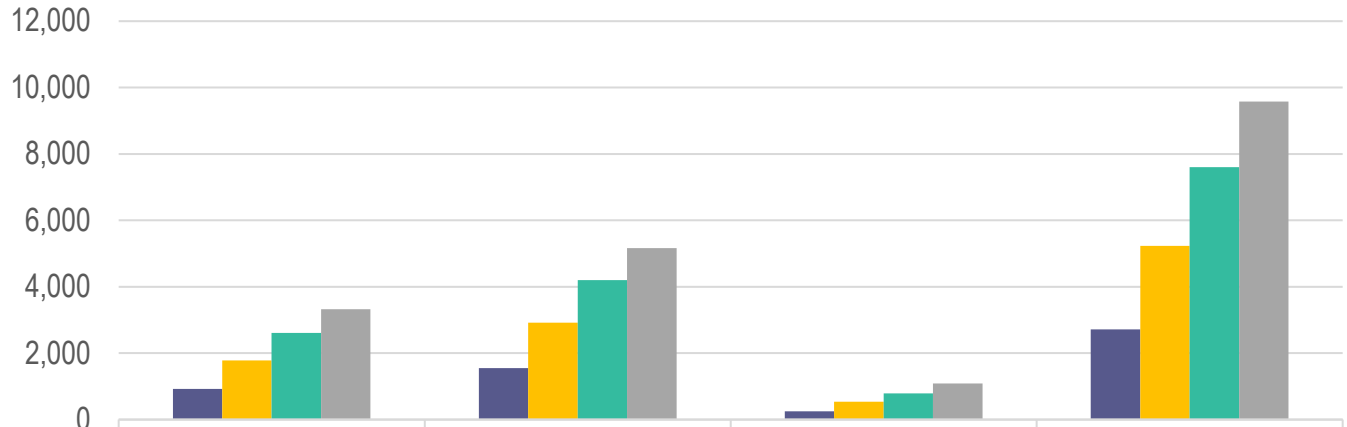
Figure 6. Tracking Measure #6 Long-Acting Reversible Contraceptive



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	168	299	42	509
Q2 2022	368	615	103	1,086
Q3 2022	567	909	158	1,634
Q4 2022	765	1,194	218	2,177

Measure Description: The MCO shall measure the use of long-acting reversible contraceptives among members ages 15 to 19 years.
Note: MCO and aggregate counts are not accumulative.

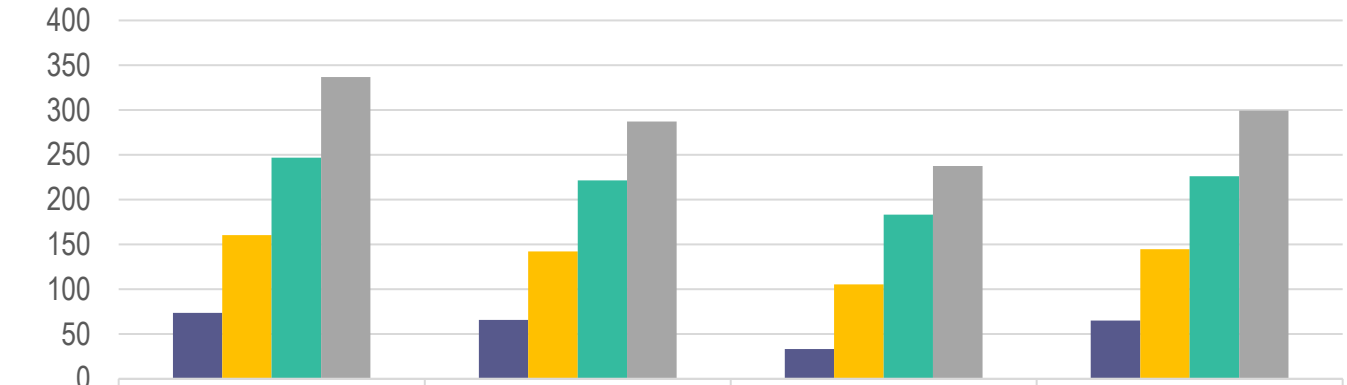
Figure 7. Tracking Measure #7 Smoking Cessation
(Unduplicated Member Quit Attempts)



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	919	1,547	251	2,717
Q2 2022	1,783	2,915	534	5,232
Q3 2022	2,614	4,202	787	7,603
Q4 2022	3,322	5,169	1,084	9,575

Measure Description: The number of smoking cessation products and counseling received by members within a calendar year.
Note: MCO and aggregate rates are accumulative.

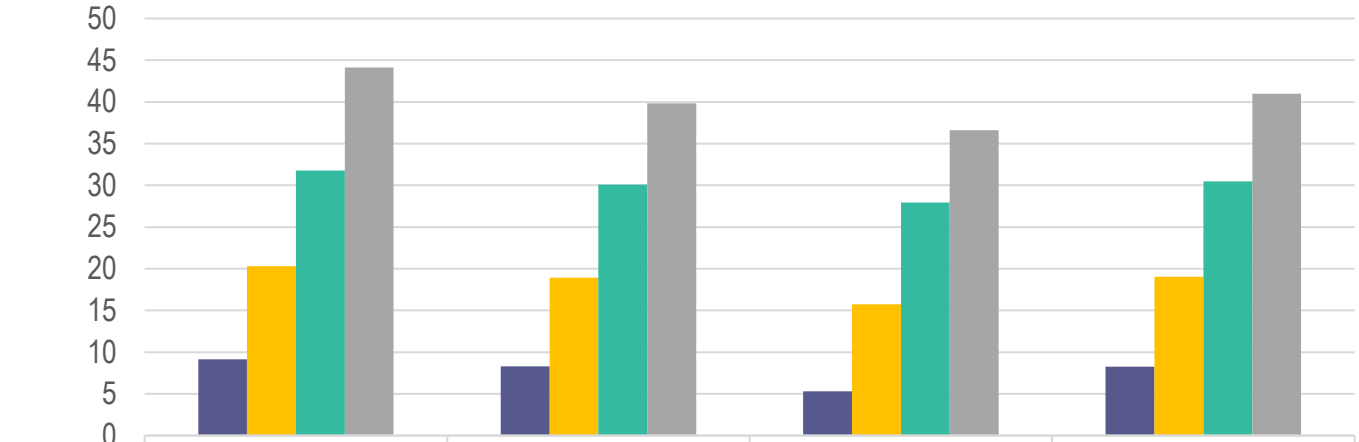
Figure 8. Tracking Measure #8 Ambulatory Outpatient Visits Per 1,000 Member Months



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	73.54	65.72	33.32	64.93
Q2 2022	160.47	142.3	105.31	144.68
Q3 2022	246.69	221.56	183.12	226.25
Q4 2022	336.99	287.33	237.43	299.41

Measure Description: Rate of outpatient visits per 1,000 member months.
Note: MCO and aggregate rates are accumulative.

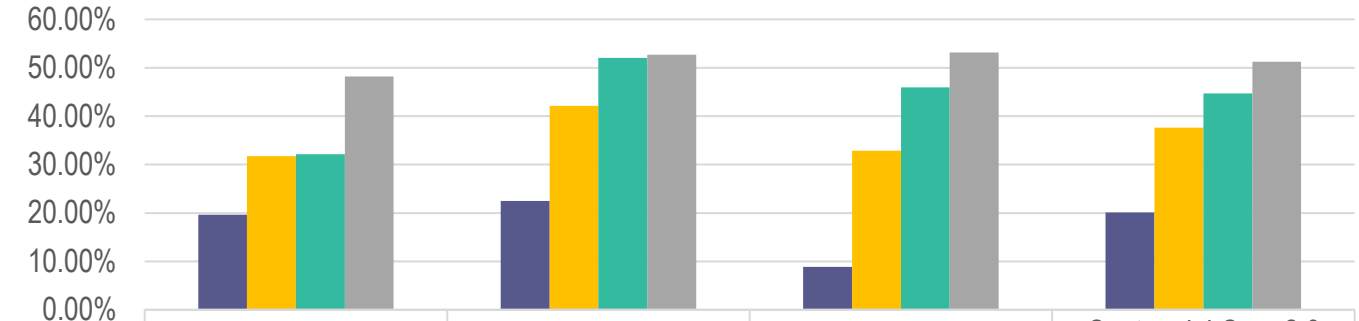
Figure 9. Tracking Measure #8b Ambulatory Care Emergency Department Visits Per 1,000 Member Months
(Lower Rate Indicates Better Performance)



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	9.15	8.31	5.31	8.28
Q2 2022	20.29	18.92	15.75	19.06
Q3 2022	31.77	30.1	27.96	30.46
Q4 2022	44.13	39.83	36.61	41.00

Measure Description: Rate of emergency department visits per 1,000 member months.
Note: MCO and aggregate rates are accumulative.

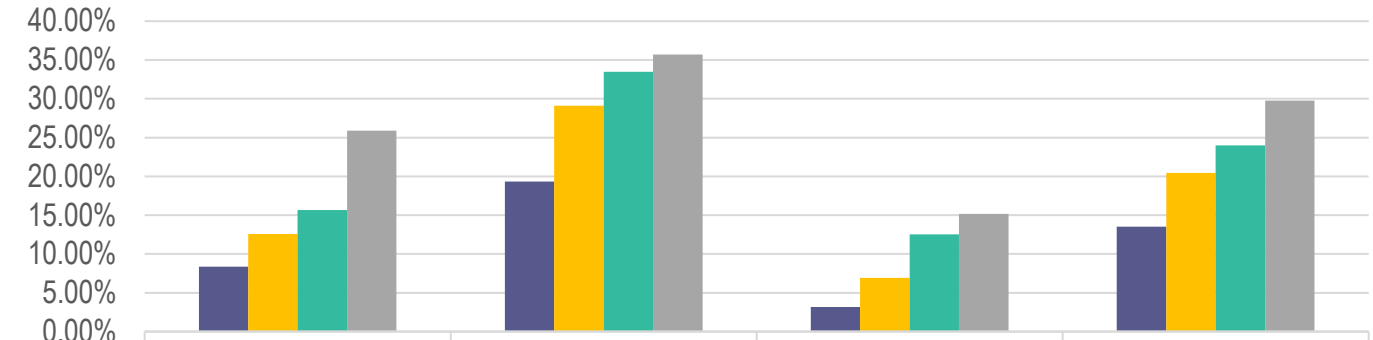
Figure 10. Tracking Measure #9 Annual Dental Visit, Age 2 to 20 Years



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	19.66%	22.46%	8.88%	20.09%
Q2 2022	31.75%	42.11%	32.88%	37.63%
Q3 2022	32.14%	52.05%	45.93%	44.70%
Q4 2022	48.18%	52.71%	53.14%	51.22%

Measure Description: The percentage of enrolled members ages 2 to 20 years of age who had at least one dental visit during the measurement year.
Note: MCO and aggregate rates are accumulative.

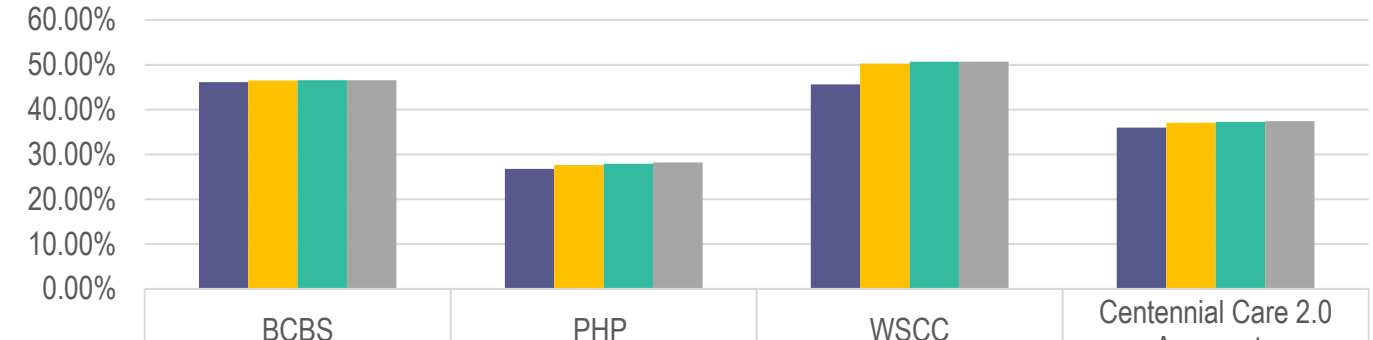
Figure 11. Tracking Measure #10 Controlling High Blood Pressure (<190/40 mm Hg), Age 18 to 85 Years



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	8.37%	19.35%	3.16%	13.52%
Q2 2022	12.59%	29.12%	6.94%	20.46%
Q3 2022	15.68%	33.48%	12.52%	23.99%
Q4 2022	25.87%	35.70%	15.17%	29.78%

Measure Description: The percentage of members ages 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).
Note 1: MCO and aggregate rates are accumulative.
Note 2: Rates in this figure were calculated using administrative data only, whereas the final audited rates in the MCOs' HEDIS submissions were calculated using hybrid data.

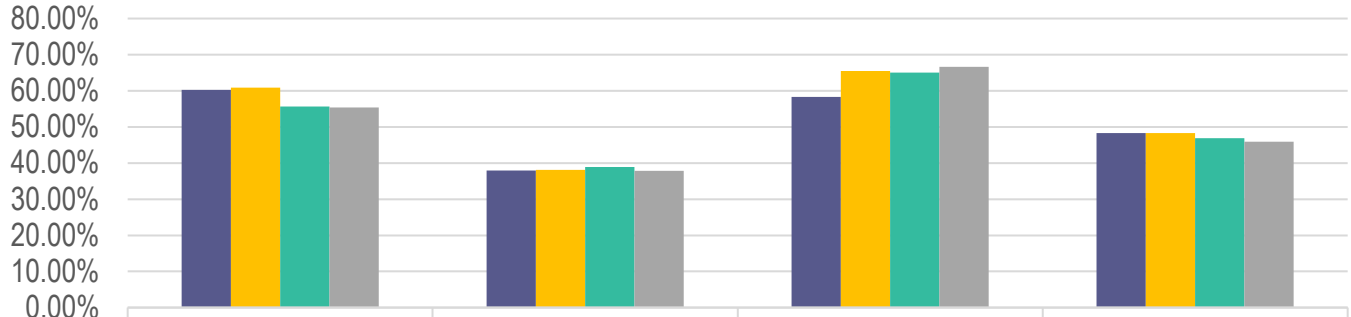
Figure 12. Tracking Measure #11 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication - Initiation Phase, Age 2 to 12 Years



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	46.09%	26.77%	45.62%	35.95%
Q2 2022	46.46%	27.65%	50.23%	37.04%
Q3 2022	46.58%	27.90%	50.68%	37.25%
Q4 2022	46.58%	28.20%	50.68%	37.41%

Measure Description: The percentage of members 6 to 12 years of age with a prescription dispensed for attention-deficit/hyperactivity disorder medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
Note: MCO and aggregate rates are accumulative.

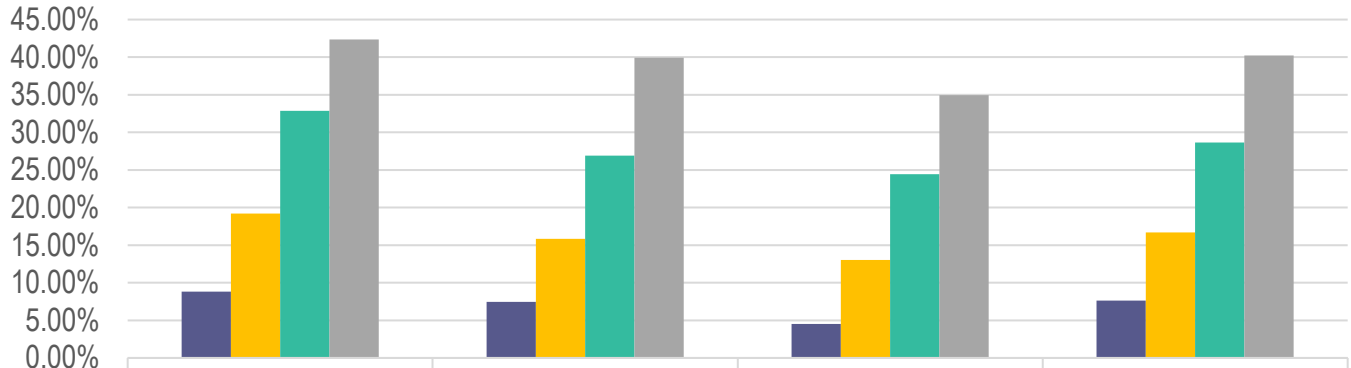
Figure 13. Tracking Measure #11b Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication - Continuation and Maintenance Phase, Age 2 to 12 Years



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	60.29%	37.97%	58.33%	48.30%
Q2 2022	60.83%	38.10%	65.52%	48.31%
Q3 2022	55.69%	38.92%	65.00%	46.88%
Q4 2022	55.37%	37.86%	66.67%	45.95%

Measure Description: The percentage of members 6 to 12 years of age with a prescription dispensed for attention-deficit/hyperactivity disorder medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Note: MCO and aggregate rates are accumulative.

Figure 14. Tracking Measure #12 Child and Adolescent Well-Care Visits, Age 3 to 21 Years



	BCBS	PHP	WSCC	Centennial Care 2.0 Aggregate
Q1 2022	8.83%	7.46%	4.53%	7.62%
Q2 2022	19.22%	15.84%	13.02%	16.68%
Q3 2022	32.87%	26.92%	24.43%	28.66%
Q4 2022	42.34%	39.94%	34.94%	40.23%

Measure Description: The percentage of members ages 3 to 21 years who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year.
Note: MCO and aggregate rates are accumulative.

Hospital Quality Measure Monitoring

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

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

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

The Human Services Department selected 2019 aggregate facility rates as the baseline statistic and the MCO aggregate 2019 audited HEDIS rates reported for 2019 as the target. The Human Services Department aligned the metrics associated with the overarching state-selected measures to improve outcomes for members. Table 2 shows aggregate facility rates for each measure and analysis for each metric selected compared to the baseline data and target.

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Table 2: Hospital Quality Monitoring – Not for Profit, For Profit, and Community Tribal Hospitals, Measurement Years 2019 to 2022

Metric	Hospital Baseline 2019 Rate	Hospital Measurement 2020 Rate	Hospital Measurement 2021 Rate	Hospital Measurement 2022 Rate	+/- Percentage Point Difference between 2019 and 2022 Rates	Target Rate	+/- Percentage Point Difference Between 2022 Rate and Target
Not For Profit Hospitals							
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.89%	14.47%	12.16%	12.14%	+1.75	9.87%	-2.27
Comprehensive Diabetes Care: HbA1c Testing	46.59%	43.69%	55.32%	76.58%	+29.99	83.41%	-6.83
Follow-Up After Hospitalization for Mental Illness – 30 Days	11.92%	14.45%	23.04%	59.82%	+47.90	40.29%	+19.53
For Profit Hospitals							
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	17.20%	15.25%	8.10%	12.32%	+4.88	9.87%	-2.45
Comprehensive Diabetes Care: HbA1c Testing	62.52%	59.29%	74.21%	77.71%	+15.19	83.41%	-5.70
Follow-Up After Hospitalization for Mental Illness – 30 Days	13.13%	16.67%	25.20%	55.65%	+42.52	40.29%	+15.36
Community Tribal Hospitals							
Plan All-Cause Readmissions *(Lower rate indicates better performance)*	13.28%	12.91%	9.87%	12.35%	+0.93	9.87%	-2.48
Comprehensive Diabetes Care: HbA1c Testing	44.70%	46.87%	56.48%	61.87%	+17.17	83.41%	-21.54
Follow-Up After Hospitalization for Mental Illness – 30 Days	5.99%	8.58%	19.42%	55.17%	+49.18	40.29%	+14.88

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

Table 3 displays the University of New Mexico Hospital's rates for each measure and analysis for each of the metrics selected in comparison to the baseline data and target for the rating period covering January 1, 2022, through December 31, 2022. Performance targets were determined with the provider based on a review of current performance by the provider, setting reasonably achievable goals for performance improvement.

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

Table 3: Hospital Quality Monitoring – University of New Mexico Hospital Metrics, Measurement Years 2019 to 2022

Metric	University of New Mexico Hospital Baseline 2019 Rate	University of New Mexico Hospital Measurement Year 2021 Rate	University of New Mexico Hospital Measurement Year 2022 Rate	+/- Percentage Point Difference between 2019 and 2022 Rates	2022 Target Rate	+/- Percentage Point Difference Between 2022 Rate and 2022 Target Rate	Target Status (Met or Not Met)
1 – Deaths among patients with serious treatable complications after surgery *(Lower rate indicates better performance)*	151.2	149.11	149.04	+2.16	150.52	+1.48	Met
2 – Percentage of outpatient computed tomography (CT) scans of the abdomen that were "combination," or double scans *(Lower rate indicates better performance)*	4.5%	4.31%	4.34%	+0.16	4.50%	+0.16	Met
3 – Serious complications that patients experienced during a hospital stay or after having a certain inpatient procedure *(Lower rate indicates better performance)*	1.29%	1.82%	1.84%	-0.55	1.25%	-0.59	Not Met
4 – Patients with alcohol abuse who received a brief intervention during their hospital stay[1]	12%	81.25%	47.81%	+35.81	13.50%	+34.31	Met
5 – Communication with Doctors (HCAHPS)	79%	79%	74.37%	-4.63	79.60%	-5.23	Not Met
6 – Communication with Nurses (HCAHPS)	76.8%	77%	71.52%	-5.28	77.30%	-5.78	Not Met
7 – Follow-Up After Emergency Department Visit for Mental Health – 7 Day (HEDIS)	38.05%	49.65%	41.36%	+3.31	38.55%	+2.81	Met
8 – Follow-Up After Emergency Department Visit for Mental Health – 30 Day (HEDIS)	52.74%	63.80%	61.51%	+8.77	53.24%	+8.27	Met
9 – Follow-Up After Hospitalization for Mental Health – 7 Day (HEDIS)	31.34%	32.50%	36.70%	+5.36	34.37%	+2.33	Met
10 – Follow-Up After Hospitalization for Mental Health – 30 Day (HEDIS)	58.41%	53.75%	62.23%	+3.82	58.91%	+3.32	Met

[1] For measurement year 2021, the University of New Mexico Hospital did not apply the same methodology used by the Human Services Department to calculate the baseline and target rates.
HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems.

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

The Human Services Department selected the 2020 Hospital Compare National Average rates as the baseline statistic and the 2021 Hospital Compare National Average rates as the targets for the 2022 Trauma Hospital Directed Payment. The Human Services Department aligned the metrics associated with the overarching state-selected measures to improve outcomes for members. Table 4 shows facility rates for each measure and analysis for each metric selected compared to the baseline data and target. (Note: UNM Sandoval Regional Medical Center commenced reporting in measurement year 2022.)

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

Table 4: Hospital Quality Monitoring – Trauma Hospitals, Measurement Years 2020 to 2022

Metric/Hospital Name	Baseline 2020 National Average Rate	Hospital Measurement Year 2020 Rate	Hospital Measurement Year 2021 Rate	Hospital Measurement Year 2022 Rate	2022 Target Rate	+/- Difference Between 2021 and 2022 Rates	Target Status (Met/ Not Met)
Communication with Doctors – Patient experience with how well doctors explained things, listened carefully, and treated patients with courtesy and respect during their hospital stay.							
University of New Mexico (level 1)	81	75	88	72	80	-8	Not Met
Carlsbad Medical Center (level 3)	81	69	88	72	80	-8	Not Met
Christus St. Vincent Regional Medical Center (level 3)	81	75	91	73	80	-7	Not Met
Eastern New Mexico Medical Center (level 3)	81	60	83	66	80	-14	Not Met
Gerald Champion Regional Medical Center (level 3)	81	74	86	71	80	-9	Not Met
Mountain View Regional Medical Center (level 3)	81	72	88	74	80	-6	Not Met
San Juan Regional Medical Center (level 3)	81	66	85	73	80	-7	Not Met
UNM Sandoval Regional Medical Center (level 3)	81	Not Available	Not Available	78	80	-2	Not Met
Gila Regional Hospital (level 4)	81	78	93	83	80	+3	Met
Memorial Medical Center (level 4)	81	74	88	74	80	-6	Not Met
Miners Colfax Medical Center (level 4)	81	91	87	83	80	+3	Met
Nor-Lea General Hospital (level 4)	81	86	81	88	80	+8	Met
Sierra Vista Hospital (level 4)	81	100	71	73	80	-7	Not Met
Union County General Hospital (level 4)	81	77	69	77	80	-3	Not Met
Discharge Information – Patient experience at discharge in receiving information about what to do during their recovery at home.							
University of New Mexico (level 1)	86	86	86	84	86	-2	Not Met
Carlsbad Medical Center (level 3)	86	84	81	77	86	-9	Not Met
Christus St. Vincent Regional Medical Center (level 3)	86	81	84	80	86	-6	Not Met
Eastern New Mexico Medical Center (level 3)	86	73	77	79	86	-7	Not Met
Gerald Champion Regional Medical Center (level 3)	86	88	85	82	86	-4	Not Met
Mountain View Regional Medical Center (level 3)	86	81	81	80	86	-6	Not Met
San Juan Regional Medical Center (level 3)	86	86	82	84	86	-2	Not Met
UNM Sandoval Regional Medical Center (level 3)	86	Not Available	Not Available	83	86	-3	Not Met
Gila Regional Hospital (level 4)	86	83	86	87	86	+1	Met
Memorial Medical Center (level 4)	86	85	84	85	86	-1	Not Met
Miners Colfax Medical Center (level 4)	86	89	92	89	86	+3	Met
Nor-Lea General Hospital (level 4)	86	96	86	88	86	+2	Met
Sierra Vista Hospital (level 4)	86	72	72	74	86	-12	Not Met
Union County General Hospital (level 4)	86	88	92	75	86	-11	Not Met

IPRO's Assessment of the New Mexico Medicaid Quality Strategy

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

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

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

Between measurement years 2021 and 2022 statewide performance met or exceeded targets in areas related to postpartum care, antidepressant medication management, initiation of treatment for substance use, and follow-up care after emergency department visits or hospitalizations for mental illness.

Opportunities to improve health outcomes exist statewide. As evidenced by 2022 state- and MCO-level performance, increased attention to primary and preventive care for children, prenatal care, and appropriate screenings for members on antipsychotic medications, is suggested.

Recommendations to the New Mexico Human Services Department

Per *Title 42 Code of Federal Regulations 438.364 External quality review results (a)(4)*, this report is required to include a description of how the Human Services Department can target the goals and the objectives outlined in its Medicaid Quality Strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to Centennial Care 2.0 enrollees. IPRO's recommendations to the Human Services Department are presented in **Table 5**.

Table 5: Recommendations to the Human Services Department

Recommendation	Suggested Application of Recommendation
1. Clarify contract language regarding requirements for credentialing and recredentialing.	▪ In future managed care service agreements, state the length of time that a disclosure is valid once signed. ▪ In future managed care service agreements, state that valid disclosures must be obtained before credentialing and recredentialing applications are approved.
2. Clarify contract language regarding the requirement for an in-home assessment following an inpatient stay.	▪ In future managed care service agreements, state that an in-home assessment is required for all members transitioning from an inpatient stay.

Recommendation	Suggested Application of Recommendation
	▪ In future managed care service agreements, strike the following language from citation 4.4.16.1.4, "may be in need of community benefits." ▪ In future managed care service agreements, state that an assessment conducted while the member is inpatient does exempt the MCO from the requirement to conduct an in-home assessment.
3. Clarify contract language regarding potential enrollee access to MCO information.	▪ In future managed care service agreements, state that the MCO must establish processes for potential enrollees to request and receive information from the MCO by mail, telephone, and electronically.
4. Conduct a focused review on members transitioning between MCOs to evaluate the quality of care provided during the rollover to Turquoise Care.	▪ As part of the 2024 Compliance Review, instruct the external quality review organization to conduct file reviews on members transitioning between MCOs.
5. At the time of enrollment, require MCOs to provide new enrollees with at least three primary care providers to select from, and a list of in-network pharmacies.	▪ The geographical location of the suggested primary care providers and local pharmacies must meet time and distance standards based on the enrollee's residential address. ▪ The suggested primary care providers must have an open panel and meet the cultural needs of the enrollee.
6. Increase the frequency of secret shopper surveys.	▪ Change the secret shopper survey schedule from semi-annually to quarterly or monthly.
7. Establish thresholds, or targets, for the MCOs to achieve.	▪ Establish a threshold for timely appointments. ▪ Establish a threshold for the reporting of provider types with low counts.
8. Define "adequate access to specialty providers."	▪ Work with IPRO to identify an indicator that informs the MCOs and the Human Services Department when members have inadequate access to specialty providers. ▪ Develop a standardized methodology for MCOs to calculate the optimal numbers of providers needed, by specialty, to adequately service their Medicaid populations. ▪ In cases where an MCO does not have enough providers in-network to meet the optimal numbers, the MCO should be required to report these specialties as "providers with low counts" in *Human Services Department Report #3*.
9. Enhance MCO provider directory requirements.	▪ Establish standard filter options to improve member identification of providers. ▪ Include date of most current training for cultural competency. ▪ Standardize how provider accessibility details are described. ▪ Develop a tool or process that evaluates MCO adherence to provider directory requirements.
10. Increase enrollee use of mail order pharmacy benefit to mitigate access barriers and to improve member medication adherence.	▪ Establish schedule for MCO reporting of mail order pharmacy utilization.

Recommendation	Suggested Application of Recommendation
11. Take enforcement actions against an MCO for failure to comply with access requirements.	▪ Require non-compliant MCOs to develop corrective action plans. ▪ Suspend enrollment for non-compliant MCOs. ▪ Suspend auto assignments for non-compliant MCOs. ▪ Limit, suspend, or terminate enrollment activities for non-compliant MCOs. ▪ Deny payment for new enrollees for non-compliant MCOs. ▪ Public reporting of MCO performance related to access. ▪ Incorporate access into the evaluation methodology of the future star rating system.

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Medicaid Managed Care Organization Profiles

In 2022, the Human Services Department contracted with three MCOs to administer health care benefits under the Centennial Care 2.0 program: BCBS, PHP, and WSCC.

Table 6 displays profiles for each Centennial Care 2.0 MCO. For each MCO, the table displays the total Medicaid enrollment for calendar year 2022, the most current NCQA accreditation rating achieved, and the MCO's website address.

Table 6: Centennial Care 2.0 MCO Profiles

MCO	Medicaid Managed Care Start Date	Medicaid Enrollment as of 12/2022[1]	NCQA Accreditation Status[2]
Blue Cross and Blue Shield of New Mexico (BCBS) https://www.bcbsnm.com/	01/01/2014	297,426	Accredited
Presbyterian Health Plan, Inc. (PHP) https://www.phs.org/	01/01/2014	426,906	Accredited
Western Sky Community Care, Inc. (WSCC) https://www.westernskycommunitycare.com/	01/01/2019	91,466	Accredited

[1] Data Sources: Medicaid Enrollment Report-December 2022.

[2] Status is as of June 30, 2023. NCQA Website: https://reportcards.ncqa.org/health-plans.

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Information Systems Capabilities Assessment – Technical Summary

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

The Centers for Medicare & Medicaid Services prescribes that at the conclusion of the information systems capabilities assessment review, the external quality review organization is to compile and analyze the information gathered through the preliminary information systems capabilities assessment review and from the MCO staff interviews. After completing its analysis, the external quality review organization writes a statement of findings about the MCO's information systems. The assessment levels used by IPRO are displayed in Table 7 while the assessment results for each MCO are displayed in Table 8.

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

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

Table 7: IPRO's Information Systems Capabilities Assessment Determination Levels

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

Description of Data Obtained

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

Comparative Results

IPRO's assessment determined that the Medicaid MCOs met or exceeded the standards reviewed. Table 8 displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO.

Table 8: MCO Information Systems Capabilities Assessment Results, 2021-2022

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

Met means that the MCO met or exceeded standards.

External Quality Review Activity 1. Validation of Performance Improvement Projects – Technical Summary

Objectives

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

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

As required by citation *4.12.4.10* of the *Medicaid Managed Care Services Agreement* and S*ubsection 18.1* of the *Managed Care Policy Manual*, New Mexico Medicaid MCOs must conduct at least five performance improvement projects on priority topic areas of the Human Services Department's choosing and consistent with federal requirements. For 2022, the MCOs were required to conduct performance improvement projects for the following areas:

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

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Human Services Department for the 15 performance improvement projects underway in 2022.

PHP started new performance improvement projects in 2022, while BCBS and WSCC continued performance improvement projects initiated in 2021 and 2019, respectively. Table 9 shows the titles of the MCOs' performance improvement projects underway in 2022.

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Table 9: MCO Performance Improvement Project Titles, 2022

MCO	Performance Improvement Project Titles
BCBS	▪ Long-Term Services and Supports – Urinary Tract Infection ▪ Timeliness of Prenatal Care and Postpartum Care ▪ Adult Obesity ▪ Diabetes Management and Short-Term Complications Admissions Rate and HbA1c Testing ▪ Screening and Management for Clinical Depression
PHP	▪ Success Within the Self-Directed Community Benefit Program ▪ Decreasing Pregnancy Risks for Native American Women in New Mexico ▪ Adult Obesity ▪ Diabetes Prevention and Management ▪ Diagnosing Depression for Improved Behavioral and Physical Health Outcomes
WSCC	▪ Fall Risk and Prevention Program ▪ Addiction in Pregnancy Program ▪ Adult Weight Management Program ▪ Diabetes Prevention and Management ▪ Management for Clinical Depression

Technical Methods of Data Collection and Analysis

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

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

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

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

are assigned based on the number of points (or percentage score) achieved. Table 10 displays the compliance levels and their applicable score ranges.

Table 10: IPRO's Performance Improvement Project Validation Scoring and Compliance Levels

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

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

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

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

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

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

Description of Data Obtained

For the 2022 external quality review, IPRO utilized performance improvement project reports populated by the MCOs during 2022 and 2023. Information obtained included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

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

WSCC's conduct of the *Diabetes Management and Prevention* and *Clinical Depression Screening and Follow-up* performance improvement projects did not fully align with Protocol 1. Through the validation process IPRO determined that for WSCC's *Diabetes Management and Prevention* and *Clinical Depression Screening and Follow-up* performance improvement projects, data collection procedures did not allow for consistent and accurate data collection over the time periods studied.

A summary of the validation assessments is in Table 11.

Table 11: MCO Performance Improvement Project Validation Results, 2022

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

Full means that the MCO received a validation score that was between 90% and 100%. **Moderate** means that the MCO received a validation score that was between 89% and 80%.

Performance improvement project summaries, including aim, interventions, results, and validation findings are reported in Table 12, Table 13, and Table 14 for BCBS, PHP and WSCC, respectively. Table 15, Table 16, Table 17, Table 18, and Table 19 display summaries of IPRO's improvement assessment for each project indicator by performance improvement project topic by MCO.

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Table 12: BCBS's Performance Improvement Project Summaries, 2022

Blue Cross Blue Shield's Performance Improvement Project Summaries
Title: Long-term Care Services – Urinary Tract Infection **Initiation Year:** 2021. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to implement sustainable interventions that improve services and member outcomes by decreasing the occurrences of urinary tract infections as rate per 1,000 days for the total long-term care residents by 10 percent overall in long-term care residents among BCBS Centennial Care community adults ages 18 years and older from 4.78 to 4.30 by December 31, 2022. Provider-level Interventions in 2022: ▪ BCBS continued to mail materials to providers including a presentation on reducing urinary tract infections for long-term care facilities and a flyer on hand hygiene. ▪ BCBS continued to identify providers for direct engagement based on urinary tract infections occurrences.
Title: Timeliness of Prenatal and Postpartum Care **Initiation Year:** 2021. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to increase baseline rates of timeliness of prenatal care (58.98%) and postpartum care (51.21%) to the goal of 82.73% and 65.95%, respectively, by December 31, 2022, for mothers who have had a live birth during the measurement year. Member-level Interventions in 2022: ▪ BCBS continued to promote to members the Special Beginnings Program, a voluntary maternity program that helps members better understand and manage their pregnancy through prenatal and postpartum health education and guidance. ▪ BCBS continued to promote the available value-added services related to infant care. ▪ BCBS continued to refer BCBS members to the Centennial Care Home Visiting Program with the University of New Mexico's Center of Development and Disability and ENMRSH, Inc. ▪ BCBS continued to conduct outreach calls to postpartum members to provide education on the importance of postpartum care and to provide these members with appointment scheduling assistance. Members who were unreachable received outreach letters. ▪ BCBS continued to outreach through text messages and emails to members within their first trimester of pregnancy with educational material and appointment scheduling assistance. ▪ BCBS continued to promote the Centennial Care Rewards program, highlighting available rewards for prenatal and postpartum care. ▪ BCBS continued to staff a 24-hour toll-free hotline with maternity nurses. ▪ BCBS continued to maintain member education materials on the BCBS website, including a video on the importance of prenatal and postpartum care. ▪ BCBS hosted a community baby shower in Roswell, New Mexico. Provider-level Interventions in 2022: ▪ BCBS continued its effort to increase the occurrence of joint operation meetings with providers as part of the provider incentive program. ▪ BCBS published articles in the provider newsletter. ▪ BCBS continued its participation in quarterly Certified Nurse-Midwives Advisory Board meetings. ▪ BCBS offered monthly gaps in care lists to providers to encourage closing gaps in care within the first trimester of pregnancy.

Blue Cross Blue Shield's Performance Improvement Project Summaries
MCO-level Interventions in 2022: ▪ BCBS continued to access laboratory services to support early outreach to pregnant members.
Title: Adult Obesity **Initiation Year:** 2021. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to improve member health outcomes by decreasing the prevalence of adult members diagnosed with obesity by two percentage points from 4.79% to 4.69%; and by increasing the hybrid and administrative blood pressure control rates among members diagnosed with hypertension from 51.09% to 55.09% and from 7.52% to 25.00%, respectively, by December 31, 2022. Member-level Interventions in 2022: ▪ BCBS published articles in the member newsletter on blood pressure management; the benefits of weight loss on blood pressure, cholesterol, and blood sugar; behaviors that influence mental and physical health; health management programs available to members; and diabetes retinal eye exams. ▪ BCBS continued to publish member-facing social media messages on hypertension and diabetes care. Provider-level Interventions in 2022: ▪ BCBS published articles in the provider newsletter on blood pressure management and clinical guidelines for cholesterol screenings in adults ages 40 to 75 years. ▪ BCBS continued to issue gaps in care reports to providers to support direct provider outreach to their patients. MCO-level Interventions in 2022: ▪ BCBS trained care coordination staff on the HEDIS *Controlling Blood Pressure* measure and encouraged staff to use BCBS deskside handbook.
Title: Diabetes Management and Short-Term Complications Admissions Rate and HbA1c Testing **Initiation Year:** 2021. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to improve services and member outcomes through interventions focused on decreasing the rate of hospital admissions by four points per 100,000 member months among adult members with diabetes-related short-term complications by December 31, 2022. Member-level Interventions in 2022: ▪ BCBS continued to distribute personal care trackers to members diagnosed with diabetes. The trackers included: reminders about diabetes testing, areas to document their biannual HbA1c and blood pressure values, annual eye exam results, and blood pressure readings. ▪ BCBS delivered health education via text to adult members with diabetes. ▪ BCBS and DentaQuest targeted health education via mail to members with diabetes. ▪ BCBS produced a diabetes health education video for social media platforms. Provider-level Interventions in 2022: ▪ BCBS continued to notify providers of members who had a short-term complications admission event. Notified providers were invited to discuss plans of care with the assigned BCBS care coordinator. ▪ BCBS published an article and questionnaire in the provider newsletter on diabetes short-term complications. The questionnaire gauged provider knowledge on diabetes short-term complications. MCO-level Interventions in 2022:

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▪ BCBS continued to share gaps in care lists with CareNet to support targeted member outreach calls. ▪ BCBS administered a quarterly survey to providers who were notified of a member's short-term complication admission event. The survey captured information to be used by BCBS's Quality Improvement Department.
Title: Screening and Management for Clinical Depression **Initiation Year:** 2021. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: BCBS aims to increase the antidepressant medication adherence for members ages 18 to 64 years to 56.7% for the acute phase and to 39.4% for the continuation phase, and for members ages 65 years and older to 84.0% for the acute phase and to 64.0% for the continuation phase over the next two years. BCBS aims to increase the rate of depression screening for members ages 18 to 64 years to 10.6% and for members ages 65 years and older to 11.4% over the next two years. Member-level Interventions in 2022: ▪ BCBS continued to conduct member engagement telephone calls prior to the member's medication refill date to encourage the member to refill their prescription for antidepressant medication. During the call, members were assessed for care coordination and support services. ▪ BCBS incentivized members to refill antidepressant medication prescriptions. Provider-level Interventions in 2022: ▪ BCBS continued to provide educational materials on the HEDIS *Antidepressant Medication Management* measure and on depression screening to providers through the BCBS website and an online seminar. ▪ BCBS's Behavioral Health Quality Department delivered education on the HEDIS *Antidepressant Medication Management* measure during monthly provider meetings. ▪ BCBS emailed providers with reminders on how to access the HEDIS *Antidepressant Medication Management* measure tip sheet on the BCBS website. MCO-level Interventions in 2022: ▪ BCBS alerted community pharmacies when members fell out of compliance with antidepressant medication management.

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Table 13: PHP's Performance Improvement Project Summaries, 2022

PHP's Performance Improvement Project Summaries
Title: Success Within the Self-Directed Community Benefit Program **Initiation Year:** 2022. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: PHP aims to support the self-directed community benefit population such that less than 10% of self-directed community benefit members transition from the Self-Directed Community Benefit to the Agency Based Community Benefit model by December 31, 2022. MCO-level Interventions in 2022: ▪ PHP enhanced its care coordination approach to ensure complex case staffing includes a Self-Directed Community Benefit subject matter expert. ▪ PHP engaged with Self-Directed Community Benefit agencies and Agency-Based Community Benefit providers to expand member access to personal care services under the Self-Directed Community Benefit model.
Title: Decreasing Pregnancy Risks for Native American Women in New Mexico **Initiation Year:** 2022. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: PHP aims to decrease high-risk pregnancy complications resulting in healthier babies at birth by developing a co-operative program with community agencies that can be duplicated in other areas of New Mexico. Member-level Interventions in 2022: ▪ PHP referred members to its Community Health Workers Department for outreach. Provider-level Interventions in 2022: ▪ PHP published educational articles in the provider newsletter. ▪ PHP educated providers on available member resources and prenatal care reward programs. MCO-level Interventions in 2022: ▪ PHP established a partnership with the Families First Pregnancy Program to assist members with accessing supports.
Title: Adult Obesity **Initiation Year:** 2022. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: PHP aims to reduce the proportion of adult members with obesity by 2 percentage points from the prior year. Member-level Interventions in 2022: ▪ 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. Provider-level Interventions in 2022: ▪ Executed a referral communication campaign on the obesity-related programs available to members.
Title: Diabetes Prevention and Management **Initiation Year:** 2022. **End Year:** 2024.

PHP's Performance Improvement Project Summaries
Validation Summary: There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: PHP aims to decrease the rate of admissions related to diabetes short-term complications by 1% annually and increase the percentage of members with controlled HbA1c by 1% annually through the coordination of activities that address healthy food needs for members with diabetes. Member-level Interventions in 2022: ▪ PHP continued targeted telephonic education and outreach to members identified by the MCO as non-adherent diabetes for diabetes-related screenings and diabetes management.
Title: Diagnosing Depression for Improved Behavioral and Physical Health Outcomes **Initiation Year:** 2022. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: PHP aims to increase depression screening among adult members by 20% from the baseline and meet or exceed regional Medicaid benchmarks for the HEDIS *Antidepressant Medication Management* measure. Member-level Interventions in 2022: ▪ PHP mailed an educational brochure to members to increase awareness of depression symptoms and management. Provider-level Interventions in 2022: ▪ PHP offered quarterly training to providers on screening for depression and appropriate coding.

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Table 14: WSCC's Performance Improvement Project Summaries, 2022

WSCC's Performance Improvement Project Summaries
Title: Fall Risk and Prevention Program **Initiation Year:** 2019. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to decrease the rate of fall-related hospitalization claims by 2% from baseline for long-term services and supports members ages 60 years or older living in the community, by the end of 2022. MCO-level Interventions in 2022: ▪ WSCC continued to outreach to members who had a fall event or deemed to be at-risk for a fall event for referral to fall prevention programs. ▪ WSCC continued to coordinate with the New Mexico Department of Health to refer members to fall risk programs such as A Matter of Balance, Otago, Tai Chi for Arthritis, and Stopping Elderly Accidents, Deaths, and Injuries. Provider-level Interventions in 2022: ▪ WSCC conducted provider engagement visits to deliver education on fall prevention, proper coding, and programs available to members.
Title: Addiction in Pregnancy Program **Initiation Year:** 2019. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to increase the HEDIS *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure rate among pregnant members by 2% from the baseline by the end of 2022. Member-level Interventions in 2022: ▪ WSCC continued to assign pregnant members who had indicators of substance abuse to a high-risk obstetrics care coordinator. Care coordination included motivational interviewing, prenatal and postpartum education and support, primary care provider assignment, education on medication-assisted treatment, and initiation of a pregnancy substance use disorder journal. Provider-level Interventions in 2022: ▪ WSCC conducted provider engagement visits to deliver education on the importance of notification of pregnancy communications and the WSCC Obstetrics/Gynecology Incentive Program.
Title: Adult Weight Management Program **Initiation Year:** 2019. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to decrease the percentage of members ages 19 years and older whose documented body mass index is equal to or greater than 30 kg/m by 1% from baseline by the end of 2022. Member-level Interventions in 2022: ▪ WSCC promoted its weight management program to members with body mass indexes of 25 kg/m and higher. Under the weight management program, members received educational materials, nutritional coaching, and access to self-management tools. Provider-level Interventions in 2022: ▪ WSCC continued outreach to educate providers on appropriate billing for body mass index assessments and the importance of documenting body mass index.
Title: Diabetes Prevention and Management

WSCC's Performance Improvement Project Summaries
Initiation Year: 2019. **End Year:** 2024. **Validation Summary:** There are no validation findings indicating the credibility of the performance improvement project results was at risk.
Aim: WSCC aims to increase the HbA1c testing rate by 3% from baseline and decrease the rate of admissions related to diabetes short-term complications by 2 points or meet the Centers for Medicare & Medicaid Services' Core Set of Adult Health Care Quality Measures benchmark by the end of 2022. Member-level Interventions in 2022: ▪ WSCC continued to conduct care coordination for members with a hospital admission for a diabetes-related short-term complication. ▪ WSCC continued to collaborate with community health workers and peer support workers to conduct member coaching for diabetes management. Provider-level Interventions in 2022: ▪ WSCC continued to outreach to educate providers on appropriate billing for lab results, medication adherence, diabetes medications, and diabetic screening guidelines.
Title: Management for Clinical Depression **Initiation Year:** 2019. **End Year:** 2024. **Validation Summary:** There are no validation findings that indicate that the credibility of the performance improvement project results was at risk
Aim: WSCC aims to increase the rate of effective acute and continuous phase treatment of antidepressant medication management by 2% from baseline or meet the current NCQA regional Medicaid benchmark for the HEDIS *Antidepressant Medication Management* measure by the end of 2022. Member-level Interventions in 2022: ▪ WSCC continued to outreach to members who had a history of mediation non-adherence. Provider-level Interventions in 2022: ▪ WSCC continued to conduct outreach to educate providers on appropriate depression screening tools and the requirement to implement a follow-up plan for members diagnosed with depression. ▪ WSCC continued to collaborate with pharmacies to implement 90-day refills and to contact prescribing providers when a request for an updated prescription is needed.

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Table 15, Table 16, Table 17, Table 18, and Table 19 display summaries of IPRO's improvement assessment for each project indicator by performance improvement project topic by MCO. In these tables, IPRO's assessment of indicator performance was based on the following categories:

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

Table 15: MCO Indicator Performance – Long-term Services and Supports Topic

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
BCBS	Indicator 1 – Rate of urinary tract infection events per 1,000 days for the total long-term care resident population *(lower rate indicates better performance)*	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members 18 years of age and older who rate their health care as a 9 or 10	Performance improvement demonstrated but target not met.
PHP	Indicator 1 – Volume of members who successfully remained eligible within the Self-Directed Community Benefit	Performance improvement demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
	Indicator 2 – Volume of members who were voluntarily terminated from the Self-Directed Community Benefit *(lower rate indicates better performance)*	Performance improvement demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
	Indicator 3 – Volume of members for whom PHP did not receive a grievance related to their experience within the Self-Directed Community Benefit	Performance decline demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
WSCC	Indicator 1 – Rate of members who experienced a fall-related hospitalization via claims in the population of long-term services and supports members ages 60 years and older living in the community during the measurement year *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.

Table 16: MCO Indicator Performance – Prenatal and Postpartum Care Topic

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
BCBS	**Indicator 1** – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	Performance improvement demonstrated and target exceeded.
	Indicator 3 – How satisfied are you with the help you received to coordinate your care in the last 6 months? (Satisfied or Very Satisfied)	Performance improvement demonstrated and target exceeded.
PHP	**Indicator 1 –** The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	Performance 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	Performance improvement demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
	Indicator 3 – The percentage of high-risk pregnant women who engage in any community service program	Currently unable to evaluate performance. PHP introduced Indicator 3 in measurement year 2022.
WSCC	**Indicator 1** – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who were initiated for treatment for alcohol and other substances 14 days within diagnosis	Performance improvement demonstrated and target exceeded
	Indicator 2 – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who engaged in treatment for alcohol and other substances within 34 days of initial treatment	Performance improvement demonstrated and target exceeded
	Indicator 3 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	Performance improvement demonstrated and target exceeded.

Table 17: MCO Indicator Performance – Adult Obesity Topic

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
BCBS	**Indicator 1** – The percentage of members ages 18 to 74 years who had at least one claim with an obesity diagnosis during the measurement year *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
	Indicator 2 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (less than 140/90) in the most recent blood pressure reading during the measurement year (hybrid review)	Performance improvement demonstrated but target not met.
	Indicator 3 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (less than 140/90) in the most recent blood pressure reading during the measurement year (administrative review)	Performance improvement demonstrated and target exceeded.
	Indicator 4 – The percentage of members ages 18 to 75 years with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year that is greater than 9% 1 *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
	Indicator 5 – The percentage of members 18 years of age and older who received material from the MCO about good health and how to stay healthy	Performance decline demonstrated and target not met.
PHP	**Indicator 1** – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members ages 19 and older with a primary diagnosis of obesity in the measurement year *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
WSCC	**Indicator 1** – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	Performance improvement demonstrated but target not met.
	Indicator 2 – The percentage of members ages 19 years and older with a documented body mass index of greater than 30 kg/m *(lower rate indicates better performance)*	Performance improvement demonstrated and target exceeded.

Table 18: MCO Indicator Performance – Diabetes Prevention and Management Topic

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
BCBS	**Indicator 1** – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 18 to 64 years *(lower rate indicates better performance)*	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, ages 65 years and older *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
	Indicator 3 – The percentage of members ages 18 to 75 years with diabetes during the measurement year who complete an HbA1c test	Performance decline demonstrated and target not met.
	Indicator 4 – The percentage of providers satisfied with the timeliness of discharge information received	Performance improvement demonstrated and target exceeded.
	Indicator 5 – The percentage of providers indicating having received adequate information about medication at discharge	Performance improvement demonstrated and target exceeded.
	Indicator 6 – The percentage of members indicating ease of getting necessary care, tests or treatment needed (Always or Usually)	Performance decline demonstrated and target not met.
PHP	**Indicator 1 –** Short-term complications rate for Native Americans in the northwest part of New Mexico state per 100,000 members *(lower rate indicates better performance)*	Performance decline demonstrated and target not met.
	Indicator 2 – The percentage of Native Americans residing in the northwestern region of New Mexico state with a hemoglobin A1c rate that is lower than 8%	Performance improvement demonstrated but target not met.
WSCC	**Indicator 1** – Rate of admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members ages 18 to 75 years of age with diabetes (type 1 and type 2) who had a HbA1c screening	Performance improvement demonstrated and target exceeded.

Table 19: MCO Indicator Performance – Clinical Depression Screening and Follow-up

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
BCBS	**Indicator 1** – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance decline demonstrated and target not met.
	Indicator 3 – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance improvement demonstrated but target not met.
	Indicator 4 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance decline demonstrated and target not met.
	Indicator 5 – The percentage of members aged 18 to 64 years screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	Performance improvement demonstrated but target not met.
	Indicator 6 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	Performance improvement demonstrated but target not met.
PHP	**Indicator 1** – The percentage of members aged 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)	Performance decline demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.

MCO	Indicator Description	Assessment of Performance From Baseline to Measurement Year to 2022
	Indicator 2 – The percentage of members aged 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance decline demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
	Indicator 3 – The percentage of members aged 18 years older who had an outpatient visit with a physical or behavioral health provider and a diagnosis of major depression during the measurement year	Performance improvement demonstrated and target exceeded.
	Indicator 4 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	Performance improvement demonstrated and target exceeded. PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.
WSCC	Indicator 1 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	Performance improvement demonstrated and target exceeded.
	Indicator 2 – The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	Performance improvement demonstrated and target exceeded.
	Indicator 3 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	Performance improvement demonstrated but target not met.

External Quality Review Activity 2. Validation of Performance Measures – Technical Summary

Objectives

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

The Human Services Department selects a set of performance measures to evaluate the quality of care delivered by the MCOs to Centennial Care 2.0 members. For 2022, the Human Services Department required the MCOs to report 10 performance measures, of which two were related to maternal health, three to child and adolescent preventive care, and five to behavioral health care. The MCOs were also required to achieve specified levels of performance as determined by the Human Services Department-determined targets outlined in the *Medicaid Managed Care Services Agreement*. Measures required for the 2022 Human Services Department Performance Measure Program are presented in Table 23.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Human Services Department for measurement year 2022.

Technical Methods for Data Collection and Analysis

For measurement year 2022, the Centennial Care 2.0 MCOs were required to submit performance measure data to the Human Services Department based on NCQA's *HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans*. To ensure compliance with these reporting requirements, each MCO contracted with an NCQA-HEDIS certified software vendor and an NCQA-certified HEDIS compliance audit licensed organization. Table 20 displays vendors and compliance audit licensed organizations by MCO.

Table 20: MCO HEDIS Vendors and HEDIS Compliance Audit Licensed Organizations, Measurement Year 2022

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

The HEDIS vendor collected data and calculated performance measure rates on behalf of the MCO for measurement year 2022. The HEDIS vendor calculated rates using NCQA's *HEDIS Measurement Year 2022 Volume 2 Technical Specifications for Health Plans*.

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

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

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

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit, HEDIS compliance auditors assessed the MCO's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the MCO has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 21 displays these standards as well as the elements audited for the standard.

Table 21: Information System Capabilities Standards

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

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

An MCO meeting all Information System Capabilities standards required for successful HEDIS reporting and submitting HEDIS data to the Human Services Department according to contractual requirements were considered strengths during IPRO's external quality review. An MCO not meeting an Information Systems Capabilities standard was considered an opportunity for improvement during IPRO's review.

HEDIS Specification Standards

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

Performance Measure Validation

Each MCO's calculated rates for the HEDIS measure set were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 22 presents these outcome designations and their definitions. Performance measure validation activities included but were not limited to:

- confirmation that rates were produced with certified code or automated source code review approved logic;
- medical record review validation;
- review of supplemental data sources;

- review of system conversions/upgrades, if applicable;
- review of vendor data, if applicable; and
- follow-up on issues identified during documentation review or previous audits.

Table 22: NCQA Performance Measure Outcome Designations

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

NCQA: National Committee for Quality Assurance.

To conclude the 2022 audit, each MCO's NCQA-certified HEDIS auditor produced a final audit report and audit review table. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each MCO submitted these documents and final validated performance measure rates to the Human Services Department and IPRO.

IPRO reviewed each MCO's final audit report and audit review table to confirm that all performance measures were reportable, and that calculation of rates for these performance measures aligned with the Human Services Department's requirements. To assess the accuracy of the reported rates, IPRO recalculated rates using denominator and numerator data, compared MCO rates to NCQA's Quality Compass regional Medicaid benchmarks and analyzed rate-level trends to identify drastic changes in performance.

As part of the measurement year 2022 performance measure validation activity, IPRO reviewed MCO quality improvement plans to assess the impact of MCO-directed improvement activities on health outcomes related to the performance measures in **Table 23**.

Table 23 displays performance measure names and definitions, steward, method of data collection, available points, and targets. Each target is the result of the measurement year 2018 MCO aggregated audited HEDIS data, calculating an average increase for each year until reaching the *2018 Quality Compass*® (measurement year 2017) regional averages plus 1 percentage point. Failure to meet the Human Services Department-assigned target for an individual performance measure resulted in a monetary penalty based on 2% of the total capitation paid to

the MCO for the agreement year, divided by the number of performance measures specified for the agreement year.

Table 23: Performance Measure Descriptions and Available Points, Measurement Year 2022

Performance Measures (PM)	Steward	Data Collection Method[1]	Available Points	Measurement Year 2022 Target
PM 1 Well-Child Visits in the First 30 Months of Life – First 15 Months (W30):[2] The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits	NCQA	Administrative	1	64.82%
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 primary care provider or obstetrician/gynecologist and who had evidence of the following during the measurement year: counseling for physical activity	NCQA	Hybrid	1	58.14%
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	82.73%
PM 4 Timeliness of Prenatal and Postpartum Care – Postpartum Care (PPC): The percentage of deliveries that had a postpartum visit on or between 7 and 84 calendar days after delivery	NCQA	Hybrid	1	65.95%
PM 5 Childhood Immunization Status – Combination 3 (CIS): The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three inactivated polio vaccine (IPV); one measles, mumps, and rubella (MMR); three *Haemophilus influenza* type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday	NCQA	Hybrid	1	70.53%
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 6 months)	NCQA	Administrative	1	35.19%

Performance Measures (PM)	Steward	Data Collection Method[1]	Available Points	Measurement Year 2022 Target
PM 7 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation (IET): The total percentage of adolescent and adult members with a new episode of alcohol and other drug dependence who received: initiation of alcohol and other drug treatment	NCQA	Administrative	1	46.14%
PM 8 Follow-Up After Hospitalization for Mental Illness – 30 Days (FUH): The percentage of discharges for members 6 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	52.02%
PM 9 Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM): The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness within 30 days of the emergency department visit	NCQA	Administrative	1	46.50%
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	82.07%

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

[2] Formerly known as Well-Child Visits in the First Fifteen (15) Months of Life (W15).

NCQA: National Committee for Quality Assurance.

Description of Data Obtained

To conduct the validation of performance measure activity, IPRO reviewed *the 2021–2022 Centennial Care Information Systems Capabilities Assessment Report* and each MCO's HEDIS measurement year 2022 final audit report and measurement year 2022 audit review table.

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

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

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

Comparative Results

Each MCO's NCQA-certified HEDIS auditor determined that the HEDIS rates reported by the MCO for measurement year 2022 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. There were no data collection or reporting issues identified for BCBS and PHP. WSCC's issues identified by its HEDIS auditor were related to *5.0 Supplemental Data* and *6.0 Data Preproduction Processing* standards and did not prevent WSCC from reporting data to NCQA. Table 24 displays the results of Information Systems Capabilities review for each MCO.

Table 24: MCO Compliance with NCQA Information Systems Capabilities Standards, Measurement Year 2022

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

At the conclusion of the 2021–2022 information systems capabilities assessment, IPRO determined that the MCOs met or exceeded the standards reviewed. Table 8 displays the assessment topics reviewed and the assessment levels achieved for each topic by each MCO.

Table 25 displays the performance measure rates for each MCO, points earned, and Centennial Care 2.0 aggregate rates for measurement year 2022. To earn a point, the MCO's report rate had to meet or exceed the target rate. Green shading indicates that the displayed rate met or exceeded the measurement year target. BCBS earned seven points. PHP earned eight points. WSCC earned five points. For four performance measures, all MCOs reported rates that exceeded the Human Services Department targets. Five Centennial Care 2.0 rates exceeded their respective targets.

Table 25: MCO Performance Measure Rates, Measurement Year 2022

Performance Measure (PM)	Measurement Year 2022 Target Rate	BCBS Measurement Year 2022 Rate	PHP Measurement Year 2022 Rate	WSCC Measurement Year 2022 Rate	Centennial Care 2.0 Measurement Year 2022 Rate	Difference Between Centennial Care 2.0 Rate and Measurement Year Target (Percentage Points)
PM 1 W30 First 15 Months	64.82%	61.70%	65.98%	55.77%	63.16%	-1.66
PM 2 WCC Physical Activity	58.14%	59.61%	58.35%	51.34%	56.42%	-1.72
PM 3 PPC Prenatal Care	82.73%	82.97%	78.14%	78.35%	79.88%	-2.85
PM 4 PPC Postpartum Care	65.95%	70.80%	72.95%	67.64%	70.37%	+4.42
PM 5 CIS Combination 3	70.53%	70.80%	70.56%	60.10%	67.15%	-3.38
PM 6 AMM Continuation	35.19%	40.83%	42.33%	43.32%	41.87%	+6.68
PM 7 IET Initiation	46.14%	45.97%	55.10%	48.30%	50.97%	+4.83
PM 8 FUH 30 Days	52.02%	54.61%	55.03%	56.22%	55.02%	+3.00
PM 9 FUM 30 Days	46.50%	56.06%	59.36%	54.61%	57.61%	+11.11
PM 10 SSD	82.07%	78.21%	80.59%	79.04%	79.54%	-2.53
Total Points Earned (Max 10)		7	8	5		

Green shading indicates that the displayed rate met or exceeded the measurement year target. **Gray shading** indicates that the table cell is blank.

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

External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards – Technical Summary

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a MCO's compliance with federal Medicaid and Children's Health Insurance Program standards is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Human Services Department conducts a variety of oversight activities to ensure that the MCOs are following both federal and state Medicaid and Children's Health Insurance Program standards. These activities include the compliance review, which is conducted annually. The annual compliance review centers on the provision of Medicaid services and is conducted for the Centennial Care 2.0 MCOs.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review to determine managed care compliance with federal Medicaid and Children's Health Insurance Program standards. To meet this federal regulation, the Human Services Department contracted with IPRO to conduct the 2022 compliance reviews.

The 2022 Compliance Review activity took place between May 2023 and January 2024, including the review period of May 1, 2022, to December 31, 2022.

Technical Methods of Data Collection and Analysis

The compliance review included a comprehensive evaluation of MCO policies and procedures, member handbooks, provider handbooks, member files and other documents as needed to demonstrate compliance with the regulatory and/or contractual subject areas outlined in Table 26.

Table 26: 2022 Federal and Centennial Care 2.0 Compliance Review Subjects

Federal Medicaid and Children's Health Insurance Program Subjects Under Review	Centennial Care 2.0 Contract Subjects Under Review	Document Review	File Review
438.56 Disenrollment Requirements and Limitations	4.2 Enrollment	Yes	No
438.100 Enrollee Rights Requirements (including 438.10)	3.5 Cultural and Linguistic Competence, 4.8 Provider Network, 4.14 Member Materials, 4.15 Member Services	Yes	No
438.114 Emergency and Post Stabilization Services (including 422.113(c))	4.5 Benefits/Service Requirements and Limitations	Yes	No
438.206 Availability of Services	4.8 Provider Network	Yes	No
438.207 Assurances of Adequate Capacity and Services	4.8 Provider Network	Yes	No
438.208 Coordination and Continuity of Care (including 44.301(c)(1))	4.4 Care Coordination, 4.8 Provider Network, 7.16 Records and Audit	Yes	Yes

Federal Medicaid and Children's Health Insurance Program Subjects Under Review	Centennial Care 2.0 Contract Subjects Under Review	Document Review	File Review
438.210 Coverage and Authorization of Services (including 441.20)	4.5 Self-Directed Community Benefit, 4.10 Provider Payments, 4.12 Quality Assurance	Yes	Yes
438.214 Provider Selection (including 438.12)	4.8 Provider Network	Yes	Yes
438.224 Confidentiality (including Part 164 Subpart E)	7.26 Disclosure and Confidentiality of Information	Yes	No
438.228 Grievance and Appeal Systems (including 438.400, 438.402, 438.404, 431.211, 431.213, 431.214, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	4.16 Grievances and Appeals Systems	Yes	Yes
438.230 Subcontractual Relationships and Delegation	7.14 Major Subcontractors and Subcontractors, 7.16 Records and Audit	Yes	No
438.236 Practice Guidelines	4.12 Quality Assurance	Yes	No
438.242 Health Information Systems	4.19 Claims Management, 4.20 Information Systems	Yes	No
438.330 Quality Assessment and Performance Improvement Program	4.6 Self-Directed Community Benefit, 4.12 Quality Assurance	Yes	No
438.608 Program Integrity	4.17 Program Integrity	Yes	No
Not Applicable	4.6 Self-Directed Community Benefit	Yes	Yes
Not Applicable	4.9 Provider Agreements	No	Yes
Not Applicable	4.11 Provider Services	Yes	No
Not Applicable	4.12 Quality Assurance	Yes	No
Not Applicable	4.13 Patient Centered Initiatives	Yes	No
Not Applicable	7.16 Medical Records	Yes	No

For this review, each regulatory element is allocated one point, and assigned a determination of "met" or "not met." Definitions of these review determinations are presented in Table 27.

Table 27: Review Determination Definitions

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

Each regulatory element is allocated one point. While the number of document elements reviewed was 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. While the number of document elements reviewed was consistent across MCOs, the number of file elements reviewed was MCO specific. Variations in the number of file elements reviewed derive from final sample sizes and not applicable elements. The Available Points Per MCO column in Table 28 displays the points that the MCOs could achieve for document

review by subject; while Table 29 displays the points that each MCO could achieve for file review by subject. The difference in available points across the MCOs was driven by the number of elements determined to be not applicable, and the total number of files reviewed for that subject.

Table 28: Available Points Per Subject – Document Review

Federal Subject Under Review	Centennial Care 2.0 Contract Subject Under Review	Available Points Per MCO
438.56 Disenrollment Requirements and Limitations	4.2 Enrollment	26
438.100 Enrollee Rights Requirements	3.5 Cultural and Linguistic Competence, 4.8 Provider Network, 4.14 Member Materials, 4.15 Member Services	86
438.114 Emergency and Post Stabilization Services	4.5 Benefits/Service Requirements and Limitations	19
438.206 Availability of Services	4.8 Provider Network	15
438.207 Assurances of Adequate Capacity and Services	4.8 Provider Network	6
438.208 Coordination and Continuity of Care	4.4 Care Coordination, 4.8 Provider Network, 7.16 Records and Audit	50
438.210 Coverage and Authorization of Services	4.5 Self-Directed Community Benefit, 4.10 Provider Payments, 4.12 Quality Assurance	30
438.214 Provider Selection	4.8 Provider Network	12
438.224 Confidentiality	7.26 Disclosure and Confidentiality of Information	68
438.228 Grievance and Appeal Systems	4.16 Grievances and Appeals Systems	119
438.230 Sub-contractual Relationships and Delegation	7.14 Major Subcontractors and Subcontractors, 7.16 Records and Audit	10
438.236 Practice Guidelines	4.12 Quality Assurance	6
438.242 Health Information Systems	4.19 Claims Management, 4.20 Information Systems	12
438.330 Quality Assessment and Performance Improvement Program	4.6 Self-Directed Community Benefit, 4.12 Quality Assurance	17
438.608 Program Integrity	4.17 Program Integrity	20
Not Applicable	4.6 Self-Directed Community Benefit	19
Not Applicable	4.11 Provider Services	39
Not Applicable	4.12 Quality Assurance	29
Not Applicable	4.13 Patient Centered Initiatives	10
Not Applicable	7.16 Medical Records	1

Table 29: Available Points Per Subject – File Review

Federal/State Subject Under Review	BCBS	PHP	WSCC
438.210 Coverage and Authorization of Services			
Adverse Benefit Determinations, Standard	300	330	330
Adverse Benefit Determinations, Expedited	300	330	187
438.208 Coordination and Continuity of Care			
Care Coordination, Continuous	606	689	640
Care Coordination, New Members	972	967	1023
Care Coordination, Transitions of Care	148	567	143
Care Coordination, Traumatic Brain Injury	151	262	146
438.214 Provider Selection			
Credentialing	228	269	234
Recredentialing	271	297	277
438.228 Grievance and Appeal System			
Member Appeals, Standard	390	373	362
Member Appeals, Expedited	420	392	294
Member Grievances	217	240	240
4.6 Self-Directed Community Benefit			
Self-Directed Community Benefit	661	660	658
4.9 Provider Agreements			
Provider Agreements	30	30	30
4.22 Obligations Relating to Member Personal Responsibility Initiatives, Primary Care Provider and Pharmacy Lock-ins			
Primary Care Provider/Pharmacy Lock-Ins - New	30	2	84
Primary Care Provider/Pharmacy Lock-Ins - Continuing	36	29	39

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 file review's case, 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 30 displays the compliance levels, score ranges and definitions.

Table 30: Compliance Level Definitions

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

Description of Data Obtained

To conduct the 2022 external quality review, IPRO utilized the *2022 Compliance Review Report* and the final audit review tools. These sources included detailed descriptions of the review methodology, scoring, and results.

Comparative Results

All MCOs achieved full compliance with *overall compliance average* scores exceeding the 90% threshold. Table 31 displays the overall compliance average scores and compliance level achieved for each MCO; while Table 32 displays the results of the compliance review by federal Medicaid standard for each MCO; and Table 33 displays the results of the compliance review by Medicaid standards specific to Centennial Care 2.0 for each MCO.

Table 31: Summary of MCO Compliance Review Results, 2022

MCO	2022 Overall Average	Compliance Level Achieved
BCBS	94.58%	Full
PHP	96.36%	Full
WSCC	96.40%	Full

Full means that the MCO met or exceeded standard.

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Table 32: MCO Compliance with Federal Medicaid Standards, 2022

Subject Area Under Review	BCBS Score	PHP Score	WSCC Score
438.56 Disenrollment Requirements and Limitations	Full	Full	Full
438.100 Enrollee Rights and Requirements	Full	Full	Full
438.114 Emergency and Post Stabilization Services	Minimal	Minimal	Minimal
438.206 Availability of Services	Moderate	Moderate	Moderate
438.207 Assurances of Adequate Capacity and Services	Moderate	Moderate	Moderate
438.208 Coordination and Continuity of Care	Full	Full	Full
438.210 Coverage and Authorization of Services	Full	Full	Full
438.214 Provider Selection	Full	Full	Full
438.224 Confidentiality	Full	Full	Full
438.228 Grievance and Appeal System	Full	Full	Full
438.230 Subcontractual Relationships and Delegation	Full	Full	Full
438.236 Practice Guidelines	Full	Full	Moderate
438.242 Health Information Systems	Moderate	Full	Full
438.330 Quality Assessment and Performance Improvement	Full	Full	Full
438.608 Program Integrity	Full	Full	Full

Full means that the MCO met or exceeded standard. Moderate means that the MCO met requirements of the standard but had deficiencies in certain areas. Minimal means that the MCO met some requirements of the standard but has significant deficiencies requiring corrective action.

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Table 33: MCO Compliance with Centennial Care 2.0 Standards, 2022

Subject Area Under Review	BCBS Score	PHP Score	WSCC Score
Document Review			
4.6 Self Directed Community Benefit	Moderate	Moderate	Full
4.11 Provider Services	Full	Full	Full
4.12 Quality Assurance	Full	Full	Full
4.13 Patient Centered Initiatives	Full	Minimal	Full
7.16 Medical Records	Full	Full	Full
File Review			
Adverse Benefit Determinations, Standard	Full	Full	Full
Adverse Benefit Determinations, Expedited	Full	Full	Full
Care Coordination, Continuing Members	Full	Full	Full
Care Coordination, New Members	Full	Full	Full
Care Coordination, Transitions of Care	Minimal	Full	Full
Care Coordination, Traumatic Brain Injury	Minimal	Full	Full
Credentialing	Full	Full	Full
Recredentialing	Full	Full	Full
Member Appeals, Standard	Full	Full	Full
Member Appeals, Expedited	Full	Full	Full
Member Grievances	Full	Full	Full
Primary Care Provider/Pharmacy Lock-Ins, New Members	Full	Full	Full
Primary Care Provider/Pharmacy Lock-Ins, Continuing Members	Full	Full	Full
Provider Agreements	Full	Full	Full
Self-Directed Community Benefit	Full	Full	Full

Full means that the MCO met or exceeded standard. **Moderate** means that the MCO met requirements of the standard but had deficiencies in certain areas. **Minimal** means that the MCO met some requirements of the standard but has significant deficiencies requiring corrective action.

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External Quality Review Activity 4. Validation of Network Adequacy – Technical Summary

Objectives

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

The Human Services Department–established access, distance, and time standards are presented for the three New Mexico geographical regions: urban, rural, and frontier. Table 34 displays the Human Services Department Medicaid provider network standards that were applicable in 2022, while a map of the state, highlighting these regions, is available earlier in this report.

Table 34: New Mexico Access and Distance Standards for Medicaid Networks

New Mexico Medicaid Access and Distance Standards
Access Requirements
▪ Member caseload, or panel, of any primary care provider should not exceed 2,000 ▪ Members have adequate access to specialty providers ▪ The MCO shall increase the number of unique members with a telemedicine visit by 20% annually, in rural, frontier, and urban areas for physical health specialists and behavioral health specialists[1]
Distance Requirements for Primary Care Providers and Pharmacies
▪ 90% of urban members shall travel no farther than 30 miles ▪ 90% of rural members shall travel no farther than 45 miles ▪ 90% of frontier members shall travel no farther than 60 miles
Distance Requirements for Behavioral Health Providers, Specialty Providers, Long-Term Care Providers, Hospitals and Transportation Providers
▪ 90% of urban members shall travel no farther than 30 miles ▪ 90% of rural members shall travel no farther than 60 miles[2] ▪ 90% of frontier members shall travel no farther than 90 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 for 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

New Mexico Medicaid Access and Distance 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 30th each year, then the MCO must maintain that same 5% at the end of each calendar year to meet this target.
[2] Unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the Human Services Department.

Further, the *Medicaid Managed Care Program Quality Strategy*[13] (revised March 2021) defines New Mexico's standards for network adequacy and service availability, as well as the accepted evidence-based practice guidelines for the Centennial Care 2.0 program. The Human Services Department network adequacy and availability standards require that MCOs:

- Coordinate health care services.
- Maintain a provider network sufficient to allow timely access.
- Have written policies and procedures that align with the provider network standards delineated in the *Medicaid Managed Care Services Agreement*[14] and *Managed Care Policy Manual*. These policies and procedures must describe how access to services will be available, including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.
- Have written policies and procedures that meet the National Committee for Quality Assurance standards and state and federal regulations for credentialing and re-credentialing of contracted providers.
- Submit a network adequacy report that summarizes the MCO's adherence to the established standards for provider panel size; distance thresholds for primary care, behavioral health, and specialty care; and timeliness thresholds.
- Establish a mechanism to monitor adherence with provider network standards.

Centennial Care 2.0 MCOs are required to meet these standards in achieving network adequacy.

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

Technical Methods of Data Collection and Analysis

In the absence of a federal protocol for network adequacy in 2022, IPRO's assessment of the adequacy of each MCO's network is based on participating provider data, secret shopper survey methodologies and results, provider directory information, and policies and procedures submitted by the MCOs to the Human Services

[13] New Mexico Medicaid Managed Care Program Quality Strategy, March 2021. Website: https://www.hsd.state.nm.us/wp-content/uploads/Quality-Strategy-2021-final.pdf.pdf
[14] Refers to *Section 4.8 Provider Network* of the *Medicaid Managed Care Agreement*.

Department for 2022. Relevant information collected by IPRO during the compliance review for 2022 was also utilized for this activity.

IPRO's analysis also included a comparison of each MCO's calculated distance analysis by specialty and by region to the *New Mexico Administrative Code* standards. A determination of whether the standard was met or not met was made.

Finally, using the MCOs' online provider directories, IPRO validated the accuracy of the information published in the provider directories and evaluated member access to timely appointments for providers found in these provider directories.

Description of Data Obtained

One of the methods the Human Services Department utilizes to monitor MCO compliance with the standards previously described is through routine, contractual reporting. Table 35 displays select reports, relevant to network adequacy, that the MCOs are required to produce and submit to the Human Services Department, and that were used in IPRO's assessment of the MCOs' network adequacy.

Table 35: Required Reporting for Centennial Care 2.0 Managed Care Organizations

Report Number and Title	Report Objective
#3 Network Adequacy	To monitor, quarterly, MCO's compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers and single-case agreements.
#48 Patient-Centered Medical Homes Report	To track, quarterly, (i) the number of patient-centered medical homes established; (ii) the number of members that were referred to and joined a patient-centered medical home; (iii) outcomes, including emergency room utilization and hospital admission and readmission; and (iv) patient-centered medical home National Committee for Quality Assurance recognition and other accreditation.
#49 Provider Network Development, Management Plan and Evaluation	To monitor and review, annually, the MCO's plans for developing and managing its provider network to ensure all medically necessary services are accessible and available.
#55 Geographic Access Report	To monitor, quarterly, access to services by county and across urban, rural, and frontier counties.
#TEL Delivery System Improvement Performance Target Telemedicine Report	To monitor, quarterly, unduplicated physical health and behavioral health telemedicine visits across urban, rural, and frontier counties.

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

Comparative Results

Compliance with Federal Access Requirements

The Human Services Department's assessment of MCO compliance with provider access standards is performed during the annual administrative compliance review conducted by the state's external quality review organization. In February 2024, IPRO concluded the compliance review of 2022 for the Centennial Care 2.0 MCOs. Results of related standards for each MCO are displayed in Table 36.

Table 36: Compliance Review Results – 2022

Federal Medicaid Standard	BCBS	PHP	WSCC
438.206 Availability of Services	Moderate	Moderate	Moderate
438.207 Assurances of Capacity and Services	Moderate	Moderate	Moderate

Moderate: Represents an achievement score between 80% and 89%; and means that the MCO met requirements of the standard but had deficiencies in certain areas.
Data Source: *2022 Compliance Review Report.*

Compliance with State Access Requirements

Provider to Member Ratios

Availability standards established by the state require that no primary care provider has more than 2,000 assigned members. At the end of 2022, six Centennial Care 2.0 providers, five in the BCBS network and one in the PHP network, were reported as having panel sizes of greater than 2,000.

Each quarter, the MCOs are required to calculate and report the primary care provider to member ratio to the Human Services Department. IPRO validates the MCO-calculated ratios reported for the 4th quarter of the calendar year. Table 37 displays the validated MCO ratios for 2019–2022. All MCOs met the provider-member ratio standard in 2022.

Table 37: Provider to Member Ratios – 2019 to 2022

Measurement Period	BCBS	PHP	WSCC
January 1, 2019 – December 31, 2019,	1:113	1:110	1:28
January 1, 2020 – December 31, 2020	1:139	1:105	1:27
January 1, 2021 – December 31, 2021	1:128	1:107	1:25
January 1, 2022 – December 31, 2022	1:130	1:106	1:24

Data Sources: *Human Services Department Report #3* for the 4th quarter of calendar years 2019–2022.

Member Patient-Centered Medical Home Assignment

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

At the end of 2022, approximately 59% of individuals enrolled in Centennial Care 2.0 were assigned to a patient-centered medical home. Table 38 displays membership assignment to patient-centered medical homes in 2020, 2021, and 2022 by MCO.

Table 38: Patient-Centered Medical Home Assignment – 2020, 2021, and 2022

Measurement Period/Measure	BCBS	PHP	WSCC	Centennial Care 2.0
January 1, 2020 – December 31, 2020				
Members Assigned to a Patient-Centered Medical Home	135,066	271,763	34,769	441,598
% of Membership Assigned	46.8%	64.2%	37.9%	55.0%
January 1, 2021 – December 31, 2021				
Members Assigned to a Patient-Centered Medical Home	175,158	287,898	41,990	505,046
% of Membership Assigned	57.0%	65.1%	45.9%	60.0%
January 1, 2022 – December 31, 2022				
Members Assigned to a Patient-Centered Medical Home	178,760	299,738	41,691	520,189
% of Membership Assigned	55.6%	65.9%	41.5%	59.3%

Data Sources: *Human Services Department Report #48* for the 4th quarters of 2020, 2021, and 2022.

Telemedicine Utilization

As part of the Delivery System Improvement Performance Target, MCOs focus on increasing telemedicine availability and utilization to achieve the Human Services Department–established goal of a 20% increase from the prior year. As part of its monitoring system, the Human Services Department collects quarterly MCO counts of unduplicated members served via telemedicine in rural, frontier, and urban areas. Table 39 shows the counts of unique members that received telemedicine services in 2020, 2021, and 2022, and the percentage change from 2021 to 2022.

Table 39: Members with At Least One Telemedicine Visit – 2020, 2021, and 2022

Members with a Telemedicine Visit, Unduplicated				
Measurement Period	BCBS	PHP	WSCC	Centennial Care 2.0
January 1, 2020 – December 31, 2020	82,809	42,562	15,986	141,357
January 1, 2021 – December 31, 2021	80,147	119,316	16,957	216,420
January 1, 2022 – December 31, 2022	68,005	100,411	16,427	184,843
Change +/- Between 2021 and 2022	-15.1%	-15.8%	-3.1%	-14.6%

Data Source: *Human Services Department Report #TEL* for the 4th quarter of 2022.

Compliance with State Distance Standards

The Human Services Department requires that at least 90% of an MCO's membership has access to providers within the established distance standards. IPRO analyzed the *Human Services Department Report #55* produced for the fourth quarter of 2022 by the MCOs to determine if the MCOs were compliant with state distance standards. Table 40 displays MCO performance in meeting the 90% threshold for distance.

Table 40: Compliance with State Distance Standards –2022, 4th Quarter

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

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

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

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

Compliance with State Timeliness Requirements

MCO-Administered Appointment Availability Surveys

The Human Services Department requires the Centennial Care 2.0 MCOs to conduct semi-annual secret shopper surveys to assess adult and child access to primary care within the urban, rural, and frontier regions. The secret shopper approach requires surveyors to act as managed care plan enrollees seeking appointments using scripted clinical scenarios. BCBS, PHP, and WSCC were compliant with this Centennial Care 2.0 requirement.

Each MCO independently contracted a vendor to administer the 2022 surveys. The methodologies applied by the vendors vary and therefore results are not suitable for comparisons across MCOs. Variations and discrepancies in vendor reporting presented barriers in IPRO's process to verify that applied methodologies align with

Centennial Care 2.0 goals and to validate the accuracy of calculated rates. Further, a lack of sufficient data did not allow for the recalculation of appointment rates including those excluded providers.

BCBS's Secret Shopper Appointment Availability Survey Results

On behalf of BCBS, TrendSource, Inc. conducted two secret shopper surveys in 2022, with calls taking place April 25 to May 26 and November 28 to December 30. BCBS surveyed pediatric and adult primary care and behavioral health providers for routine, routine symptomatic, and urgent appointments. A combined total of 3,666 physical primary care providers and 4,499 behavioral health providers were sampled and surveyed by BCBS in 2022.

IPRO recommends that the results of BCBS's 2022 surveys be interpreted with caution. Timely appointment rates are likely to be inflated due to BCBS's exclusion of surveys calls resulting in no appointment made from the denominator.

Combined results from BCBS's surveys were calculated by IPRO and are displayed in Table 41.

Table 41: BCBS's Appointment Availability Results Reported by BCBS – 2022

Appointment Type	Total Providers Surveyed Who Accept New Patients	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers Who Accept New Patients
Physical Primary Care			
Routine, Asymptomatic	272	212	77.9%
Routine, Symptomatic	317	218	68.8%
Urgent	290	120	41.4%
Behavioral Health Care			
Routine, Substance Use Disorder	48	29	60.4%
Urgent, Substance Use Disorder	52	9	17.3%
Routine, Clinics and Agencies	9	9	100.0%
Urgent, Clinics and Agencies	6	4	66.7%
Routine, Facilities	236	176	74.6%
Urgent, Facilities	221	120	54.3%
Routine, Practitioner	272	212	77.9%
Urgent, Practitioner	317	218	68.8%

Note: IPRO recommends that these results be interpreted with caution. Timely appointment rates are likely to be inflated due to BCBS's exclusion of surveys calls resulting in no appointment made from the denominator.
Data Sources: *Blue Cross Blue Shield of New Mexico Semi Annual Secret Shopper Report SA1 CY 2022* and *Blue Cross Blue Shield of New Mexico Semi Annual Secret Shopper Report SA2 CY 2022*.

PHP's Secret Shopper Appointment Availability Survey Results

On behalf of PHP, Research and Polling, Inc. conducted two secret shopper surveys in 2022, with calls taking place January 10 to January 17 and June 13 to June 17. PHP surveyed pediatric and adult primary care and specialty care providers for routine, preventive, urgent, and specialty care appointments. A combined total of 850 providers were sampled and surveyed by PHP in 2022.

IPRO recommends that the results of PHP's 2022 surveys be interpreted with caution (Table 42). Timely appointment rates are likely to be inflated due to PHP's exclusion of surveys calls resulting in no appointment made from the denominator.

Table 42: PHP's Appointment Availability Results Reported by PHP – 2022

Appointment Type	Total Number of Appointments Made	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers
Physical Primary and Specialty Care			
Routine Care	35	16	45.7%
Preventive Care	30	14	46.7%
Urgent Care	18	4	22.2%
Specialty Care	127	43	33.9%

Note: IPRO recommends that these results be interpreted with caution. Timely appointment rates are likely to be inflated due to PHP's exclusion of surveys calls resulting in no appointment made from the denominator.
Data Sources: *Presbyterian Health Plan & Presbyterian Insurance Company, Inc. Practitioner Services/Patient Access*, January 2022, and *Presbyterian Health Plan & Presbyterian Insurance Company, Inc. Practitioner Services/Patient Access*, July 2022.

WSCC's Secret Shopper Appointment Availability Survey Results

On behalf of WSCC, Faneuil, Inc. conducted four secret shopper surveys in 2022, with primary and specialty care survey calls taking place May 31 to June 13 and December 2 to December 12; and behavioral health calls taking place June 2 to June 6 and December 1 to December 12. WSCC surveyed pediatric and adult providers for primary care, specialty care, and behavioral health for routine and urgent appointments. Sample sizes could not be calculated by IPRO due to lack of data in WSCC's reporting.

IPRO recommends that the results of WSCC's 2022 surveys be interpreted with caution. WSCC's survey reports do not clearly describe the applied methodology or present data in a manner allowing IPRO to validate the accuracy of WSCC's calculated rates. Combined results from WSCC's surveys were calculated by IPRO and are displayed in Table 43.

Table 43: WSCC's Appointment Availability Results Reported by WSCC – 2022

Appointment Type	Total Number of Providers Who Completed the Survey	Total Timely Appointments Made	Timely Appointment Rates Among Surveyed Providers
Primary and Specialty Care			
Routine	970	921	94.9%
Urgent	970	931	96.0%
Behavioral Health Care			
Routine, Substance Use Disorder and Community Mental Health Centers, Adult and Child	824	806	97.8%
Urgent, Substance Use Disorder and Community Mental Health Centers, Adult and Child	824	810	98.3%

Note: IPRO recommends that these results be interpreted with caution. WSCC's survey reports do not clearly describe the applied methodology or present data in a manner allowing IPRO to validate the accuracy of WSCC's calculated rates.
Data Sources: *WSCC Community Care January 2022 Physical Health Secret Shopper Survey Report* and *WSCC Community Care January 2022 Behavioral Health Secret Shopper Survey Report*.

External Quality Review Organization-Administered Appointment Availability Surveys

On behalf of the Human Services Department, IPRO conducted a secret shopper survey in 2022 for the Centennial Care 2.0 MCOs. IPRO surveyed primary care providers and obstetricians/gynecologists for routine and non-urgent symptomatic appointments. Survey calls took place between September 26 and October 24. A combined total of 383 providers were surveyed across BCBS, PHP, and WSCC. Table 44 and Table 45 present the results of the IPRO-administered secret shopper survey.

Table 44: Centennial Care 2.0 Secret Shopper Survey Results Reported by IPRO – 2022

Metric	BCBS	PHP	WSCC	Centennial Care 2.0
Number of Primary Care Providers and Obstetricians/Gynecologists Surveyed	125	145	113	383
Number of Appointments Made	21	42	37	100
Number of Timely Appointments Made	18	25	26	69
% of Appointments Made (Denominator Is Number of Providers Surveyed)	16.8%	29.0%	32.7%	26.1%
% of Timely Appointments Made (Denominator Is Number of Providers Surveyed)	14.4%	17.2%	23.0%	18.0%

Table 45: Centennial Care 2.0 Secret Shopper Survey Failures Reported by IPRO – 2022

Failure Reason	BCBS	PHP	WSCC	Centennial Care 2.0
Provider Not at Site and No Alternative Provider Available	26	29	11	66
Provider Not Accepting New Patients	20	15	24	59
Provider Practice Required Information That the Surveyor Could Not Provide (Social Security Number; Medicaid Number; Home Address; Telephone Number)	10	11	16	37
Untimely Appointment	3	17	11	31
Provider Is Not a Primary Care Provider or Obstetrician/Gynecologist	10	14	5	29
Staff Not Scheduling Any Appointments at This Time (Provider on Maternity Leave; Waiting List; No Appointments Available)	11	9	3	23
Answering Machine/Voice Mail System	6	5	4	15
Constant Busy Signal	6	4	4	14
Patient Must Complete a Health Form/Get Provider Approval Before Appointment Can Be Made	7	3	3	13
Instructed To Go to Emergency Room/Urgent Care	2	3	1	6
Provider Does Not Participate With MCO	0	4	2	6
Wrong Telephone Number	3	1	0	4
No Answer	1	1	1	3
Referral Required	1	1	1	3
Staff Required Previous Medical Records	0	1	1	2
Other	1	0	0	1
Provider Practice Not Making Appointments Via Telephone	0	1	0	1
Put On Hold for More Than 10 Minutes	0	1	0	1
Total Failures	107	120	87	314

Provider Directory Information Verification Audit

On behalf of the Human Services Department, IPRO conducted a provider directory information verification audit for the Centennial Care 2.0 MCOs in August 2022. Using online Centennial Care 2.0 provider directories available on the BCBS, PHP, and WSCC public websites, IPRO attempted to have audited providers verify the accuracy of the information printed in the directories. A combined total of 239 primary care providers and obstetricians/gynecologists and 63 specialists were surveyed across BCBS, PHP, and WSCC. Table 46 and Table 47 present the results of IPRO's provider directory information audit for primary care providers and obstetricians/gynecologists; and Table 48 and Table 49 present the results of the audit for specialists.

Table 46: Centennial Care 2.0 Primary Care Provider Directory Information Audit Results Reported by IPRO – 2022

Metric	BCBS	PHP	WSCC	Centennial Care 2.0
Number of Primary Care Providers and Obstetricians/Gynecologists Audited	82	79	78	239
Number of Primary Care Providers and Obstetricians/Gynecologists Who Verified Participation with MCO	40	46	47	133
Number of Primary Care Providers and Obstetricians/Gynecologists Who Verified Participation with MCO and Accepting New Patients	32	39	39	110
% of Providers Who Verified Participation with MCO and Accepting New Patients (Denominator is Number of Providers Audited)	39.0%	49.4%	50.0%	46.0%

Table 47: Centennial Care 2.0 Primary Care Provider Directory Information Audit Failures Reported by IPRO – 2022

Failure Reason	BCBS	PHP	WSCC	Centennial Care 2.0
Provider Not at Site	16	21	12	49
Provider Not Accepting New Patients	8	7	8	23
Answering Machine	10	3	1	14
Wrong Specialty Listed in Directory	3	3	6	12
Wrong Number	2	1	7	10
Provider Does Not Participate with MCO	3	3	1	7
Call Put on Hold	6	0	0	6
Busy Signal	1	1	1	3
Practice Representative Refused to Answer	0	1	1	2
No Answer	1	0	1	2
Disconnected Telephone Number	0	0	1	1
Total Failures	50	40	39	129

Table 48: Centennial Care 2.0 Specialist Provider Directory Information Audit Results Reported by IPRO – 2022

Metric	BCBS	PHP	WSCC	Centennial Care 2.0
Number of Specialists Audited	22	21	20	63
Number of Specialists Who Verified Participation with MCO	14	18	12	44
Number Specialists Who Verified Participation with MCO and Accepting New Patients	12	18	12	42
% of Providers Who Verified Participation with MCO and Accepting New Patients (Denominator is Number of Providers Audited)	**54.5%**	**85.7%**	**60.0%**	**66.7%**

Table 49: Centennial Care 2.0 Specialist Provider Directory Information Audit Failures Reported by IPRO – 2022

Failure Reason	BCBS	PHP	WSCC	Centennial Care 2.0
Provider Not at Site	4	3	4	11
Answering Machine	2	0	1	3
Wrong Specialty Listed in Directory	1	0	1	2
Provider Does Not Participate with MCO	1	0	1	2
Provider Not Accepting New Patients	2	0	0	2
Wrong Number	0	0	1	1
Total Failures	**10**	**3**	**8**	**21**

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External Quality Review Activity 6. Validation of Quality-of-Care Surveys – Technical Summary

Objectives

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

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

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

Each MCO independently contracted with a certified CAHPS vendor to administer the adult and child surveys for measurement year 2022.

Technical Methods of Data Collection and Analysis

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

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2022, continuously enrolled for at least five of the last six months of 2022, and currently enrolled in the MCO.

Table 50 provides a summary of the technical methods of data collection by MCO.

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Table 50: CAHPS Technical Methods of Data Collection by MCO, Measurement Year 2022

	BCBS	PHP	WSCC
Adult CAHPS Survey			
Survey Vendor	Press Ganey	Press Ganey	Press Ganey
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Adult	5.1H Medicaid Adult
Survey Period	02/24/2023-5/15/2023	02/21/2023-05/10/2023	03/07/2023-5/17/2023
Method of Collection	Mail, Telephone	Mail, Telephone	Mail, Telephone
Sample Size	1,755	2,430	4,127
Response Rate	12.1%	10.5%	11.0%
Child CAHPS Survey			
Survey Vendor	Press Ganey	Press Ganey	Press Ganey
Survey Tool	5.1H Medicaid Child	5.1H Medicaid Child	5.1H Medicaid Child
Survey Period	02/24/2023-5/15/2023	02/21/2023-05/10/2023	03/07/2023-5/17/2023
Method of Collection	Mail, Telephone	Mail, Telephone	Mail, Telephone
Sample Size	1,898	3,020	3,300
Response Rate	10.2%	8.7%	10.1%

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

For the global ratings, composite measures, composite items, and individual item measures, the scores were calculated using a 100-point scale. Responses were classified into response categories. **Table 51** displays these categories and the measures by which these response categories are used.

Table 51: CAHPS Categories and Response Options

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

To assess MCO performance, IPRO compared MCO scores to national Medicaid performance reported in the *2023 Quality Compass* (measurement year 2022) for all lines of business that reported measurement year 2021 CAHPS data to NCQA.

Description of Data Obtained

For each MCO, IPRO received a copy of the final measurement year 2022 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as MCO-level results and analyses.

Comparative Results

When compared to national Medicaid benchmarks for measurement year 2022, no MCO achieved a score for the 2023 CAHPS Adult Medicaid Survey or 2023 CAHPS Child Medicaid Survey that met the 90th percentile.

Table 52 displays the results of the 2023 CAHPS Adult Medicaid Survey for measurement year 2022 while Table 53 displays the results of the 2023 CAHPS Child Medicaid Survey for measurement year 2022. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2023 Quality Compass* for measurement year 2022.

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Table 52: Adult Member CAHPS Results, Measurement Year 2022

	BCBS Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	PHP Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	WSCC Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	National 2022 Medicaid Average[1]
Rating of Health Plan[2]	74.3%	25th	80.2%	66.67th	73.0%	10th	77.69%
Rating of All Health Care[2]	74.0%	33.33rd	76.7%	66.67th	73.0%	25th	74.55%
Rating of Personal Doctor[2]	84.9%	66.67th	80.1%	10th	79.0%	10th	82.40%
Rating of Specialist[2]	Small Sample	Not Applicable	Small Sample	Not Applicable	78.8%	25th	81.40%
Getting Care Quickly[3]	Small Sample	Not Applicable	76.0%	25th	76.1%	25th	80.36%
Getting Needed Care[3]	73.6%	<10th	76.2%	10th	76.8%	10th	80.99%
Customer Service[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	91.4%	75th	89.18%
How Well Doctors Communicate[3]	91.8%	33.33rd	90.8%	10th	91.8%	33.33rd	92.49%
Coordination of Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	82.3%	25th	84.61%

[1] National Medicaid benchmarks displayed in these tables come from *NCQA's 2023 Quality Compass* for measurement year 2022.

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

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

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

Table 53: General Population-Child Member CAHPS Results, Measurement Year 2022

	BCBS Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	PHP Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	WSCC Measurement Year 2022	National 2022 Medicaid Percentile Rank Achieved[1]	National 2022 Medicaid Average[1]
Rating of Health Plan[2]	84.0%	10th	87.8%	50th	87.3%	50th	86.21%
Rating of All Health Care[2]	84.0%	10th	84.7%	25th	82.2%	10th	86.16%
Rating of Personal Doctor[2]	91.0%	66.67th	89.0%	33.33rd	86.6%	10th	89.33%
Rating of Specialist[2]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	85.63%
Getting Care Quickly[3]	Small Sample	Not Applicable	79.2%	10th	82.1%	10th	85.46%
Getting Needed Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	78.5%	10th	82.71%
Customer Service[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	83.2%	<10th	87.64%
How Well Doctors Communicate[3]	93.1%	33.33rd	91.5%	10th	92.1%	25th	93.62%
Coordination of Care[3]	Small Sample	Not Applicable	Small Sample	Not Applicable	Small Sample	Not Applicable	83.81%

[1] National Medicaid benchmarks displayed in these tables come from *NCQA's 2023 Quality Compass* for measurement year 2022.

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

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

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

NCQA Accreditation – Technical Summary

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

Within each standards category, the total number of points is added. The MCOs achieve 1 of 3 accreditation levels based on how they score on each standards category. Table 54 displays the accreditation determination levels and points needed to achieve each level.

Table 54: 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 released every September. The *2023 Health Insurance Plan Ratings 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, health plan services, and customer service (measures in the Patient Experience category).
2. Clinical Measures: The proportion of eligible members who received preventive services (measures in the Prevention and Equity composite) and the proportion of eligible members who received recommended care for certain conditions (measures in the Treatment composite).
3. NCQA Health Plan Accreditation: For a plan with 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 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 55.

Table 55: 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.

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website[15] to review the *Health Plan Report Cards 2023* 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, 2023.

Comparative Results

BCBS, PHP, and WSCC were compliant with the state's requirement to achieve and maintain NCQA health plan accreditation. Further, the MCOs have sought or are currently seeking NCQA distinction in other programs. Table 56 displays each MCO's health plan accreditation level achieved, effective dates of the accreditation, and upcoming scheduled review dates, while Table 58 displays a summary of MCO participation in other NCQA programs.

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

Table 56: MCO Medicaid Health Plan Accreditation Status

MCO	Accreditation Level Achieved	Start Date	Expiration Date	Next Review Date
BCBS	Accredited	11/4/2021	11/4/2024	5/26/2026
PHP	Accredited	8/28/2020	8/28/2023	8/6/2024
WSCC	Accredited	3/26/2021	3/26/2024	1/9/2024

Accredited means that the MCO achieved at least 80% of applicable points.

BCBS, PHP, and WSCC achieved an overall health plan star rating of 3.0 out of 5.0 for *Health Plan Ratings 2023*. Further, all three MCOs achieved 5.0 stars for the Equity subcategory. (The Equity subcategory performance is based on a single measure: *Race and Ethnicity of Members*.) **Table 57 shows the MCOs' overall health plan star ratings and the ratings for the three overarching categories and their subcategories under review.**

Table 57: MCO NCQA Rating by Category, Measurement Year 2022

Overarching and Subcategories *(Number of Measures Included in Subcategory)*	MCO and Star Rating Achieved *(out of 5 stars)*		
	BCBS	PHP	WSCC
	3.0 Stars Overall	3.0 Stars Overall	3.0 Stars Overall
Patient Experience	**3.0 Stars**	**3.0 Stars**	**2.5 Sars**
Getting Care *(2)*	Insufficient Data	2.0 Stars	2.0 Stars
Satisfaction with Plan Physicians *(1)*	3.0 Stars	4.0 Stars	2.0 Stars
Satisfaction with Plan and Plan Services *(2)*	3.0 Stars	3.0 Stars	3.0 Stars
Prevention and Equity	**3.0 Stars**	**3.0 Stars**	**2.5 Stars**
Children and Adolescent Well Care *(4)*	3.5 Stars	3.5 Stars	2.5 Stars
Women's Reproductive Health *(3)*	2.5 Stars	2.5 Stars	2.5 Stars
Cancer Screening *(2)*	2.0 Stars	1.5 Stars	1.0 Star
Equity *(1)*	5.0 Stars	5.0 Stars	5.0 Stars
Other Preventive Services *(3)*			
Chlamydia Screening	2.0 Stars	2.0 Stars	2.0 Stars
Flu Shots	Not Applicable	3.0 Stars	3.0 Stars
Smoking Advise	Not Applicable	1.0 Star	1.0 Star
Treatment	**2.5 Stars**	**2.5 Stars**	**2.5 Stars**
Respiratory *(6)*	2.5 Stars	2.5 Stars	1.5 Stars
Diabetes *(6)*	1.5 Stars	2.0 Stars	2.0 Stars
Heart Disease *(3)*	2.0 Stars	2.0 Stars	2.0 Stars
Behavioral Health-Care Coordination *(4)*	3.0 Stars	3.0 Stars	3.0 Stars
Behavioral Health-Medication Adherence *(3)*	2.5 Stars	2.5 Stars	2.5 Stars
Behavioral Health-Access, Monitoring and Safety *(5)*	3.0 Stars	3.0 Stars	3.5 Stars
Risk-Adjusted Utilization *(1)*	3.0 Stars	5.0 Stars	3.0 Stars
Overuse of Opioids *(3)*	3.0 Stars	3.5 Stars	3.5 Stars
Other Treatment Measures *(1)*	3.0 Stars	3.0 Stars	2.0 Stars

Gray shading means that an aggregate score for the subcategory is not available.

Table 58: Other NCQA Programs and MCO Participation

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

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

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Managed Care Organization Response to the 2021 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the external quality review organization during the previous year's external quality review." Table 59 displays the assessment categories used by IPRO to describe MCO progress towards addressing the 2021 external quality review recommendations. Table 60, Table 61, and Table 62 display BCBS's, PHP's, and WSCC's progress related to the recommendations made in the *Centennial Care 2.0 External Quality Review Technical Report, Calendar Year 2021*, as well as IPRO's assessment of the MCO's response. In these tables, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by gray shading).

Table 59: 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, more time is needed to observe for performance improvement.
Remains an Opportunity for Improvement
MCO's quality improvement response did not address the recommendation; or performance declined.

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Table 60: IPRO's Assessment of BCBS's Response to the 2021 External Quality Review Recommendations

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of BCBS's Response to the 2021 Recommendation	Quality	Timeliness	Access
Performance Improvement Project	As all performance improvement projects were initiated in 2021, BCBS should plan to continue these projects until targets are met and sustainable improvement is realized. BCBS should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	Partially addressed.	X	X	X
Performance Measures	BCBS should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, BCBS should focus on the areas of care in which its rates did not meet the target.	Partially addressed.	X	X	X
Compliance with Medicaid Standards	BCBS should conduct routine monitoring to ensure compliance is maintained.	Partially addressed.	X	X	X
Network Adequacy	Concerning the provider who exceeded the maximum panel size, BCBS should implement steps to reduce the provider's panel size, and routinely monitor the provider's ability to meet the established access, distance, and timeliness standards until the panel size is reduced.	Remains an opportunity for improvement.		X	X
	BCBS should continue its efforts to address "low count" provider types.	Remains an opportunity for improvement.		X	X
	BCBS should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but BCBS was not, for example, for certified nurse midwifery and psychology in the rural region, BCBS	Remains an opportunity for improvement.		X	X

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of BCBS's Response to the 2021 Recommendation	Quality	Timeliness	Access
	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.				
	In the absence of a state-established threshold for timely appointments, BCBS should identify a threshold to work toward. Although not required by the Human Services Department, BCBS should also expand its secret shopper survey to include additional physical health specialties. Based on BCBS's reasons for no appointment, BCBS should work to improve the accuracy of its provider data, specifically telephone number, participation status and panel status to reduce barriers members face when attempting to obtain appointments. BCBS should also educate its provider network on unintended barriers to care such as requests for previous medical records before an appointment will be given.	Remains an opportunity for improvement.		X	X
Quality-of-Care Survey	BCBS should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	Remains an opportunity for improvement.	X	X	X

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Table 61: IPRO's Assessment of PHP's Response to the 2021 External Quality Review Recommendations

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2021 Recommendation	Quality	Timeliness	Access
Performance Improvement Project	To ensure future performance improvement project methodologies are effectively designed and managed, PHP staff should continue to utilize the report template issued by the external quality review organization, and fully address issues identified by the external quality review organization during the proposal phase, interim reporting phase, and final reporting phase. Lastly, PHP should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	Partially addressed.	X	X	X
Performance Measures	PHP should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, PHP should focus on the areas of care in which its rates did not meet the target.	Partially addressed.	X	X	X
	PHP should enhance its quality improvement strategy, by tailoring broad interventions to address the specific barriers members and providers face when engaging the health care system; and consider conducting personalized appointment reminder calls to pregnant members and members with newborns and use the live contact opportunity to provide support for barriers attending scheduled appointments.	Partially addressed.	X	X	X
Compliance with Medicaid Standards	PHP should conduct routine monitoring to ensure compliance is maintained.	Partially addressed.	X	X	X
Network Adequacy	Concerning the provider who exceeded the maximum panel size, PHP should implement steps to reduce the provider's panel size, and routinely monitor the provider's ability to	Remains an opportunity for improvement.		X	X

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of PHP's Response to the 2021 Recommendation	Quality	Timeliness	Access
	meet the established access, distance, and timeliness standards until the panel size is reduced.				
	PHP should develop a method for communicating provider cultural competency information, which is current and accurate, with members.	Remains an opportunity for improvement.	X		
	PHP should continue its efforts to address "low count" provider types.	Remains an opportunity for improvement.		X	X
	PHP should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but PHP was not, for example, for otolaryngology in the rural and frontier regions, PHP should compare networks to identify opportunities to contract with new providers. PHP should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.	Remains an opportunity for improvement.		X	X
	In the absence of a state-established threshold for timely appointments, PHP should identify a threshold to work toward. PHP should increase Centennial Care 2.0 sample sizes for the semi-annual secret shopper surveys to produce results that are reliable. PHP should continue to re-educate network providers on the appointment wait time standards and unintended barriers to care such as requests for previous medical records before an appointment will be given. PHP should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action.	Remains an opportunity for improvement.		X	X
Quality-of-Care Survey	PHP should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	Partially addressed.	X	X	X

Table 62: IPRO's Assessment of WSCC's Response to the 2021 External Quality Review Recommendations

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2021 Recommendation	Quality	Timeliness	Access
Performance Improvement Project	WSCC should extend the duration of the current performance improvement projects to allow itself a reasonable amount of time to achieve goals and sustained improvement. WSCC should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	Partially addressed.	X	X	X
Performance Measures	WSCC should continue to utilize the results of the Human Services Performance Measure Program in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, WSCC should focus on the areas of care in which its rates did not meet the target.	Partially addressed.	X	X	X
	To enhance its quality improvement strategy, WSCC should include member, program, and provider-level interventions for each focus area to adequately address a comprehensive set of factors that contribute to members not receiving the services and supports that are clinically indicated.	Partially addressed.	X	X	X
Compliance with Medicaid Standards	WSCC should reeducate staff on supporting care coordination policies and procedures; identify automated solutions for alerting care coordination staff of time sensitive required action; and enhance current internal monitoring of care coordination procedures with a focused review of staff compliance to the citations noted in this table.	Addressed.	X	X	X
	WSCC should conduct routine monitoring to ensure compliance is achieved and maintained.	Partially addressed.	X	X	X
Network Adequacy	WSCC should continue its efforts to address "low count" provider types.	Remains an opportunity for improvement.		X	X

External Quality Review Activity	2021 External Quality Review Recommendation	IPRO's Assessment of WSCC's Response to the 2021 Recommendation	Quality	Timeliness	Access
	WSCC should continue to identify opportunities to increase member access to provider types for which minimum distance standards were not met. In cases where one or more of the other MCOs were able to meet distance standards but WSCC was not, for example, for general hospitals with psychiatric units in the urban region and hematology/oncology in the frontier region, WSCC should compare networks to identify opportunities to contract with new providers. WSCC should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.	Remains an opportunity for improvement.		X	X
	In the semi-annual secret shopper reports, WSCC should include data tables displaying reasons why contact with the provider was not made and reasons why an appointment was not given. WSCC should continue to re-educate network providers on the appointment wait time standards, and although not required by the Human Services Department, WSCC should expand its secret shopper survey to include additional physical health specialties. WSCC should utilize other data sources, such as member grievances, to identify providers who have a pattern of not meeting appointment standards and require corrective action.	Remains an opportunity for improvement.		X	X
Quality-of-Care Survey	WSCC should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	Remains an opportunity for improvement.	X	X	X

Strengths, Opportunities, and 2022 Recommendations Related to Quality, Timeliness, and Access

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

- Quality is the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- Timeliness is the MCO's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- Access is the timely use of services to achieve 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' 2022 performance, as well recommendations for improving quality, timeliness, and access to care are presented in Table 63, Table 64, and Table 65. 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 gray shading).

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Table 63: BCBS's Strengths, Opportunities and Recommendations for Improvement, 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	BCBS met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Projects	Five of five performance improvement projects conducted in 2022 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	Between 2020 and 2022, two of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Prenatal and Postpartum Care	Between 2020 and 2022, three of the three indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Adult Obesity	Between 2020 and 2022, two of five indicators demonstrated performance improvement.	X		
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2022, two of six indicators demonstrated performance improvement.	X		
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2022, four of six indicators demonstrated performance improvement.	X	X	X
Performance Measures	BCBS met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			
	BCBS exceeded target rates for seven of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	BCBS achieved "full" compliance with an *overall compliance average* score exceeding the 90% threshold.	X	X	X
Network Adequacy	As of December 2022, approximately 56% of BCBS's membership was assigned to a patient-centered medical home provider.	X		
	Approximately 68,005 unique BCBS members completed a telemedicine visit in 2022, which accounted for 37% of Centennial Care 2.0 members with a telemedicine service in 2022.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	In the 4th quarter of 2022, BCBS met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse practitioners, ▪ dental providers, ▪ federally qualified health centers, ▪ federally qualified health centers with primary care providers only, ▪ hematologists/oncologists, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, ▪ pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ community mental health centers, ▪ core service agencies, ▪ federally qualified health centers providing behavioral health services, ▪ other licensed independent behavioral health providers, ▪ outpatient provider agencies ▪ psychiatrists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, ▪ personal care service agencies, and ▪ transportation.		X	X
Quality-of-Care Survey	None.			
NCQA Accreditation	In 2022, BCBS was NCQA accredited.	X	X	X
	BCBS achieved five stars for the Equity subcategory.	X	X	X
	BCBS was awarded NCQA Health Equity Accreditation and Long-Term Services and Support distinction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project – Long-Term Care Services and Supports	None.			
Performance Improvement Project	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
– Prenatal and Postpartum Care				
Performance Improvement Project – Adult Obesity	Between 2020 and 2022, three of five indicators demonstrated a decline in performance.	X		
Performance Improvement Project – Diabetes Prevention and Management	Between 2020 and 2022, four of six indicators demonstrated a performance decline.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2020 and 2022, two of six indicators demonstrated performance declines.	X	X	X
Performance Measures	BCBS did not meet target rates for three of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	BCBS achieved "moderate" compliance in four subject areas under review and "minimal" compliance in three subject areas under review. BCBS achieved "moderate" compliance for: ▪ 438.206 Availability of Services ▪ 438.207 Assurance of Adequate Capacity and Services ▪ 438.242 Health Information Systems ▪ 4.6 Self Directed Community Benefit BCBS achieved "minimal" compliance for: ▪ 438.114 Emergency and Post Stabilization Services ▪ Care Coordination, Transitions of Care ▪ Care Coordination, Traumatic Brain Injury	X	X	X
Network Adequacy	BCBS achieved "moderate" compliance for its provider network policies and procedures reviewed during the compliance review of 2022.	X	X	X
	Five providers in the BCBS network reported a panel that exceeded the maximum threshold of 2,000 patients.	X	X	X
	BCBS did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ rural health clinics,		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	▪ assertive community treatment providers, ▪ day treatment service providers, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ multi-systemic therapy, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ rural health clinics providing behavioral health services, ▪ treatment foster care I and II, and ▪ assisted living facilities.			
	Of the primary care providers and obstetricians/gynecologists surveyed by IPRO on behalf of BCBS, 14.4% reported timely appointments.		X	X
	Of the primary care providers and obstetricians/gynecologists audited by IPRO on behalf of BCBS, 39% verified the accuracy of information presented in BCBS's online provider directory.		X	X
	Of the specialists audited by IPRO on behalf of BCBS, 54.5% verified the accuracy of information presented in BCBS's online provider directory.		X	X
Quality-of-Care Survey	BCBS achieved four adult CAHPS scores and three child CAHPS scores that did not meet the national Medicaid average.	X	X	X
NCQA Accreditation	Although BCBS achieved NCQA accreditation status, BCBS achieved three of the possible five stars under NCQA's Star Rating program.	X	X	X
Recommendations				
Performance Improvement Projects	BCBS should plan to continue the performance improvement projects until targets are met and sustainable improvement is realized. BCBS should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
Performance Measures	BCBS should continue to use the Human Services Performance Measure Program results in developing its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	care, and experienced unfavorable health outcomes, BCBS should focus on the areas of care in which its rates did not meet the target.			
Compliance with Medicaid Standards	*438.114 Emergency and Post Stabilization* Services – BCBS should ensure that submitted evidence meets the requirements established by the external quality review organization. *438.206 Availability of Services* – BCBS should continue its work to improve adherence to the credentialing requirements outlined in the Centennial Care 2.0 Contract and New Mexico Administrative Code. Specifically, BCBS should ensure required disclosures are obtained in a timely manner. *438.207 Assurances of Adequate Capacity and Services* – BCBS should consider new and innovative approaches to addressing the gaps in the breadth and size of its provider network. BCBS should update the Network Adequacy Policy to address scenarios identified in the Code of Federal Regulations that would trigger a submission of required documentation to the state. *438.242 Health Information Systems* – BCBS should ensure that evidence is submitted as requested by the external quality review organization. *4.6 Self Directed Community Benefit* – BCBS should ensure that future agreements with the fiscal management agency include required language. *Care Coordination, Transitions of Care* – BCBS should update policies and procedures to reflect transition of care requirements for the "turning 21 years of age" population. BCBS should develop staff training and tools to support implementation of transitions of care requirements for the "turning 21 years of age" population. BCBS should verify that all transitions of care groups identified by the Human Services Department in the managed care agreement and Managed Care Policy	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Manual are incorporated into BCBS's transitions of care policies and procedures. *Care Coordination, Traumatic Brain Injury* – BCBS should reeducate staff on supporting care coordination policies and procedures. BCBS should enhance current internal monitoring of care coordination procedures with a focused review of staff compliance with the citations noted in this table.			
Network Adequacy	BCBS should address the areas of noncompliance identified during the 2022 Compliance Review. Specifically, BCBS should enhance its network development and maintenance plan to ensure its compliance with state credentialing requirements, improve member access to timely appointments, and increase the size of its Medicaid provider network.	X	X	X
	Concerning the five provider who exceeded the maximum panel size, BCBS should implement steps to reduce the providers' panel size, and routinely monitor the providers' ability to provide high quality care and to meet the established access, distance, and timeliness standards until the panel size is reduced.	X	X	X
	BCBS should evaluate the decline in member utilization of telemedicine services.	X	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 urology in the frontier region and psychology in the rural region, BCBS should compare networks to identify opportunities to contract with new providers. BCBS should also consider collaborating with the other MCOs and state agencies to recruit providers to the State of New Mexico.	X	X	X
	BCBS should reference the Network Adequacy Protocol developed by the Centers for Medicare & Medicaid Services when designing		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	future secret shopper surveys to ensure indicator rates are calculated appropriately.			
	BCBS should consider corrective actions to address the findings from IPRO's secret shopper survey and provider directory audits.		X	X
Quality-of-Care Survey	BCBS should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

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Table 64: PHP's Strengths, Opportunities and Recommendations for Improvement, 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	PHP met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Projects	Five of five performance improvement projects conducted in 2022 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	Two of three indicators demonstrated performance improvement.	X		
Performance Improvement Project – Prenatal and Postpartum Care	Two of three indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Adult Obesity	One of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Diabetes Prevention and Management	One of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Clinical Depression Screening and Follow-Up	One of four indicators demonstrated performance improvement.	X	X	X
Performance Measures	PHP met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			
	PHP exceeded target rates for eight of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	PHP achieved "full" compliance with an *overall compliance average* score exceeding the 90% threshold.	X	X	X
Network Adequacy	As of December 2022, 65.9% of PHP's membership was assigned to a patient-centered medical home provider.	X	X	X
	Approximately 100,411 PHP members completed a telemedicine visit in 2022, which accounted for 54% of Centennial Care 2.0 members with a telemedicine service in 2021.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	In the 4th quarter of 2022, PHP met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse practitioners, ▪ dental providers, ▪ federally qualified health centers, ▪ hematologists/oncologists, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, ▪ pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ urologists, ▪ core service agencies, ▪ federally qualified health centers providing behavioral health services, ▪ intensive outpatient service providers, ▪ other licensed independent behavioral health providers, ▪ outpatient provider agencies, ▪ psychiatrists, ▪ psychologists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, ▪ personal care service agencies, and ▪ transportation providers.		X	X
	Of the specialists audited by IPRO on behalf of PHP, 85.7% verified the accuracy of information presented in PHP's online provider directory.		X	X
Quality-of-Care Survey	None.			
NCQA Accreditation	In 2022, PHP was NCQA accredited.	X	X	X
	PHP achieved five stars for the Equity subcategory and the Risk Adjusted Utilization subcategory which is related to the reduction of all-cause readmissions.	X	X	X
	PHP was awarded NCQA Long Term Services and Support distinction.	X	X	X
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project – Long-Term Care Services and Supports	One of three indicators demonstrated a decline in performance.	X		
	For all three indicators, PHP selected a target rate for improvement that is lower than baseline performance.			
Performance Improvement Project – Prenatal and Postpartum Care	For one of three indicators, PHP selected a target rate for improvement that is lower than baseline performance.			
Performance Improvement Project – Adult Obesity	One of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Diabetes Prevention and Management	One of two indicators demonstrated a decline in performance.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Three of four indicators demonstrated a decline in performance.	X	X	X
	For three of four indicators, PHP selected a target rate for improvement that is lower than baseline performance.			
Performance Measures	PHP did not meet target rates for two of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	PHP achieved "moderate" compliance in three subject areas under review and "minimal" compliance in two subject areas under review. PHP achieved "moderate" compliance for: ▪ 438.206 Availability of Services ▪ 438.207 Assurances of Adequate Capacity and Services ▪ 4.6 Self Directed Community Benefit PHP achieved "minimal" compliance for: ▪ 438.114 Emergency and Post Stabilization Services ▪ 4.13 Patient Centered Initiatives	X	X	X
Network Adequacy	PHP achieved "moderate" compliance for its provider network policies and procedures	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	reviewed during the compliance review of 2022.			
	One provider in the PHP network reported a panel that exceeded the maximum threshold of 2,000 patients.	X	X	X
	PHP did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ neurosurgeons, ▪ accredited residential treatment centers, ▪ day treatment service providers, ▪ freestanding psychiatric hospitals, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ rural health clinics providing behavioral health services, and ▪ treatment foster care I and II.		X	X
	Of the primary care providers and obstetricians/gynecologists surveyed by IPRO on behalf of PHP, 17.2% reported timely appointments.		X	X
	Of the primary care providers and obstetricians/gynecologists audited by IPRO on behalf of PHP, 49.4% verified the accuracy of information presented in PHP's online provider directory.		X	X
Quality-of-Care Survey	PHP achieved four adult CAHPS scores and four child CAHPS scores that did not the national Medicaid average.	X	X	X
NCQA Accreditation	Although PHP achieved NCQA accreditation status, PHP only achieved three of the possible five stars under NCQA's Star Rating program.	X	X	X
Recommendations				
Performance Improvement Projects	PHP should reassess its target-setting process to ensure improvement goals are appropriately challenging and aligned with performance expectations. Setting targets lower than baseline performance may not sufficiently drive meaningful improvement or address underlying issues.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	PHP should plan to continue the performance improvement projects until meaningful targets are met and sustainable improvement is realized. PHP should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
Performance Measures	PHP should continue to use the Human Services Performance Measure Program results in developing its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, PHP should focus on the areas of care in which its rates did not meet the target.	X	X	X
	PHP should enhance its quality improvement strategy, by tailoring broad interventions to address the specific barriers members and providers face when engaging the health care system; and consider conducting personalized appointment reminder calls to pregnant members and members with newborns and use the live contact opportunity to provide support for barriers attending scheduled appointments.	X	X	X
Compliance with Medicaid Standards	*438.114 Emergency and Post Stabilization Services – PHP should incorporate federal language around emergency and post–stabilization services requirements in a way that informs MCO staff, enrollees, and potential enrollees.* *438.206 Availability of Services* – PHP should continue its work to improve adherence to the credentialing requirements outlined in the Centennial Care 2.0 Contract and New Mexico Administrative Code. Specifically, PHP should ensure required disclosures are obtained in a timely manner. *438.207 Assurances of Adequate Capacity and Services* – PHP should consider new and innovative approaches to addressing the gaps in the breadth and size of its provider network.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	4.6 Self Directed Community Benefit – PHP should ensure that future agreements with the fiscal management agency include required language. *4.13 Patient Centered Initiatives* – PHP should determine the effective way to incorporate the requirement to record member choice into its processes such that providers and PHP staff are aware of the requirement. PHP should ensure that submitted evidence meets the requirements established by the external quality review organization. PHP should document applied processes of monitoring activities and the outcome of these activities.			
Network Adequacy	PHP should address the areas of noncompliance identified during the 2022 Compliance Review. Specifically, PHP should enhance its network development and maintenance plan to ensure its compliance with state credentialing requirements, improve member access to timely appointments, and increase the size of its Medicaid provider network.	X	X	X
	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 provide high quality care and to meet the established access, distance, and timeliness standards until the panel size is reduced.	X	X	X
	PHP should evaluate the decline in member utilization of telemedicine services	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 otolaryngology and federally qualified health center primary care provider 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	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	agencies to recruit providers to the State of New Mexico.			
	PHP should reference the Network Adequacy Protocol developed by the Centers for Medicare & Medicaid Services when designing future secret shopper surveys to ensure indicator rates are calculated appropriately.		X	X
	PHP should consider corrective actions to address the findings from IPRO's secret shopper survey and provider directory audits.		X	X
Quality-of-Care Survey	PHP should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

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Table 65: WSCC's Strengths, Opportunities and Recommendations for Improvement, 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Information System Capabilities Assessment	WSCC met all standards evaluated during the 2021–2022 Information System Capabilities Assessment.			
Performance Improvement Projects	Five of five performance improvement projects conducted in 2022 passed performance improvement project validation.			
Performance Improvement Project – Long-Term Care Services and Supports	None.			
Performance Improvement Project – Prenatal and Postpartum Care	Between 2019 and 2022, three of the three indicators demonstrated performance improvement.		X	X
Performance Improvement Project – Adult Obesity	Between 2019 and 2022, two of two indicators demonstrated performance improvement.	X		
Performance Improvement Project – Diabetes Prevention and Management	Between 2019 and 2022, two of two indicators demonstrated performance improvement.	X	X	X
Performance Improvement Project – Clinical Depression Screening and Follow-Up	Between 2019 and 2022, three of the three indicators demonstrated performance improvement.	X	X	X
Performance Measures	WSCC met all information system and validation requirements to successfully report HEDIS data to NCQA and the Human Services Department.			
	WSCC exceeded target rates for five of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	WSCC achieved "full" compliance with an *overall compliance average* score exceeding the 90% threshold.	X	X	X
Network Adequacy	As of December 2022, approximately 41.5% of WSCC's membership was assigned to a patient-centered medical home provider.	X	X	X
	Approximately 16,427 WSCC members completed a telemedicine visit in 2022, which accounted for 9% of Centennial Care		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	2.0 members with a telemedicine service in 2022.			
	In the 4th quarter of 2021, WSCC met state distance standards in all regions for the following provider types: ▪ adult and child primary care providers, ▪ cardiologists, ▪ certified nurse midwives, ▪ certified nurse practitioners, ▪ dermatologists, ▪ dental providers, ▪ otolaryngologists, ▪ federally qualified health centers, ▪ federally qualified health centers with primary care providers only, ▪ hematologists/oncologists, ▪ neurologists, ▪ obstetricians/gynecologists, ▪ orthopedists, ▪ pharmacies, ▪ physician assistants, ▪ podiatrists, ▪ surgeons, ▪ urologists, ▪ behavioral health management services, ▪ federally qualified health centers providing behavioral health services, ▪ intensive outpatient services, ▪ methadone clinics, ▪ other licensed independent behavioral health providers, ▪ outpatient provider agencies, ▪ psychiatrists, ▪ psychologists, ▪ Suboxone-certified medical doctors, ▪ general hospitals, ▪ nursing facilities, ▪ personal care service agencies, and ▪ transportation providers.		X	X
Quality-of-Care Survey	None.			
NCQA Accreditation	In 2022, WSCC was NCQA accredited.	X	X	X
	WSCC achieved five stars for the Equity subcategory.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	WSCC was awarded NCQA Long Term Services and Supports distinction and Multicultural Health Care distinction.	X	X	X
Opportunities for Improvement				
Performance Improvement Projects	Although WSCC's performance improvement projects passed validation, WSCC's data collection procedures for two projects resulted in the recalculation of indicator rates.			
Performance Improvement Project – Long-Term Care Services and Supports	Between 2019 and 2022, the single indicator demonstrated a performance decline.	X		
Performance Improvement Project – Prenatal and Postpartum Care	None.			
Performance Improvement Project – Adult Obesity	None.			
Performance Improvement Project – Diabetes Prevention and Management	None.			
Performance Improvement Project – Clinical Depression Screening and Follow-Up	None.			
Performance Measures	WSCC did not meet target rates for five of the 10 performance measures reported to the Human Services Department.	X	X	X
Compliance with Medicaid Standards	WSCC achieved "moderate" compliance in three subject areas under review and "minimal" compliance in one subject area under review. WSCC achieved "moderate" compliance for: ▪ 438.206 Availability of Services ▪ 438.207 Assurances of Adequate Capacity and Services ▪ 438.236 Practice Guidelines WSCC achieved "minimal" compliance for: ▪ 438.114 Emergency and Post Stabilization Services	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	WSCC achieved "moderate" compliance for its provider network policies and procedures reviewed during the compliance review of 2022.	X	X	X
	WSCC reported low provider counts for six physical health specialties, nine behavioral health specialties, and eight long-term care specialties.		X	X
	WSCC did not meet state distance standards for the following provider types in any region: ▪ Indian Health Services/Tribal 638/Urban Indian Health providers, ▪ rheumatologists, ▪ accredited residential treatment centers, assertive community treatment, ▪ community mental health centers, ▪ core service agencies, ▪ day treatment service providers, ▪ general hospitals with psychiatric units, ▪ Indian Health Service and Tribal 638s providing behavioral health services, ▪ non-accredited residential treatment centers and group homes, ▪ partial hospital programs, ▪ treatment foster care I and II, and ▪ assisted living facilities.		X	X
	Of the primary care providers and obstetricians/gynecologists surveyed by IPRO on behalf of WSCC, 23% reported timely appointments.		X	X
	Of the primary care providers and obstetricians/gynecologists audited by IPRO on behalf of WSCC, 50% verified the accuracy of information presented in WSCC's online provider directory.		X	X
	Of the specialists audited by IPRO on behalf of WSCC, 60% verified the accuracy of information presented in WSCC's online provider directory.		X	X
Quality-of-Care Survey	WSCC achieved one adult CAHPS score and one child CAHPS score that did not meet the national Medicaid average.	X		
NCQA Accreditation	Although WSCC achieved NCQA accreditation status, WSCC only achieved 2.5	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	of the possible five stars under NCQA's Star Rating program.			
Recommendations				
Performance Improvement Projects	WSCC should extend the duration of the current performance improvement projects to allow itself a reasonable amount of time to achieve goals and sustained improvement. WSCC should continue to routinely monitor the effectiveness of implemented interventions and modify them as needed.	X	X	X
	WSCC should evaluate its data collection procedures and tools to ensure that the validity and reliability of performance improvement project results are not compromised.			
Performance Measures	WSCC should continue to use the Human Services Performance Measure Program results in developing its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, WSCC should focus on the areas of care in which its rates did not meet the target.	X	X	X
	To enhance its quality improvement strategy, WSCC should include member, program, and provider-level interventions for each focus area to adequately address a comprehensive set of factors that contribute to members not receiving the services and supports that are clinically indicated.	X	X	X
Compliance with Medicaid Standards	*438.114 Emergency and Post Stabilization Services* – WSCC should incorporate federal language around emergency and post stabilization services requirements in a manner that informs MCO staff, enrollees, and potential enrollees. *438.206 Availability of Services* – WSCC should continue its work to improve adherence to the credentialing requirements outlined in the Centennial Care 2.0 Contract and New Mexico Administrative Code.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Specifically, WSCC should ensure required disclosures are obtained promptly. *438.207 Assurances of Adequate Capacity and Services* – WSCC should consider new and innovative approaches to addressing the gaps in the breadth and size of its provider network. *438.236 Practice Guidelines* – WSCC should establish a clear process for potential enrollees to request and receive information about the MCO, including the adopted practice guidelines.			
Network Adequacy	WSCC should address the areas of noncompliance identified during the 2022 Compliance Review. Specifically, WSCC should enhance its network development and maintenance plan to ensure its compliance with state credentialing requirements, improve member access to timely appointments, and increase the size of its Medicaid provider network.	X	X	X
	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 rheumatology and general hospitals with psychiatric units 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	X
	WSCC should evaluate the decline in member utilization of telemedicine services.	X	X	X
	WSCC should reference the Network Adequacy Protocol developed by the Centers for Medicare & Medicaid Services when designing future secret shopper surveys to ensure indicator rates are calculated appropriately. WSCC should include a thorough description of the applied		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	methodology in secret shopper reports to ensure that the external quality review organization has sufficient information to conduct the required validation steps.			
	WSCC should consider corrective actions to address the findings from IPRO's secret shopper survey and provider directory audits.		X	X
Quality-of-Care Survey	WSCC should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid average.	X	X	X

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Appendix A: Centennial Care 2.0 Tracking Measures Program

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description
#1	Fall Risk Management	The percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months, and who received fall risk intervention from their current practitioner.
# 2	Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with principal diagnosis codes for diabetes short-term complications for Medicaid members ages 18 and older. (A lower rate indicates improvement for this measure.)
# 3	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid members ages 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
#4	Follow-Up After Hospitalization for Mental Illness	Percent of seven-day follow-up visits into community-based behavioral health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days.
	Inpatient Psychiatric Facility/Unit	Discharges for members six years of age or older at the time of discharge who were hospitalized for treatment of mental health disorders for a continuous period of four days or more (i.e., discharge date more than three days after admission date). Includes only psychiatric units in general hospitals and freestanding psychiatric hospitals. For the purposes of tracking discharges and follow-ups, claims data should be used.
	Follow-Up After Hospitalization for Mental Illness	Discharges for members six years of age or older at the time of discharge who were hospitalized for treatment of mental health disorders for a continuous period of four days or more and who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within seven calendar days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment.
		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 this calculation, use age at time of discharge. Measure should be sorted by two categories and in two member groups: ▪ Number of inpatient facility discharges of members 6 to 17 years of age during the quarter; ▪ Number of inpatient facility discharges of members 18 years of age and older during the quarter; ▪ Number of members 6 to 17 years of age who had a follow-up visit within seven days after an inpatient facility discharge during the quarter; and ▪ Number of members 18 years of age and older who had a follow-up visit within seven days after an inpatient facility discharge during the quarter.

Tracking Measure Number	Tracking Measure Name	Tracking Measure Description
# 5	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Report rates for each vaccine and one combination rate.
# 6	Long-Acting Reversible Contraceptive	The MCO shall measure the use of long-acting reversible contraceptives among members ages 15 to 19 years.
# 7	Smoking Cessation	The MCO shall monitor and report quarterly, the use of smoking cessation products and counseling utilization within a calendar year.
# 8	Ambulatory Care Outpatient Visits	Utilization of outpatient visits reported as a rate per 1,000 member months. An increase in rate indicates improvement for this measure.
	Ambulatory Care Emergency Department Visits	Utilization of emergency department visits reported as a rate per 1,000 member months. (A lower rate indicates improvement for this measure.)
# 9	Annual Dental Visit	The percentage of enrolled members ages 2 to 20 years of age who had at least one dental visit during the measurement year.
# 10	Controlling High Blood Pressure	The percentage of members ages 18 to 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.
#11	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	The percentage of members ages 6 to 12 years newly prescribed attention-deficit/hyperactivity disorder medication who remained on the medications for at least 210 days who, in addition to the visit in the Initiation Phase had at least two follow-up visits with a practitioner within 9-months after the Initiation Phase. An increase in percentage indicates improvement for this measure.
#12	Child and Adolescent Well-Care Visits	The percentage of members ages 3 to 21 years who had at least one comprehensive well-care visit with a primary care provider or an obstetrician/gynecologist practitioner during the measurement year. An increase in percentage indicates improvement for this measure.

Appendix B: Managed Care Organization Performance Improvement Project Indicator Tables

BCBS Performance Improvement Project 1 – Long-Term Care Services – Urinary Tract Infection Indicators, Measurement Years 2020 to 2022

BCBS's Performance Improvement Project 1 – Long-Term Care Services and Support				
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Rate of urinary tract infection events per 1,000 days for the total long-term care resident population *(lower rate indicates better performance)*	4.78	4.70	2.83	4.30
Indicator 2 – The percentage of members 18 years of age and older who rate their health care as a 9 or 10	58.06%	56.59%	60.63%	61.60%

BCBS Performance Improvement Project 2 – Timeliness of Prenatal and Postpartum Care Indicators, Measurement Years 2020 to 2022

BCBS's Performance Improvement Project 2 – Prenatal and Postpartum Care				
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO[1]	79.32%	82.00%	82.97%	82.73%
Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery[1]	67.40%	69.10%	70.80%	65.95%
Indicator 3 – How satisfied are you with the help you received to coordinate your care in the last 6 months? (Satisfied or Very Satisfied)	73.84%	76.47%	77.55%	73.60%

[1] The rates for measurement years 2020 and 2021 are different than the rates presented in the *2021 Performance Improvement Project Validation Report*. The rates presented above were calculated using the hybrid method (medical record and claims review), while the rates presented in the *2021 Performance Improvement Project Validation Report* were calculated using the administrative method (claims review).

BCBS Performance Improvement Project 3 – Adult Obesity Indicators, Measurement Years 2020 to 2022

BCBS's Performance Improvement Project 3 – Adult Obesity				
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had at least one claim with an obesity diagnosis during the measurement year *(lower rate indicates better performance)*	4.79%	3.92%	5.93%	4.69%
Indicator 2 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (less than 140/90) in the most recent blood pressure reading during the measurement year[1]	51.09%	46.47%	52.80%	55.09%
Indicator 3 – The number of members ages 18 to 85 years who had a diagnosis of hypertension with blood pressure control (less than 140/90) in the most recent blood pressure reading during the measurement year[2]	7.52%	20.83%	25.87%	25.00%
Indicator 4 – The percentage of members ages 18 to 75 years with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year that is greater than 9% 1 *(lower rate indicates better performance)*	52.31%	51.34%	53.28%	46.61%
Indicator 5 – The percentage of members 18 years of age and older who received material from the MCO about good health and how to stay healthy	55.84%	52.13%	48.22%	60.80%

[1] Rate calculated using the hybrid method (medical record and claims review).
[2] Rate calculated using the administrative method (claims review).

BCBS Performance Improvement Project 4 – Diabetes Management and STCA Rate HbA1c Testing Indicators, Measurement Years 2020 to 2022

BCBS's Performance Improvement Project 4 – Diabetes Prevention and Management				
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 18 to 64 years *(lower rate indicates better performance)*	24.06	21.68	24.84	20.06
Indicator 2 – Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members, ages 65 years and older *(lower rate indicates better performance)*	22.81	20.82	27.10	18.81
Indicator 3 – The percentage of members ages 18 to 75 years with diabetes during the measurement year who complete an HbA1c test	78.83%	80.05%	68.68%	82.83%
Indicator 4 – The percentage of providers satisfied with the timeliness of discharge information received	35.10%	58.62%	49.21%	39.00%
Indicator 5 – The percentage of providers indicating having received adequate information about medication at discharge	43.07%	67.24%	53.85%	47.00%
Indicator 6 – The percentage of members indicating ease of getting necessary care, tests or treatment needed (Always or Usually)	New Indicator Beginning Measurement Year 2021	86.29%	79.07%	85.50%

BCBS Performance Improvement Project 5 – Screening and Management for Clinical Depression Indicators, Measurement Years 2020 to 2022

BCBS's Performance Improvement Project 5 – Clinical Depression Screening and Follow-Up				
Performance Indicator Description	Baseline Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	52.68%	59.41%[1]	59.38%	≥56.70%
Indicator 2 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	80.00%	73.97%	73.85%	≥84.00%
Indicator 3 – The percentage of members ages 18 to 64 years who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	35.38%	40.63%[1]	40.83%	≥39.40%
Indicator 4 – The percentage of members ages 65 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	60.00%	35.85%[1]	50.77%	≥64.00%
Indicator 5 – The percentage of members aged 18 to 64 years screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	0.55%	1.37%	1.90%	≥10.60%
Indicator 6 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	1.39%	1.83%	1.74%	≥11.40%

[1] Measurement year 2021 rates for Indicator #1, Indicator #3, and Indicator #4 are different than the rates presented in the *2021 Performance Improvement Project Validation Report*. Indicator #1, measurement year 2021 was previously reported as 55.98%. Indicator #3, measurement year 2021 was previously reported as 35.85%. Indicator #4, measurement year 2021 was previously reported as 53.42%.

PHP Performance Improvement Project 1 – Success Within the Self-Directed Community Benefit Program Indicators, Measurement Years 2021 to 2022

PHP's Performance Improvement Project 1 Indicator Summary – Long-Term Care Services and Supports			
Performance Indicator Description	Baseline Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Volume of members who successfully remained eligible within the Self-Directed Community Benefit	98.01%	98.05%	95.00%[1]
Indicator 2 – Volume of members who were voluntarily terminated from the Self-Directed Community Benefit *(lower rate indicates better performance)*	1.99%	1.88%	7.00%[1]
Indicator 3 – Volume of members for whom PHP did not receive a grievance related to their experience within the Self-Directed Community Benefit	99.59%	99.46%	95.00%[1]

[1] PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance.

PHP Performance Improvement Project 2 – Decreasing Pregnancy Risks for Native American Women in New Mexico Indicators, Measurement Years 2021 to 2022

PHP's Performance Improvement Project 2 – Prenatal and Postpartum Care			
Performance Indicator Description	Baseline Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of deliveries that received a prenatal care visit as a member of the contractor's MCO in the first trimester or within 42 calendar days of enrollment in the MCO	67.22%	78.14%	82.73%
Indicator 2 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	68.33%	72.95%	65.95%[1, 2]
Indicator 3 – The percentage of high-risk pregnant women who engage in any community service program	New Measure in 2022	31.30%	Not Yet Established

[1] PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance. [2] The target rate selected by PHP is the target rate established by the Human Services Department under the Performance Measure Program for PM 4 *Timeliness of Prenatal and Postpartum Care – Postpartum Care.* The Human Services Department does not require Centennial Care 2.0 MCOs to utilize Performance Measure Program-specific target rates for MCO-led performance improvement projects.

PHP Performance Improvement Project 3 – Adult Obesity Indicators, Measurement Years 2021 to 2022

PHP's Performance Improvement Project 3 Indicator Summary – Adult Obesity			
Performance Indicator Description	Baseline Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	58.12%	62.20%	60.12%
Indicator 2 – The percentage of members ages 19 and older with a primary diagnosis of obesity in the measurement year *(lower rate indicates better performance)*	0.51%	1.05%	0.50%

PHP Performance Improvement Project 4 – Diabetes Prevention and Management Indicators, Measurement Years 2021 to 2022

PHP's Performance Improvement Project 4 Indicator Summary – Diabetes Prevention and Management			
Performance Indicator Description	Baseline Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Short-term complications rate for Native Americans in the northwest part of New Mexico state per 100,000 members *(lower rate indicates better performance)*	37.80[1]	42.46	34.80
Indicator 2 – The percentage of Native Americans residing in the northwestern region of New Mexico state with a hemoglobin A1c rate that is lower than 8%	7.00%[1]	9.13%	10.00%

[1] The rate represents the period from January 1, 2021 to October 31, 2021.

PHP Performance Improvement Project 5 – Diagnosing Depression for Improved Behavioral and Physical Health Outcomes Indicators, Measurement Years 2021 to 2022

PHP's Performance Improvement Project 5 Indicator Summary – Clinical Depression Screening and Follow-Up			
Performance Indicator Description	Baseline Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of members aged 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)	63.72%	61.99%	55.75%[1]
Indicator 2 – The percentage of members aged 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)	44.80%	42.33%	35.19%[1, 2]
Indicator 3 – The percentage of members aged 18 years older who had an outpatient visit with a physical or behavioral health provider and a diagnosis of major depression during the measurement year	4.18%	5.34%	5.02%
Indicator 4 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	1.72%	2.21%	1.32%[1]

[1] PHP's performance to the target rate should be considered with caution. PHP selected a target rate for improvement that is lower than baseline performance. [2] The target rate selected by PHP is the target rate established by the Human Services Department under the Performance Measure Program for PM 6 *Antidepressant Medication Management – Continuation Phase*. The Human Services Department does not require Centennial Care 2.0 MCOs to utilize Performance Measure Program-specific target rates for MCO-led performance improvement projects.

WSCC Performance Improvement Project 1 – Fall Risk and Prevention Program Indicators, Measurement Years 2019 to 2022

Performance Improvement Project 1 Indicator Summary – Long-term Care Services and Supports					
Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Rate of members who experienced a fall-related hospitalization via claims in the population of long-term services and supports members ages 60 years and older living in the community during the measurement year *(lower rate indicates better performance)*	190.78[1]	882.35	565.22	196.72	152.00

[1] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2019 was previously reported as 545.47 (in 2020).

WSCC Performance Improvement Project 2 – Addiction in Pregnancy Program Indicators, Measurement Years 2019 to 2022

WSCC's Performance Improvement Project 2 Indicator Summary – Prenatal and Postpartum Care					
Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who were initiated for treatment for alcohol and other substances 14 days within diagnosis	44.74%[1]	46.49%	44.91%	58.14%	48.50%
Indicator 2 – Percentage of pregnant members ages 13 years and older who have experienced a new episode of alcohol and other drug abuse or dependence as of December 31 of the measurement year who engaged in treatment for alcohol and other substances within 34 days of initial treatment	15.79%[2]	14.91%	16.11%	17.44%	16.90%
Indicator 3 – The percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery	42.43%	46.91%	60.10%[3]	67.64%[3]	48.91%

[1] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2019 was previously reported as 46.21% (in 2021). [2] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #2, measurement year 2019 was previously reported as 14.39% (in 2021). [3] Rates for measurement years 2021 and 2022 were calculated using the hybrid methodology.

WSCC Performance Improvement Project 3 – Adult Weight Management Program Indicators, Measurement Years 2019 to 2022

WSCC's Performance Improvement Project 3 Indicator Summary – Adult Obesity					
Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – The percentage of members ages 18 to 74 years who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	10.20%[1]	36.70%	25.07%[2,3]	25.07%[3]	41.70%[4]
Indicator 2 – The percentage of members ages 19 years and older with a documented body mass index of greater than 30 kg/m *(lower rate indicates better performance)*	59.45%[5]	34.90%	6.69%	6.20%	54.40%

[1] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2019 was previously reported as 17.20% (in 2021). [2] The measurement year 2021 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2021 was previously reported as 6.70% (in 2021). [3] Rate reflects measurement year 2021 and 2022 data. Starting with measurement year 2021, the data collection methodology for this measure was modified to include a two-year reporting period. [4] For measurement year 2021, the target rate was increased to 41.70% from the initial target rate of 20.20%. [5] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #2, measurement year 2019 was previously reported as 63.70% (in 2021).

WSCC Performance Improvement Project 4 – Diabetes Prevention and Management, Measurement Years 2019 to 2022

WSCC's Performance Improvement Project 4 Indicator Summary – Diabetes Prevention and Management					
Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 – Rate of admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 members ages 18 years and older *(lower rate indicates better performance)*	24.35[1]	16.94	10.33[2]	10.07	19.35
Indicator 2 – The percentage of members ages 18 to 75 years of age with diabetes (type 1 and type 2) who had a HbA1c screening	40.93%[3]	66.84%[4]	75.43%[5]	69.21%[4]	66.66%

[1] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2019 was previously reported as 23.53 (in 2020) and 7.42 (in 2021). [2] The measurement year 2021 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2021 was previously reported as 23.94 (in 2021). [3] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #2, measurement year 2019 was previously reported as 52.59% (in 2021). [4] Rate calculated using the administrative method (claims review). [5] Rate calculated using the hybrid method (medical record and claims review).

WSCC Performance Improvement Project 5 – Management for Clinical Depression Indicators, Measurement Years 2019 to 2022

WSCC's Performance Improvement Project 5 Indicator Summary – Clinical Depression Screening and Follow-up					
Performance Indicator Description	Baseline Period Measurement Year 2019	Interim Period Measurement Year 2020	Interim Period Measurement Year 2021	Interim Period Measurement Year 2022	Target Rate
Indicator 1 - The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)	45.26%[1]	53.17%	60.60%	60.86%	55.17%[2]
Indicator 2 - The percentage of members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months)	32.85%[3]	36.46%	43.67%	40.32%	38.46%[4]
Indicator 3 – The percentage of members aged 18 years and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter	0.41%[5]	1.96%[6]	1.13%	0.88%	1.08%

[1] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #1, measurement year 2019 was previously reported as 36.23 (in 2021). [2] For measurement year 2022, the target rate was increased to 55.17% from the initial target rate of 37.34%. [3] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #2, measurement year 2019 was previously reported as 0.37% (in 2020) and 18.85% (in 2021). [4] For measurement year 2022, the target rate was increased to 38.46% from the initial target rate of 34.76%. [5] The measurement year 2019 rate differs from what was previously reported by WSCC. Indicator #3, measurement year 2019 was previously reported as 0.42% (in 2021). [6] The measurement year 2020 rate differs from what was previously reported by WSCC. Indicator #3, measurement year 2020 was previously reported as 0.37 (in 2020) and 2.03% (in 2021).

Appendix C: Managed Care Organization Performance Measure Tables, Measurement Years 2019 to 2022

BCBS Performance Measure Rates for Measurement Years 2019 to 2022

Performance Measure (PM)	BCBS Measurement Year 2019 Rate	BCBS Measurement Year 2020 Rate	BCBS Measurement Year 2021 Rate	BCBS Measurement Year 2022 Rate	Difference Between BCBS's Measurement Years 2021 and 2022 Rates (Percentage Points)	Measurement Year 2022 Target Rate
PM 1 W30 First 15 Months	65.94%	56.89%	58.54%	61.70%	+3.16	64.82%
PM 2 WCC Physical Activity	45.50%	50.36%	55.72%	59.61%	+3.89	58.14%
PM 3 PPC Prenatal Care	84.43%	79.32%	82.00%	82.97%	+0.97	82.73%
PM 4 PPC Postpartum Care	64.48%	67.40%	69.10%	70.80%	+1.70	65.95%
PM 5 CIS Combo 3	70.80%	70.56%	69.59%	70.80%	+1.21	70.53%
PM 6 AMM Continuation	37.35%	39.81%	40.63%	40.83%	+0.20	35.19%
PM 7 IET Initiation	41.05%	43.77%	42.91%	45.97%	+3.06	46.14%
PM 8 FUH 30 Day	41.62%	51.94%	56.60%	54.61%	-1.99	52.02%
PM 9 FUM 30 Day	56.27%	59.36%	56.57%	56.06%	-0.51	46.50%
PM 10 SSD	79.02%	76.46%	77.59%	78.21%	+0.62	82.07%
Available Points	19	10	10	10		
Points Earned	12	8	7	7		

PHP Performance Measure Rates for Measurement Years 2019 to 2022

Performance Measure (PM)	PHP Measurement Year 2019 Rate	PHP Measurement Year 2020 Rate	PHP Measurement Year 2021 Rate	PHP Measurement Year 2022 Rate	Difference Between PHP's Measurement Years 2021 and 2022 Rates (Percentage Points)	Measurement Year 2022 Target Rate
PM 1 W30 First 15 Months	66.67%	49.63%	44.37%	65.98%	+21.61	64.82%
PM 2 WCC Physical Activity	49.15%	49.88%	58.15%	58.35%	+0.20	58.14%
PM 3 PPC Prenatal Care	90.51%	68.61%	67.22%	78.14%	+10.92	82.73%
PM 4 PPC Postpartum Care	75.43%	69.59%	68.33%	72.95%	+4.62	65.95%
PM 5 CIS Combo 3	69.83%	67.64%	63.02%	70.56%	+7.54	70.53%
PM 6 AMM Continuation	39.31%	42.38%	44.80%	42.33%	-2.47	35.19%
PM 7 IET Initiation	42.79%	54.12%	54.25%	55.10%	+0.85	46.14%
PM 8 FUH 30 Day	40.22%	54.84%	53.84%	55.03%	+1.19	52.02%
PM 9 FUM 30 Day	61.01%	64.83%	63.40%	59.36%	-4.04	46.50%
PM 10 SSD	79.51%	75.14%	78.48%	80.59%	+2.11	82.07%
Available Points	19	10	10	10		
Points Earned	11	6	6	8		

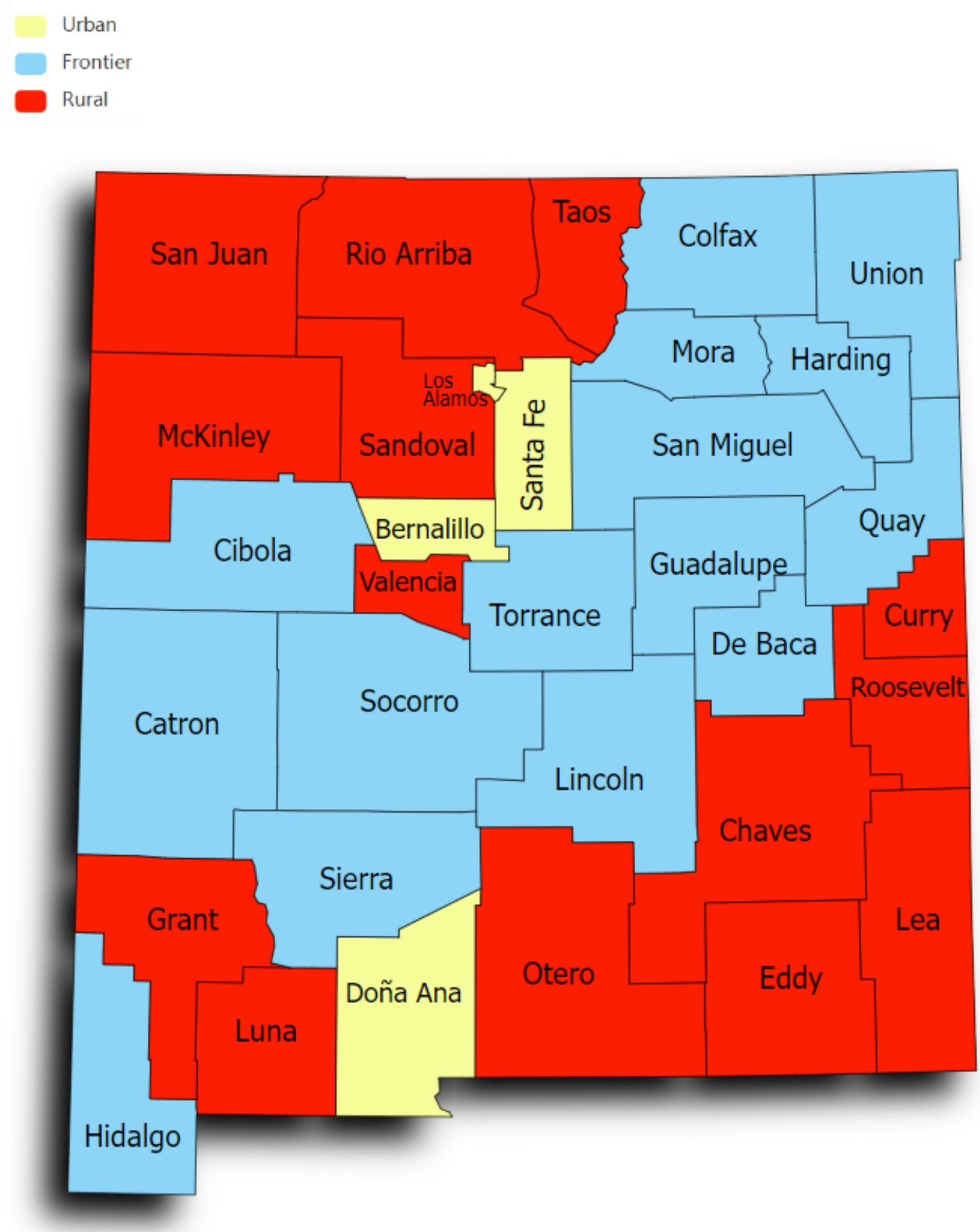
WSCC Performance Measure Rates for Measurement Years 2019 to 2022

Performance Measure (PM)	WSCC Measurement Year 2019 Rate	WSCC Measurement Year 2020 Rate	WSCC Measurement Year 2021 Rate	WSCC Measurement Year 2022 Rate	Difference Between WSCC's Measurement Years 2021 and 2022 Rates (Percentage Points)	Measurement Year 2022 Target Rate
PM 1 W30 First 15 Months	Small Denominator	42.70%	51.18%	55.77%	+4.59	64.82%
PM 2 WCC Physical Activity	50.36%	43.31%	51.82%	51.34%	-0.48	58.14%
PM 3 PPC Prenatal Care	70.80%	68.37%	61.31%	78.35%	+17.04	82.73%
PM 4 PPC Postpartum Care	59.12%	59.85%	60.10%	67.64%	+7.54	65.95%
PM 5 CIS Combo 3	58.33%	61.56%	58.88%	60.10%	+1.22	70.53%
PM 6 AMM Continuation	32.85%	36.46%	43.67%	43.32%	-0.35	35.19%
PM 7 IET Initiation	41.89%	43.26%	44.91%	48.30%	+3.39	46.14%
PM 8 FUH 30 Day	35.36%	53.85%	53.94%	56.22%	+2.28	52.02%
PM 9 FUM 30 Day	45.70%	42.76%	46.62%	54.61%	+7.99	46.50%
PM 10 SSD	70.79%	73.69%	77.54%	79.04%	+1.50	82.07%
Available Points	19	10	10	10		
Points Earned	Not Applicable[1]	2	4	5		

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

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

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



Appendix E: Managed Care Organization CAHPS Tables, Measurement Years 2019 to 2022

BCBS Adult CAHPS Results, Measurement Years 2019 to 2022

Adult CAHPS Measures	BCBS			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	79.0%	79.0%	84.5%	74.3%
Rating of All Health Care	78.8%	75.8%	76.0%	74.0%
Rating of Personal Doctor[1]	88.1%	82.5%	80.7%	84.9%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	Small Sample	81.1%	76.9%	73.6%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	96.0%	93.0%	88.1%	91.8%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

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

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

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

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BCBS General Population-Child CAHPS Results, Measurement Years 2019 to 2022

General Population Child CAHPS Measures	BCBS			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	88.9%	85.4%	83.1%	84.0%
Rating of All Health Care	86.0%	86.1%	88.0%	84.0%
Rating of Personal Doctor[1]	90.8%	90.7%	89.4%	91.0%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample	Small Sample
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	93.8%	Small Sample	Small Sample	93.1%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

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

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

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

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PHP Adult CAHPS Results, Measurement Years 2019 to 2022

Adult CAHPS Measures	PHP			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	78.7%	73.2%	78.2%	80.2%
Rating of All Health Care	78.7%	76.5%	68.7%	76.7%
Rating of Personal Doctor[1]	82.1%	81.4%	79.9%	80.1%
Rating of Specialist Seen Most Often[1]	89.4%	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	80.8%	81.4%	74.5%	76.0%
Getting Needed Care[2]	81.6%	81.4%	76.4%	76.2%
Customer Service[2]	92.6%	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	93.2%	88.7%	90.2%	90.8%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

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

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

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

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PHP General Population-Child CAHPS Results, Measurement Years 2019 to 2022

General Population Child CAHPS Measures	PHP			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	87.3%	88.2%	86.8%	87.8%
Rating of All Health Care	87.8%	85.5%	81.5%	84.7%
Rating of Personal Doctor[1]	91.1%	92.3%	90.4%	89.0%
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	87.9%	Small Sample	Small Sample	79.2%
Getting Needed Care[2]	85.2%	Small Sample	Small Sample	Small Sample
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample
How Well Doctors Communicate[2]	95.5%	94.9%	91.4%	91.5%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

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

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

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

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WSCC Adult CAHPS Results, Measurement Years 2019 to 2022

Adult CAHPS Measures	WSCC			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	Small Sample	76.7%	77.7%	73.0%
Rating of All Health Care	Small Sample	Small Sample	Small Sample	73.0%
Rating of Personal Doctor[1]	Small Sample	83.2%	Small Sample	79.0%
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample	78.8%
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	76.1%
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample	76.8%
Customer Service[2]	Small Sample	Small Sample	Small Sample	91.4%
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample	91.8%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	82.3%

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

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

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

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WSCC General Population-Child CAHPS Results, Measurement Years 2019 to 2022

General Population Child CAHPS Measures	WSCC			
	2020 CAHPS Measurement Year 2019	2021 CAHPS Measurement Year 2020	2022 CAHPS Measurement Year 2021	2023 CAHPS Measurement Year 2022
Rating of Health Plan[1]	Small Sample	84.3%	87.8%	87.3%
Rating of All Health Care	Small Sample	Small Sample	Small Sample	82.2%
Rating of Personal Doctor[1]	Small Sample	91.5%	87.6%	86.6%
Rating of Specialist Seen Most Often[1]	Small Sample	Small Sample	Small Sample	Small Sample
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	82.1%
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample	78.5%
Customer Service[2]	Small Sample	Small Sample	Small Sample	83.2%
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample	92.1%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Small Sample

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

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

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

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