State of New Mexico

Michelle Lujan Grisham
Governor

June 7, 2019

The Hon. Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

I am pleased to submit New Mexico's request to amend its Section 1115 Demonstration Waiver for the state's Medicaid managed care program, Centennial Care 2.0.

The state's goals for amending the demonstration are to continue providing the most effective, efficient, and high-quality health care possible for covered New Mexicans while we advance the care and service delivery reforms that were initiated during the previous demonstration period. Specifically, New Mexico's goals are to:

- Assure that Centennial Care members 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 New Mexico Medicaid program.

Today, Centennial Care 2.0 features an integrated and comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care, pharmacy benefits, behavioral health services, institutional care, and home and community-based services (HCBS). However, there are several policy decisions reflected in the approved waiver that the state does not intend to pursue under my administration, and which we are seeking to change through the amended waiver.

Below please find a summary of the specific waiver changes that New Mexico is requesting:

- **Removal of co-payment requirements for Centennial Care members.** The waiver

Special Terms and Conditions (STCs) refer to new co-payments for non-emergency use of the hospital emergency department (ED) and non-preferred prescription drugs. New Mexico sees value in reducing unnecessary use of the health care system, but does not believe that co-payments will be an effective strategy in driving changes in provider or member behavior. New Mexico's rate of preferred/generic drug utilization already exceeds 85 percent, indicating that the Centennial Care program is very effectively managing the Medicaid pharmacy benefit. Our state is interested in working with its hospital partners to examine alternative policy options for reducing unnecessary ED use without passing additional costs onto low-income New Mexicans or placing an administrative hardship on our provider network through new co-pays.

- **Premiums for members of the Adult Expansion Group.** As written, the waiver STCs include the authority to implement new monthly premiums for members in the Adult Expansion category who have income above 100 percent of the federal poverty level (FPL). I have serious concerns about the impact that premiums could have on maintaining continuity of coverage for these low-income adults by burdening them with an unnecessary financial hardship. Implementing premiums would also negatively affect New Mexico's already strained provider network by increasing uncompensated care and unpaid medical bills, ultimately resulting in higher costs and greater pent-up demand for services over the long-term. Instead of implementing premiums, we are very interested in pursuing other policy strategies that will help keep eligible individuals enrolled to avoid lapses in coverage and needed medical care.

- **Limitations on retroactive eligibility.** The waiver STCs require New Mexico to phase-out retroactive eligibility for non-pregnant adults over a two-year timeframe. Starting January 1, 2019, New Mexico implemented the first phase, which institutes a maximum one-month retroactive eligibility period for affected individuals. Phase two, which would be the complete elimination of retroactive eligibility for these individuals, is scheduled to begin on January 1, 2020. As stated above, I am very concerned about the financial strain that this policy change will have on low-income New Mexicans and on an already fragile health care workforce through additional costs, uncompensated care, and unmet medical needs. While the state has already implemented the first phase of this policy change in accordance with the waiver, we are interested in discussing the best and fastest way to reverse this decision; and we do not intend to execute the second phase to eliminate retroactive coverage for this population altogether.

- **Increase the number of Community Benefit slots by 1,500 between 2019 and 2023.** Centennial Care expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. New Mexico projects the need to increase the number of slots by 1,500 through the waiver amendment from 4,289 to 5,789 in order to accommodate the growth rate of this population and their medical service needs.

- **Expand the Centennial Home Visiting (CHV) pilot program.** The CHV pilot program focuses on prenatal care, post-partum care and early childhood development in up to four

state-designated counties. New Mexico is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by the state throughout the term of the waiver.

Thank you in advance for your partnership with New Mexico in discussing these provisions of the waiver amendment. We look forward to working with your team at the Centers for Medicare and Medicaid Services (CMS) to discuss the terms of these revisions as we work toward achieving the goals of the demonstration amendment waiver.

Sincerely,

[redacted]

Michelle Lujan Grisham
Governor

State of New Mexico
Human Services Department

Centennial Care 2.0 1115 Demonstration
Amendment Request

to

The Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Dr. David R. Scrase, M.D., Cabinet Secretary
New Mexico Human Services Department

Nicole Comeaux J.D., M.P.H., Director
Medical Assistance Division

June 12, 2019

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SECTION 1: PURPOSE, GOALS AND OBJECTIVES

A. Statement of Purpose

The New Mexico Human Services Department (HSD) is seeking federal authority to amend the 1115 Centennial Care 2.0 Demonstration (Project Number 11W-00285/6) to make the following changes:

- Remove co-payment requirements for non-emergency use of the hospital emergency department (ED) and non-preferred prescription drugs.
- Remove premium requirements for Centennial Care 2.0 members in the Adult Expansion Group category with household income above 100% of the Federal Poverty Level (FPL), including removal of the grace period and lock-out provisions for non-payment of premiums.
- Remove the requirement to phase-out and eliminate the three-month retroactive coverage period for non-pregnant adults covered under Centennial Care 2.0.
- Increase the number of Community Benefit (CB) allocation slots for members who do not meet standard Medicaid financial eligibility and who have been determined to meet nursing facility level of care (NF LOC). The state proposes an increase of 1,500 slots over the demonstration period from 4,289 to 5,789.
- Expand the number of Centennial Home Visiting (CHV) pilot counties beyond the four counties that are currently approved to allow for future expansion in other parts of the state and to additional Centennial Care 2.0 members.

The requested changes will impact the currently approved waiver authorities, expenditure authorities and Special Terms and Conditions (STCs) for the period between July 1, 2019 and December 31, 2023. Please visit the following link to see the current approved waiver authorities, expenditure authorities and STCs:

http://www.hsd.state.nm.us/approvals.aspx

Please note that the STCs for Centennial Care 2.0 are currently being modified by CMS to make technical corrections identified by both HSD and CMS.

B. Centennial Care 2.0 Goals and Objectives

The state's goals for amending the demonstration for New Mexico's Medicaid managed care program, known as Centennial Care 2.0, include providing the most effective, efficient health care possible for covered New Mexicans and to continue the health care delivery reforms that were initiated during the previous demonstration period. Specifically, the state's goals are to:

- Assure that Centennial Care 2.0 members 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.

Today, Centennial Care 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and community-based services (HCBS).

The demonstration provides an opportunity for the state to continue advancing successful initiatives while implementing new, targeted strategies to address specific gaps in care and improve health care outcomes for its most vulnerable members. Key initiatives of the Centennial Care 2.0 demonstration include:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

As part of the demonstration amendment, the state will continue to expand access to LTSS through the Community Benefit (CB) that includes both the personal care and HCBS benefits, and by allowing eligible members who meet a NF LOC to access the CB without the need for a demonstration slot. Individuals who are not otherwise Medicaid eligible and meet the criteria for the 217-like group will be able to access the CB if a slot is available. As is the case today, managed care enrollment will be required for all members who meet NF level of care or who are dually eligible.

C. Public Process

The state has fully complied with Centennial Care 2.0 STCs #6, #7 and #9 in submitting this amendment request to CMS.

For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such a request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

In addition, the state must apply with tribal and Indian Health Program/Urban Indian Organization consultation requirements in section 1902(a) (73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC #6 or extension, are proposed by the state.

Please refer to Section 8 for details about the proposed timeline, public input and Tribal Consultation process for this amendment application.

SECTION 2: AMENDMENT PROPOSALS

Amendment Proposal #1: Remove co-payment requirements for non-emergency use of the hospital ED and non-preferred prescription drugs.

The current Centennial Care 2.0 demonstration would allow co-payments of $8 for non-emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care 2.0 members. HSD does not intend to implement these co-payments, and seeks to move this authority from the demonstration.

HSD sees value in reducing unnecessary use of the health care system but does not believe that co-payments will be an effective strategy in driving changes in provider or member behavior. HSD will work collaboratively with its hospital partners to examine alternative policy options for reducing unnecessary ED use without passing additional costs onto low-income New Mexicans or placing an administrative hardship on the state's provider network through new co-payments.

Amendment Proposal #2: Remove premium requirements for the Adult Expansion Group population with household income above 100% FPL

The current Centennial Care 2.0 demonstration requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% FPL. HSD does not intend to implement premiums, and seeks to remove the requirement to implement them from the demonstration. This includes all references in the demonstration to the grace period and lock-out provisions for premium non-payment.

HSD is concerned about the impact that implementing premiums would have on maintaining continuity of coverage for these low-income adults by burdening them with an unnecessary financial hardship. Implementing premiums would also negatively affect New Mexico's already strained provider network by increasing uncompensated care and unpaid medical bills, ultimately resulting in higher costs and greater pent-up demand for services over the long-term.

Amendment Proposal #3: Reinstate Retroactive Eligibility

The current Centennial Care 2.0 demonstration includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care 2.0. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the demonstration requires the Department to eliminate retroactive coverage for this population completely.

HSD is concerned about the financial strain that removing or limiting retroactive coverage will have on low-income New Mexico residents and on a fragile health care workforce through additional costs, uncompensated care and unmet medical needs. HSD does not intend to proceed with eliminating retroactive coverage in 2020, and seeks federal approval to reinstate the full retroactive coverage period for all affected individuals as quickly as possible. The Department's proposed effective date for reinstating retroactive coverage is July 1, 2019.

Amendment Proposal #4: Increase the number of Community Benefit slots by 1,500 between 2019 and 2023.

Centennial Care 2.0 expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a demonstration allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care 2.0 demonstration. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase. The Department is proposing to increase the number of slots by 1,500 through the demonstration amendment.

The increased slots will permit the state to:

- Continue coverage of the CB for members in the Other Adult Expansion population that lose coverage due to aging out of that category;
- Continue coverage of members that are currently receiving the CB who lose full disability coverage;
- Transition members in nursing facilities to the community through a community reintegration allocation;
- Add new members allocated from the central registry; and
- Provide more individuals access to community services and supports.

Amendment Proposal #5: Expand the number of areas that can be served by the Centennial Home Visiting (CHV) Pilot Program.

The CHV pilot program focuses on prenatal care, post-partum care and early childhood development in up to four state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by the Department throughout the term of the demonstration.

Specifically, HSD's proposed changes to this approved program includes:

- Permitting additional CHV pilot sites beyond the currently approved state-designated four counties;
- Increasing the number of members enrolled in the pilot beyond 300; and
- Allowing the state authority to expand beyond the Nurse Family Partnership (NFP) and Parents as Teachers (PAT) models to include emerging evidence-based models during the duration of the demonstration.

SECTION 3: CURRENT PROGRAM DESIGN

A. Current Populations Covered

Table 1 represents the eligibility groups currently served in Centennial Care 2.0. As of May 2018, New Mexico's Medicaid program covered approximately 828,000 individuals, with more than 660,000 enrolled in Centennial Care. Since the end of 2013, HSD has enrolled more than 390,000 new individuals into the program, with the largest growth attributed to the Medicaid adult expansion program.

Table 1 – Eligibility Groups Covered in Centennial Care 2.0

Population Group	Populations
TANF and Related	Newborns, infants, and children Children's Health Insurance Program (CHIP) Foster children Adopted children Pregnant women Low-income parent(s)/caretaker(s) and families Breast and cervical cancer Refugees Transitional medical assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI

The following populations are excluded from Centennial Care 2.0:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with an Intellectual Disability;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only; and
- Mi Via 1915(c) waiver participants for HCBS.

Appendix F provides the complete table of mandatory and optional populations covered in the current demonstration and outlined in the approved STCs.

B. Current Demonstration Benefits

Centennial Care 2.0 provides a comprehensive package of services that include behavioral health, physical health, and long-term care services and supports. Members meeting NF LOC are able to access LTSS through CB services (i.e., home and community-based services) without a demonstration slot. The CB is available through agency-based community benefit services (ABCB) (services provided by a provider agency) and self-directed community benefit services (SDCB) (services that a participant can control and direct).

Centennial Care 2.0 also includes services only available for individuals enrolled in Centennial Care 2.0, including the Community Interveners for deaf and blind individuals. A Community Intervener is a trained professional who works one-on-one with deaf-blind individuals who are older than four years of age to provide critical connections to other people and the community.

Appendix G provides the comprehensive benefits currently available to Centennial Care 2.0 members and outlined in the approved STCs.

SECTION 4: WAIVER LIST

The following table represents the currently approved waiver authorities that should be eliminated to address the demonstration amendment proposals outlined in Section 3. All other currently approved waiver authorities should remain in force.

A. Title XIX Demonstration Amendment Language Removal/Elimination

2. Reasonable Promptness and Medical Assistance	**Section 1902(a)(8) and (10)**
To the extent necessary to enable the state to begin benefit coverage on the first day of the month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable the state to prohibit initial enrollment for individuals who fail to pay required premiums. To the extent necessary to enable the state to suspend coverage for individuals detailed in STC 60(a) who fail to pay required premiums until such time the premiums are paid in full or a hardship waiver, as detailed in STC 60(a)(1), is granted.	
3. Retroactive Eligibility	**Sections 1902(a)(10) and (34) 42 CFR 435.915**
To the extent necessary to enable the state to reduce, and then eliminate in demonstration year 7, coverage for the three-month period prior to the date that an application for medical assistance (and treatment as eligible for medical assistance) is made for specified eligibility groups, as described in STC 23. This waiver does not apply with respect to individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.	
4. Premiums	**Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).	
5. Comparability	**Sections 1902(a)(17) and 1902(a)(10)(B)**
To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).	

B. Expenditure Authority Requests

No language changes are required as part of the demonstration amendment proposals.

SECTION 5: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The current demonstration including current STCs were approved in December 2018 and are effective for the five-year period between January 1, 2019 to December 31, 2023. As currently approved, New Mexico is compliant with the requirements of the approved Centennial Care 2.0 demonstration.

SECTION 6: APPROACH TO BUDGET NEUTRALITY

A. Budget Neutrality Overview

The proposed demonstration amendment proposals will have a minimal impact to the budget neutrality.

B. CHIP Allotment Neutrality

The amendment proposals will not impact allotment neutrality.

C. Budget Neutrality Summary

The federal share of the combined Medicaid expenditures for the populations included in this demonstration, excluding those covered under the Title XXI Allotment Neutrality, will not exceed the federal share of Medicaid expenditures would have been without the demonstration.

HSD makes the following assumptions with regard to budget neutrality:

- HSD proposes a per capita budget neutrality model for the populations covered under the demonstration and outline the per capita limit by Medicaid Eligibility Group (MEG) and proposes an aggregate cap, trended annually for uncompensated care and Hospital Quality Improvement Incentive expenditures;
- State administrative costs are not subject to the budget neutrality calculations;
- The projected savings is the difference between the without and with waiver projections;
- Nothing in this demonstration application precludes HSD from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that HSD is adversely affected by future changes to federal medical assistance percentages.

Table 2 – Current Approved Without Waiver and With Waiver Projected Medicaid Expenditures (Total Computable)

Demonstration Period Description	Current Approved	Amendment Proposals
Total 5 Year Member Months (Without Waiver)	49,447,203	49,447,203
Total 5 Year Member Months (With Waiver)	49,430,633	49,447,203
Current Waiver Variance (DY1-DY5)	$3,762,696,140	$3,762,696,140
Renewal Demonstration (DY6-DY10)		
Without Waiver	$40,462,231,933	$40,462,231,933
With Waiver	$34,373,294,831	$34,387,745,340
Savings (Without Less With Waiver)	$6,088,937,102	$6,074,486,593
Savings after Phasedown of Savings	$4,166,461,030	$4,157,251,743
Savings with D1-DY5 Carryover and DY6-DY10 Phase-down	**$7,929,157,170**	**$7,919,947,883**

Budget Neutrality Exhibit 1 – Current Period PMPM limits, actual member months and expenditures (Total Computable)

Without Waiver	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY1-DY5
Member Months - Actual						
MEG 1 - TANF and Related	4,517,149	4,454,290	4,621,656	4,620,724	4,794,344	**23,008,163**
MEG 2 - SSI Medicaid Only	497,958	494,529	493,577	487,965	493,777	**2,467,806**
MEG 3 - SSI Dual	428,025	435,140	447,801	441,565	454,413	**2,206,944**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	2,799	2,382	2,987	3,830	3,957	**15,955**
MEG 5 - 217-Like group Dual	26,895	27,063	31,866	40,287	41,859	**167,970**
MEG 6 - VIII Group (Medicaid Expansion)	1,887,728	2,748,632	3,078,074	3,140,843	3,219,148	**14,074,425**
Total Member Months	**7,360,554**	**8,162,036**	**8,675,961**	**8,735,214**	**9,007,497**	**41,941,262**
Without Waiver PMPMs						
MEG 1 - TANF and Related	$ 385.80	$ 400.77	$ 416.32	$ 432.47	$ 449.25	**$ 417.43**
MEG 2 - SSI Medicaid Only	$ 1,763.90	$ 1,842.83	$ 1,925.21	$ 2,008.00	$ 2,094.34	**$ 1,926.36**
MEG 3 - SSI Dual	$ 1,780.77	$ 1,857.34	$ 1,937.21	$ 2,020.51	$ 2,107.39	**$ 1,942.83**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 4,936.92	$ 5,090.46	$ 5,248.77	$ 5,412.01	$ 5,580.32	**$ 5,291.83**
MEG 5 - 217-Like group Dual	$ 1,776.90	$ 1,853.31	$ 1,933.00	$ 2,016.12	$ 2,102.81	**$ 1,957.42**
MEG 6 - VIII Group (Medicaid Expansion)	$ 577.87	$ 607.34	$ 638.31	$ 670.87	$ 705.08	**$ 646.69**
Total PMPM	**$ 616.22**	**$ 641.55**	**$ 666.65**	**$ 695.96**	**$ 724.45**	**$ 671.44**
Without Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,742,724,978	$ 1,785,150,637	$ 1,924,092,463	$ 1,998,344,184	$ 2,153,879,288	**$ 9,604,191,550**
MEG 2 - SSI Medicaid Only	$ 878,350,269	$ 911,332,022	$ 950,239,887	$ 979,831,334	$ 1,034,137,005	**$ 4,753,890,517**
MEG 3 - SSI Dual	$ 762,214,336	$ 808,204,553	$ 867,484,358	$ 892,186,288	$ 957,625,947	**$ 4,287,715,482**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 13,818,444	$ 12,125,476	$ 15,678,086	$ 20,727,999	$ 22,078,742	**$ 84,428,746**
MEG 5 - 217-Like group Dual	$ 47,789,749	$ 50,156,064	$ 61,596,973	$ 81,223,380	$ 88,022,421	**$ 328,788,588**
MEG 6 - VIII Group (Medicaid Expansion)	$ 1,090,856,222	$ 1,669,350,032	$ 1,964,773,916	$ 2,107,087,019	$ 2,269,759,489	**$ 9,101,826,677**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	$ 68,889,323	**$ 344,446,615**
HQII	$ -	$ 2,824,462	$ 5,764,727	$ 8,825,544	$ 12,011,853	**$ 29,426,586**
Total Expenditures	**$ 4,604,643,320**	**$ 5,308,032,569**	**$ 5,858,519,734**	**$ 6,157,115,071**	**$ 6,606,404,068**	**$ 28,534,714,762**

With Waiver	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
With Waiver PMPMs						
MEG 1 - TANF and Related	$ 329.56	$ 344.71	$ 339.89	$ 320.25	$ 331.34	**$ 333.07**
MEG 2 - SSI Medicaid Only	$ 1,656.46	$ 1,785.14	$ 1,753.81	$ 1,729.49	$ 1,797.09	**$ 1,744.30**
MEG 3 - SSI Dual	$ 1,333.20	$ 1,342.69	$ 1,353.24	$ 1,264.02	$ 1,312.01	**$ 1,320.93**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 2,380.17	$ 2,347.27	$ 2,539.53	$ 3,276.11	$ 3,378.05	**$ 2,867.63**
MEG 5 - 217-Like group Dual	$ 3,226.87	$ 3,143.68	$ 2,879.63	$ 2,792.74	$ 2,912.94	**$ 2,965.23**
MEG 6 - VIII Group (Medicaid Expansion)	$ 454.02	$ 477.23	$ 452.76	$ 452.41	$ 475.48	**$ 462.83**
Total PMPM	**$ 520.98**	**$ 539.68**	**$ 522.76**	**$ 506.90**	**$ 526.01**	**$ 523.14**
With Waiver Expenditures						
MEG 1 - TANF and Related	$ 1,488,667,702	$ 1,535,460,173	$ 1,570,847,385	$ 1,479,771,354	$ 1,588,545,862	**$ 7,663,292,476**
MEG 2 - SSI Medicaid Only	$ 824,848,758	$ 882,801,472	$ 865,639,419	$ 843,930,022	$ 887,363,765	**$ 4,304,583,436**
MEG 3 - SSI Dual	$ 570,641,057	$ 584,259,220	$ 605,981,392	$ 558,147,336	$ 596,196,493	**$ 2,915,225,498**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 6,662,084	$ 5,591,208	$ 7,585,577	$ 12,547,497	$ 13,365,365	**$ 45,751,731**
MEG 5 - 217-Like group Dual	$ 86,786,741	$ 85,077,407	$ 91,762,281	$ 112,511,133	$ 121,933,866	**$ 498,071,428**
MEG 6 - VIII Group (Medicaid Expansion)	$ 857,072,658	$ 1,311,717,799	$ 1,393,624,749	$ 1,420,952,207	$ 1,530,653,327	**$ 6,514,020,740**
Safety Net Care Pool						
Uncompensated Care	$ 68,889,323	$ 67,294,973	$ 68,889,323	$ 68,889,324	$ 68,889,323	**$ 342,852,266**
HQII	$ -	$ 2,824,462	$ 7,359,077	$ -	$ 12,011,853	**$ 22,195,392**
Total Expenditures	**$ 3,903,568,323**	**$ 4,475,026,714**	**$ 4,611,689,203**	**$ 4,496,748,873**	**$ 4,818,959,853**	**$ 22,305,992,966**

Budget Neutrality Variance	New Mexico Budget Neutrality Status By Calendar Year					
	DY1 - 2014 Actual	DY2 - 2015 Actual	DY3 - 2016 Actual	DY4 - 2017 Actual	DY5 - 2018 ***Projected	5-Year Total DY 01-DY 05
Without Less With Waiver Expenditures	**$ 499,132,065**	**$ 502,166,347**	**$ 699,348,513**	**$ 988,513,095**	**$ 1,073,536,120**	**$ 3,762,696,140**
Cumulative Variance	**$ 499,132,065**	**$ 1,001,298,412**	**$ 1,700,646,925**	**$ 2,689,160,020**	**$ 3,762,696,140**	**$ 3,762,696,140**

** Variance excludes Hypothetical Groups and Safety Net Care Pool Expenditures*

Expenditure Variance By Waiver Group						
MEG 1 - TANF and Related	$ 254,057,276	$ 249,690,464	$ 353,245,078	$ 518,572,830	$ 565,333,426	**$ 1,940,899,075**
MEG 2 - SSI Medicaid Only	$ 53,501,511	$ 28,530,550	$ 84,600,468	$ 135,901,312	$ 146,773,240	**$ 449,307,081**
MEG 3 - SSI Dual	$ 191,573,279	$ 223,945,333	$ 261,502,966	$ 334,038,952	$ 361,429,453	**$ 1,372,489,984**
Hypothetical Group						
MEG 4 - 217-Like Medicaid	$ 7,156,360	$ 6,534,268	$ 8,092,509	$ 8,180,502	$ 8,713,377	**$ 38,677,015**

MEG 5 - 217-Like group Dual	$ (38,996,992)	$ (34,921,343)	$ (30,165,308)	$ (31,287,753)	$ (33,911,445)	**$ (169,282,840)**
MEG 6 - VIII Group (Medicaid Expansion)	$ 233,783,564	$ 357,632,233	$ 571,149,167	$ 686,134,812	$ 739,106,162	**$ 2,587,805,937**
Safety Net Care Pool						
Uncompensated Care	$ -	$ 1,594,350	$ -	$ (1)	$ -	**$ 1,594,349**
HQII	$ -	$ 0	$ (1,594,350)	$ 8,825,544	$ -	**$ 7,231,194**
Total Variance	**$ 701,074,997**	**$ 833,005,855**	**$ 1,246,830,531**	**$ 1,660,366,198**	**$ 1,787,444,214**	**$ 6,228,721,795**

Budget Neutrality Exhibit 2 – Amendment PMPM limits, actual member months and expenditures (Total Computable)

Without Waiver	Annualized Trend	New Mexico Budget Neutrality Status By Calendar Year: Adjustments to DY5	DY6 - 2019 Projected	DY7 - 2020 Projected	DY8 - 2021 Projected	DY9 - 2022 Projected	DY10 - 2023 Projected	5-Year Total DY6-DY10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	4,087	4,222	4,362	4,506	4,655	**21,832**
MEG 5 - 217-Like group Dual	3.9%	-	43,493	45,191	46,954	48,787	50,691	**235,117**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Total Member Months	**3.1%**	-	**9,288,765**	**9,579,325**	**9,879,497**	**10,189,610**	**10,510,006**	**49,447,203**
Without Waiver PMPM								
MEG 1 - TANF and Related	3.8%	$ (6.10)	$ 460.00	$ 477.48	$ 495.62	$ 514.45	$ 534.00	**$ 497.68**
MEG 2 - SSI Medicaid Only	4.1%	$ (20.59)	$ 2,158.77	$ 2,247.28	$ 2,339.42	$ 2,435.34	$ 2,535.19	**$ 2,345.43**
MEG 3 - SSI Dual	4.1%	$ (130.82)	$ 2,057.62	$ 2,141.98	$ 2,229.80	$ 2,321.22	$ 2,416.39	**$ 2,238.54**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ (6.38)	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,128.24**
MEG 5 - 217-Like group Dual	4.1%	$ 1,414.18	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 3,986.18**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Total PMPM	**3.9%**	**$ (4.40)**	**$ 747.95**	**$ 776.93**	**$ 807.04**	**$ 838.32**	**$ 870.82**	**$ 810.11**
Without Waiver Expenditure								
MEG 1 - TANF and Related		$ (29,231,764)	$ 2,288,249,485	$ 2,464,449,112	$ 2,654,216,451	$ 2,858,596,241	$ 3,078,713,669	**$ 13,344,224,957**
MEG 2 - SSI Medicaid Only		$ (10,166,391)	$ 1,078,650,304	$ 1,136,249,871	$ 1,196,925,236	$ 1,260,840,644	$ 1,328,169,115	**$ 6,000,835,170**
MEG 3 - SSI Dual		$ (59,444,427)	$ 962,212,283	$ 1,030,807,756	$ 1,104,293,355	$ 1,183,017,693	$ 1,267,354,237	**$ 5,547,685,323**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ (25,230)	$ 23,490,632	$ 25,021,403	$ 26,651,926	$ 28,388,703	$ 30,238,657	**$ 133,791,320**
MEG 5 - 217-Like group Dual		$ 59,196,558	$ 159,236,444	$ 172,234,893	$ 186,294,405	$ 201,501,592	$ 217,950,139	**$ 937,217,473**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Total Expenditures		**$ (39,671,254)**	**$ 7,028,413,770**	**$ 7,454,503,788**	**$ 7,985,193,934**	**$ 8,542,197,132**	**$ 9,152,306,752**	**$ 40,162,615,376**

With Waiver	Annualized Trend	New Mexico Budget Neutrality Status By Calendar Year: Adjustments to DY5	DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Member Months								
MEG 1 - TANF and Related	3.8%	-	4,974,487	5,161,399	5,355,334	5,556,556	5,765,338	**26,813,113**
MEG 2 - SSI Medicaid Only	1.2%	-	499,659	505,610	511,633	517,727	523,894	**2,558,523**
MEG 3 - SSI Dual	2.9%	-	467,635	481,241	495,244	509,653	524,482	**2,478,255**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.3%	-	4,087	4,222	4,362	4,506	4,655	**21,832**
MEG 5 - 217-Like group Dual	3.9%	-	43,493	45,191	46,954	48,787	50,691	**235,117**
MEG 6 - VIII Group (Medicaid Expansion)	2.5%	-	3,299,404	3,381,662	3,465,970	3,552,381	3,640,945	**17,340,362**
Total Member Months	**3.1%**	-	**9,288,765**	**9,579,325**	**9,879,497**	**10,189,610**	**10,510,006**	**49,447,203**
With Waiver PMPMs								
MEG 1 - TANF and Related	3.5%	$ -	$ 344.65	$ 356.58	$ 368.93	$ 381.71	$ 394.93	**$ 370.29**
MEG 2 - SSI Medicaid Only	3.9%	$ -	$ 1,880.45	$ 1,953.96	$ 2,030.34	$ 2,109.70	$ 2,192.17	**$ 2,035.17**
MEG 3 - SSI Dual	3.8%	$ -	$ 1,374.41	$ 1,426.59	$ 1,480.76	$ 1,536.98	$ 1,595.34	**$ 1,485.98**
Hypothetical Group								
MEG 4 - 217-Like Medicaid	3.1%	$ -	$ 5,747.30	$ 5,926.04	$ 6,110.34	$ 6,300.37	$ 6,496.31	**$ 6,128.24**
MEG 5 - 217-Like group Dual	4.1%	$ -	$ 3,661.18	$ 3,811.29	$ 3,967.56	$ 4,130.23	$ 4,299.57	**$ 3,986.18**
MEG 6 - VIII Group (Medicaid Expansion)	4.7%	$ -	$ 738.22	$ 772.92	$ 809.24	$ 847.28	$ 887.10	**$ 812.78**
Total PMPM	**3.7%**	**$ -**	**$ 636.81**	**$ 660.38**	**$ 684.82**	**$ 710.17**	**$ 736.46**	**$ 687.26**
With Waiver Expenditures								
MEG 1 - TANF and Related		$ -	$ 1,714,448,701	$ 1,840,473,788	$ 1,975,762,682	$ 2,120,996,344	$ 2,276,905,791	**$ 9,928,587,306**
MEG 2 - SSI Medicaid Only		$ -	$ 939,585,332	$ 987,942,075	$ 1,038,787,549	$ 1,092,249,839	$ 1,148,463,621	**$ 5,207,028,415**
MEG 3 - SSI Dual		$ -	$ 642,719,561	$ 686,534,045	$ 733,335,383	$ 783,327,189	$ 836,726,959	**$ 3,682,643,136**
Hypothetical Group								
MEG 4 - 217-Like Medicaid		$ -	$ 23,490,632	$ 25,021,403	$ 26,651,926	$ 28,388,703	$ 30,238,657	**$ 133,791,320**
MEG 5 - 217-Like group Dual		$ -	$ 159,236,444	$ 172,234,893	$ 186,294,405	$ 201,501,592	$ 217,950,139	**$ 937,217,473**
MEG 6 - VIII Group (Medicaid Expansion)		$ -	$ 2,435,685,299	$ 2,613,740,753	$ 2,804,812,563	$ 3,009,852,259	$ 3,229,880,935	**$ 14,093,971,810**
Safety Net Care Pool								
Uncompensated Care Pool		$ -	$ 68,889,323	$ -	$ -	$ -	$ -	**$ 68,889,323**
HQII		$ -	$ 12,000,000	$ 12,000,000	$ 12,000,000	$ -	$ -	**$ 36,000,000**
Total Expenditures		**$ -**	**$ 5,996,055,291**	**$ 6,337,946,957**	**$ 6,777,644,507**	**$ 7,236,315,925**	**$ 7,740,166,103**	**$ 34,088,128,783**

Budget Neutrality Variance	DY1 - DY5 Savings	Adjustments to DY5	New Mexico Budget Neutrality Status By Calendar Year					
			DY 06 - 2019 Projected	DY 07 - 2020 Projected	DY 08 - 2021 Projected	DY 09 - 2022 Projected	DY 10 - 2023 Projected	5-Year Total DY 06-DY 10
Expenditure Variance By Waiver Group								
MEG 1 - TANF and Related			$ 573,800,784	$ 623,975,324	$ 678,453,769	$ 737,599,896	$ 801,807,878	**$ 3,415,637,651**
MEG 2 - SSI Medicaid Only			$ 139,064,973	$ 148,307,796	$ 158,137,687	$ 168,590,806	$ 179,705,494	**$ 793,806,755**
MEG 3 - SSI Dual			$ 319,492,722	$ 344,273,711	$ 370,957,972	$ 399,690,504	$ 430,627,278	**$ 1,865,042,187**
Hypothetical Group								
MEG 4 - 217-Like Medicaid			$ -	$ -	$ -	$ -	$ -	$ -
MEG 5 - 217-Like group Dual			$ -	$ -	$ -	$ -	$ -	$ -
MEG 6 - VIII Group (Medicaid Expansion)			$ -	$ -	$ -	$ -	$ -	$ -
Safety Net Care Pool								
Uncompensated Care Pool			$ -	$ -	$ -	$ -	$ -	$ -
HQII			$ -	$ -	$ -	$ -	$ -	$ -
Total Variance			**$ 1,032,358,479**	**$ 1,116,556,831**	**$ 1,207,549,427**	**$ 1,305,881,206**	**$ 1,412,140,650**	**$ 6,074,486,593**
Expenditure Variance, Carry-over and Phase Down								
DY1 - DY5 Variance Carry-over	**$3,762,696,140**							
DY6 - DY10 Variance								
Savings by DY			$ 1,032,358,479	$ 1,116,556,831	$ 1,207,549,427	$ 1,305,881,206	$ 1,412,140,650	
Phase Down %			90.0%	80.0%	70.0%	60.0%	50.0%	
Savings after phase-down			$ 929,122,630.74	$ 893,245,465	$ 845,284,599	$ 783,528,724	$ 706,070,325	**$ 4,157,251,743**
Cumulative Savings			**$ 4,691,818,770**	**$ 5,585,064,235**	**$ 6,430,348,834**	**$ 7,213,877,558**	**$ 7,919,947,883**	**$ 7,919,947,883**

SECTION 7: EVALUATION DESIGN AND QUALITY STRATEGY

The current demonstration includes current STCs that were approved in December 2018 and are effective for the five-year period between January 1, 2019 to December 31, 2023. The current approval provided New Mexico up to 180 days from January 1, 2019 to develop the evaluation design and 90 days from January 1, 2019 to develop the quality strategy. As of the date of this amendment request, the evaluation design and quality strategy is under development and the quality strategy was delivered to CMS on March 14, 2019.

SECTION 8: STATE PUBLIC NOTICE

Draft Demonstration Amendment Application

This draft demonstration amendment application and all related documents can be found at HSD's website: http://www.hsd.state.nm.us/centennial-care-2-0.aspx. The website also provides information about scheduled public input sessions including meeting dates, times and locations.

HSD published the draft demonstration amendment application on February 28, 2019. Table 3 outlines the scheduled public hearings scheduled by HSD.

Table 3 – Renewal Timeline

Event	Dates
Notice Period - 60-day advanced notification to Native American/Tribal stakeholders regarding 1115 demonstration renewal application	March 1, 2019
Publish Date – Draft 1115 Demonstration Amendment Application	February 28, 2019
Gather Feedback – Draft Demonstration Amendment Application Public Hearings sites: • Public meeting: Las Cruces • Public meeting: Santa Fe (MAC meeting)	 April 10, 2019 April 15, 2019
Final Demonstration Application Submission to CMS	June 10, 2019

APPENDICES

Appendix A: Glossary

Acronym	Term
ABCB	Agency-Based Community Benefit
ABP	Alternative Benefit Plan
CB	Community Benefit
CFR	Code of Federal Regulations
CHV	Centennial Home Visiting
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
FPL	Federal Poverty Limit
HCBS	Home and Community-Based Services
HSD	New Mexico's Human Services Department
LTSS	Long Term Services and Supports
MAGI	Modified adjusted gross income
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
NF	Nursing Facility
NFP	Nurse Family Partnership
NF LOC	Nursing Facility Level of Care
NM	New Mexico
NMAC	New Mexico Administrative Code
PAT	Parents as Teachers
SDCB	Self-Directed Community Benefit
STC	Special Terms and Conditions
SUD	Substance Use Disorder

Appendix B: Interim Evaluation Report

The interim evaluation report is available on HSD's website at:
http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20B%20-%20Interim%20Evaluation%20Report.pdf

Appendix C: State Public Notices

Attached are the copies of the following documents demonstrating HSD's adherence to the public notice requirements set forth under 42 CFR Part 431.408.

Public Notice

1. 30-day state public notice and comment period on the Centennial Care 2.0 demonstration amendment providing a comprehensive program description, February 28, 2019
    a. HSD website: https://www.hsd.state.nm.us/centennial-care-2-0.aspx
2. Public notice (abbreviated notice) in the state's newspaper with the widest circulation
    a. Las Cruces Sun-News, March 1, 2019, re: public meetings in Las Cruces and Santa Fe
    b. Albuquerque Journal, March 1, 2019, re: public meetings in Las Cruces and Santa Fe
3. Proposal posting (abbreviated notice) via HSD's electronic mailing lists
    a. Letter and email distribution, March 1, 2019, re: public hearings, website posting and public comment submission

Public Hearings on the 1115 Demonstration Amendment

1. Public meetings in Las Cruces, April 10, 2019
    a. Presentation, Centennial Care 2.0, 1115 Demonstration Amendment – Public Hearing
2. MAC Meeting – Santa Fe, April 15, 2019, Public Hearing
    a. Agenda
    b. Presentation, Centennial Care 2.0, 1115 Demonstration Amendment, Public Hearing

All documents related to the above public notices and input is available on HSD's website at https://www.hsd.state.nm.us/centennial-care-2-0.aspx

Appendix D: Summary of Stakeholder Feedback (including Feedback from Federally Recognized Tribal Nations) and State Response

HSD has tracked comments received since the Draft Centennial Care 2.0 1115 Demonstration Amendment was released on February 28, 2019. Attached are the following documents demonstrating the feedback the feedback received on the draft waiver application.

1. Summary of comments received and HSD's response to the Centennial Care 2.0 1115 Demonstration Amendment Request is available on HSD's website at: https://www.hsd.state.nm.us/centennial-care-2-0.aspx

2. Comprehensive public comments on the Draft 1115 Demonstration Amendment is available on HSD's website at: https://www.hsd.state.nm.us/centennial-care-2-0.aspx

Appendix E: Documents Demonstrating Quality

Attached are the following documents that provide strong evidence of HSD's commitment to quality currently and ongoing:

1. Centennial Care 1.0 Quality Strategy is available on HSD's website at: http://www.hsd.state.nm.us/providers/2017-nm-quality-strategy-final.pdf
2. EQRO Summary Reports are available on HSD's website at: http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Final%20Waiver%20Documents/Appendix%20E_2%20-%20EQRO%20Summary%20Report.pdf

Appendix F: Centennial Care 2.0 Eligibility Groups

Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in the current 1115 Demonstration Standard Terms and Conditions.

- Table 4 describes the mandatory State Plan populations included in Centennial Care 2.0;
- Table 5 describes the optional State Plan populations included in Centennial Care 2.0; and
- Table 6 below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

Table 4 – Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Parents/Caretaker Relatives	Low Income Families (1931) 42 CFR 435.110	No	TANF and Related
Transitional Medical Assistance	Families with 12 month extension due to earnings • §408(a)(11)(A) • §1931(c)(2) • §1925 • §1902(a)(52) and 1902(e)(1)	No	TANF and Related
Extension due to Spousal Support	Families with 4 month extension due to increased collection of spousal support • §408(a)(11)(B) • §1931(c)(1) 42 CFR 435.115	No	TANF and Related
Pregnant Women	Consolidated group for pregnant women • §§1902(a)(10)(A)(i)(III) and (IV) • §§1902(a)(10)(A)(ii)(I), (IV) and (IX) • §1931(b) and (d) 42 CFR 435.116	No	TANF and Related
Children under Age 19	Consolidated group for children under age 19 • §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) • §§1902(a)(10)(A)(ii)(IV) and (IX) • §1931(b) and (d) 42 CFR 435.118	No	TANF and Related
Continuous Eligibility for Hospitalized Children	Children eligible under 42 CFR 435.118 receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay §1902(e)(7) 42 CFR 435.172	No	TANF and Related
Deemed Newborns	Newborns deemed eligible for one year §1902(e)(4) 42 CFR 435.117	No	TANF and Related

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Adoption Assistance and Foster Care Children	Children receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements • §1902(a)(10)(i)(I) • §473(b)(3) 42 CFR 435.145	No	TANF and Related
Former Foster Care Children	Former foster care children under age 26 not eligible for another mandatory group 1902(a)(10)(A)(i)(IX) 42 CFR 435.150	No	TANF and Related
Adult group	Non-pregnant individuals age 19 through 64 with income at or below 133% FPL 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	No	VIII Group
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals under age 21 eligible for Medicaid in the month they apply for SSI 1902(a)(10(A)(i)(II)(cc)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individual whose earning exceed SSI substantial gainful activity level 1902(a)(10)(A)(i)(II) 1619(a)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Individuals receiving mandatory state supplements 42 CFR 435.130	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR 435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR 435.133	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 42 CFR 435.134	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals ineligible for SSI because of requirements inapplicable in Medicaid 42 CFR 435.122	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled widows and widowers Early widows/widowers 1634(b) 42 CFR 435.138	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR 435.135	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	1939(a)(5)(E) Disabled adult children 1634(c)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individuals whose earnings are too high to receive SSI cash 1619(b)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard 1902(a)(10)(A)(ii)(V) 1905(a) 42 CFR 435.236	NF LOC: Included PACE: Excluded ICFMR: Excluded	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 5. Optional State Plan Populations

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Optional Targeted Low Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 Note: If sufficient Title XXI allotment is available as described under STC 84, uninsured individuals in this eligibility group are funded through the Title XXI allotment. Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 85, then all individuals in this eligibility group are funded through Title XIX.	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR 435.222	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR 435.226	No	TANF and Related
Out-of-State Former Foster Care Children	Individuals under age 26 who were in foster care in a state other than New Mexico or tribe in such other state when they aged out of foster care 1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Institutionalized Individuals	Individuals who would be eligible for SSI cash if not in an institution 1902(a)(10)(A)(ii)(IV) 1905(a) 42 CFR 435.211	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Uninsured individuals under 65 screened and found to need treatment for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII) 42 CFR 435.213	No	TANF and Related
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration(217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Developmentally Disabled waiver	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that are continuing outside the demonstration(217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Act, through the state's 1915(c) Medically Fragile waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home and Community Based 1915(c) Waivers that are continuing outside of the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 6. Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
Home and Community Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the state had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR 435.217, 435.236 and 435.2276 and section 1924 of the Act	Income test: 300% of Federal Benefit Rate with Nursing Facility Level of Care determination. Resource test: $2000	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Appendix G: Centennial Care 2.0 Benefits

Table 7 describes the current non-CB services, including services available under the Alternative Benefit Plan (ABP). Table 8 lists the CB services. Table 9 lists the services available only through Centennial Care 2.0 including the three new BH services

Table 7 – Centennial Care 2.0 Non-Community Benefit Services

Service	Medicaid State Plan	ABP Services
Accredited Residential Treatment Center Services	X	X Age limited
Applied Behavior Analysis (ABA)	X	X Age Limited
Adult Psychological Rehabilitation Services	X	X
Ambulatory Surgical Center Services	X	X
Anesthesia Services	X	X
Assertive Community Treatment Services	X	X
Bariatric Surgery	X	X Lifetime limit
Behavior Management Skills Development Services	X	X Age Limited
Behavioral Health Professional Services: outpatient behavioral health and substance abuse services	X	X
Cancer Clinical Trials	X	X
Case Management	X	
Comprehensive Community Support Services	X	X
Day Treatment Services	X	X Age limited
Dental Services	X	X
Diagnostic Imaging and Therapeutic Radiology Services	X	X
Dialysis Services	X	X
Durable Medical Equipment and Supplies	X	X Limits apply
Emergency Services (including emergency department visits, psychiatric ER, and ground/air ambulance services)	X	X
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[1]	X	X

[1] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Service	Medicaid State Plan	ABP Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	X	X Age Limited
EPSDT Personal Care Services	X	X Age Limited
EPSDT Private Duty Nursing	X	X Age Limited
EPSDT Rehabilitation Services	X	X Age Limited
Family Planning	X	X
Federally Qualified Health Center Services	X	X
Hearing Aids and Related Evaluations	X	
Home Health Services	X	X Limits apply
Hospice Services	X	X
Hospital Inpatient (including Detoxification services and medical/surgical care)	X	X
Hospital Outpatient	X	X
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	X	X
Inpatient Rehabilitative Facilities	X	X Skilled nursing or acute rehab facility only
Intensive Outpatient Program Services	X	X
Immunizations	X	X
IV Outpatient Services	X	X
Diagnostic Labs, X-Ray and Pathology	X	X
Labor/Delivery and Inpatient Maternity Services	X	X
Medication Assisted Treatment for Opioid Dependence	X	X
Midwife Services	X	X
Multi-Systemic Therapy Services	X	
Non-Accredited Residential Treatment Centers and Group Homes	X	X Age limited
Nursing Facility Services	X	X
Nutritional Services	X	

Service	Medicaid State Plan	ABP Services
Occupational Therapy Services	X	X Limits apply
Outpatient Hospital based Psychiatric Services and Partial Hospitalization	X	X
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	X	X
Outpatient Health Care Professional Services	X	X
Outpatient Surgery	X	X
Prescription Drugs	X	X
Primary Care Services	X	X
Physical Therapy	X	X Limits apply
Physician Visits	X	X
Podiatry Services	X	X Limits apply
Pre- and Post-Natal Care	X	X
Pregnancy Termination Procedures	X State-funded	X State-funded
Preventive Services	X	X
Prosthetics and Orthotics	X	X Limits apply
Psychosocial Rehabilitation Services	X	X
Radiation Therapy and Chemotherapy	X	X
Radiology Facilities	X	X
Rehabilitation Option Services (Psycho social rehab)	X	X Limits apply
Rehabilitation Services Providers	X	X Limits apply
Reproductive Health Services	X	X
Rural Health Clinics Services	X	X
School-Based Health Center Services	X	X
Smoking Cessation Services	X	X
Specialist Visits	X	X
Speech and Language Therapy	X	X

Service	Medicaid State Plan	ABP Services
		Limits apply
Swing Bed Hospital Services	X	X
Telemedicine Services	X	X
Tot-to-Teen Health Checks	X	X Age Limited
Organ and Tissue Transplant Services	X	X Lifetime limit
Transportation Services (medical)	X	X
Treatment Foster Care	X	X Age Limited
Treatment Foster Care II	X	X Age Limited
Treatment of Diabetes	X	X
Urgent Care Services/Facilities	X	X
Vision Care Services	X	X Only for eye injury or disease; routine vision care not covered

Table 8 – Centennial Care 2.0 Current Community Benefit Services

Service Description	ABCB	SDCB
Adult Day Health	X	
Assisted Living	X	
Behavioral Support Consultation	X	X
Community Transition *(community reintegration members only)*	X	
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications *($5,000 every 5 years)*	X	X
Home Health Aide	X	X
Homemaker		X
Nutritional Counseling		X
Personal Care Services *(Consumer Directed and Consumer Delegated)*	X	X
Private Duty Nursing Services for Adults (RN or LPN)	X	X
Related Goods *(phone, internet, printer etc...)*		X
Respite	X	X
Skilled Maintenance Therapy Services *(occupational, physical and speech therapy)*	X	X
Specialized Therapies *(acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, Hippotherapy, massage therapy, Naprapathy, Native American Healers)*		X
Non-Medical Transportation		X

Refer to Appendix H for additional details about each community benefit including benefit limitations.

Table 9 – Services Available to Centennial Care 2.0 Members Only

Service Description
Family Support
Behavioral Health Respite
Recovery Services
Community Interveners for the Deaf and Blind
Institutional for Mental Disorder with SUD diagnosis *Subject to Waiver Requirements/Limits*
Home Visiting *Subject to Waiver Requirements/Limits*
Pre-Tenancy *Subject to Waiver Requirements/Limits*

Appendix H: Currently Approved Benefit Definitions and Limits

I. Adult Day Health (ABCB)

Adult Day Health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of members by the care plans incorporated into the care plan.

Adult Day Health Services are provided by a licensed adult day-care, community-based facility that offers health and social services to assist members to achieve optimal functioning. Private Duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the Adult Day Health setting and in conjunction with the Adult Day Health services but would be reimbursed separately from reimbursement for Adult Day Health services.

II. Assisted Living (ABCB)

Assisted Living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by and incorporated in the care plan.

Core services provide assistance to the member in meeting a broad range of activities of daily living including; personal support services (homemaker, chore, attendant services, meal preparation), and companion services; medication oversight (to the extent permitted under State law), 24-hour, on-site response capability to meet scheduled or unpredictable member's needs and to provide supervision, safety, and security. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

> **Limits or Exclusions:** The following services will not be provided to members in Assisted Living facilities: Personal Care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.

III. Behavior Support Consultation (ABCB and SDCB)

Behavior Support Consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the member, parents, family enrollees and/or primary caregivers with coping skills which promote maintaining the member in a home environment.

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary

therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member's care plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)
Community Transition Services are one-time set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are determined by the MCO based on the state's criteria outlined in these STCs and in 8.308.12.13.D.NMAC, and are monitored by the state to ensure the expenses are reasonable. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy; and
- Moving expenses.

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $3,500 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a nursing facility stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)
Customized Community Supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

VI. Emergency Response (ABCB and SDCB)
Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing,

testing and maintaining equipment; training members, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response and emergency response high need.

VII. Employment Supports (ABCB and SDCB)
Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a member may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the member and co-workers on rights and responsibilities; and benefits counseling. The service must be tied to a specific goal specified in the member's care plan.

Job development is a service provided to members by skilled staff. The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

> **Limits or Exclusions:** Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. FFP cannot be claimed to defray expenses associated with starting up or operating a business.

VIII. Environmental Modifications (ABCB and SDCB)
Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence. Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light- activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified

switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family enrollees, providers and contractors concerning environmental modification projects to the member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

> **Limits or Exclusions:** Environmental Modification services are limited to five thousand dollars ($5,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Health Aide (ABCB and SDCB)

Home Health Aide services provide total care or assist a member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The Home Health Aide services assist the member in a manner that promotes an improved quality of life and a safe environment for the member. Home Health Aide services can be provided outside the member's home. State plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for members who need this service for a long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. Must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether goals are being met. Home Health Aide Services must be provided by a state licensed Home Health Agency under the supervision of a registered nurse.

X. Non-Medical Transportation (SDCB)

Non-Medical Transportation services enable SDCB members to travel to and from community services, activities and resources as specified in the SDCB care plan.

Limits or Exclusions: Limited to 75 miles radius of the member's home. Non-Medical Transportation is limited to $1,000 per year. Not a covered service for minors.

XI. Nutritional Counseling (ABCB and SDCB)
Nutritional Counseling services include assessment of the member's nutritional needs, development and/or revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan. Nutritional counseling must be provided by a state licensed dietician.

XII. Personal Care Services (ABCB and SDCB)
Personal Care Services (PCS) provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There are two delivery models for ABCB and one for SDCB as follows:

Agency-Based Community Benefit:

1. Consumer delegated PCS allows the member to select the PCS agency to perform all PCS employer related tasks. The agency is responsible for ensuring PCS is delivered to the member in accordance with the care plan.
2. Consumer directed PCS allows the member to oversee his or her own PCS delivery, and requires the member to work with his or her PCS agency who then acts as a fiscal intermediary agency.

Self-Directed Community Benefit:

1. The member has employer authority and directly hires PCS caregivers or contracts with an agency.

XIII. Private Duty Nursing for Adults (ABCB and SDCB)
Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for members who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the member's home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self- care assistance.
Limits or Exclusions: All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)
Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying

condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.

The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

> **Limits or Exclusions:** Experimental or prohibited treatments and goods are excluded. Related goods are limited to $2,000 per person per care plan year.

XV. Respite (ABCB and SDCB)

Respite services are provided to members unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or nursing facility or an ICF/IDD meeting the qualifications for provider certification. When respite care services are provided to a member by an institution, that individual will not be considered a resident of the institution for purposes of demonstration eligibility. Respite care services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder car; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and case manager, ensuring the health and safety of the member at all times.

> **Limits or Exclusions:** Respite services are limited to a maximum of 300 hours annually per care plan year.

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

Skilled maintenance therapy services include Physical Therapy (PT), Occupational Therapy (OT) or Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships. Services in this category include:

> **Physical Therapy**

Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Physical Therapy services must be provided by a state licensed physical therapist.

Occupational Therapy Services
OT services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Occupational Therapy services must be provided by a state licensed occupational therapist.

Speech Language Therapy
SLT services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the member's environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Speech Language Therapy services must be provided by a state licensed speech and language pathologist.

Limits or Exclusions: A signed therapy referral for treatment must be obtained from the member's primary care physician. The referral must include frequency, estimated duration of therapy, and treatment/procedures to be rendered.

XVII. Specialized Therapies (SDCB)
Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid

institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

Acupuncture
Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. Acupuncture services providers must be licensed by the NM Board of Acupuncture and Oriental Medicine.

Biofeedback
Biofeedback uses visual, auditory or other monitors to feed back to members' physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re- education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Chiropractic
Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. Chiropractic services providers must be licensed by the NM Board of Chiropractic Examiners.

Cognitive Rehabilitation Therapy
Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive

problems. Cognitive Rehabilitation Therapy providers must have a license or certification with the appropriate specialized training, clinical experience and supervision, and their scope of practice must include Cognitive Rehabilitation Therapy.

Hippotherapy
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy providers must have a state license in physical therapy, occupational therapy, or speech therapy, and their scope of practice must include Hippotherapy.

Massage Therapy
Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Naprapathy
Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. Naprapathy providers must have a state license in Naprapathy.

Native American Healers
Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2000 annual specialized therapies limits. These services may also be a value added service provided by the MCO, for which the

MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community- recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life.

Limits and Exclusions: Specialized therapies are limited to $2,000 annually.

Deloitte.

Centennial Care:

Evaluation Interim Report

Demonstration Years 1 – 2 and Preliminary Demonstration Year 3:

January 2014 – December 2016

October 2017

Table of Contents

Executive Summary

New Mexico's Section 1115 Demonstration Waiver program, known as Centennial Care, is largely progressing with the major designated goals, including efforts to improve access to care, coordinated care, quality of care, and the member experience while reducing the growth trend in program expenditures.

When reading the contents of this report in detail, it is important to understand that total Centennial Care member months increased from DY1 to DY3 by about 1,306,000, or 17.8%[1]. The vast majority of this increase was driven by Medicaid Eligibility Group (MEG) 6, (named "VIII Group"), which is the Medicaid adult expansion group. Enrollment in VIII Group grew by 63.3% from DY1 to DY3. Members eligible under this MEG are individuals at or below 133% federal poverty level (FPL) who are between ages 19 and 64 and who do not qualify for Medicaid under a previously implemented MEG (e.g. not disabled and not pregnant women).

The increase in members served by Centennial Care under this MEG may have significant impacts on the results of various measures as the members participating in Centennial Care in DY2 and DY3 may not have participated in Centennial Care in DY1. When making longitudinal comparisons, readers should keep this context in mind as results are presented. Given the high-level nature of the data used to support this report, the impact of this membership increase was not directly quantifiable at the measure level. However, the discussion section of each measure indicates where this membership change may have had a relatively significant impact on the results.

Highlights from the interim waiver evaluation, based on data through calendar year (CY) 2015 and preliminary CY2016 data, include:

- **Improving Access to Care –** The 1115 Waiver Evaluation noted mixed progress in timely access to care related to several measures as compared to the baseline[2] of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  Conversely, declines were found in the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the number of adult members accessing preventive/ambulatory services, the percentage of members who had a PCP visit, the percentage of PCPs with open panels (though the overall percentage of open panels remained above 90%), breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care, and the percentage of members utilizing mental health services (as indicated by their principal diagnosis)[3]. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

  It should be noted that a significant transition within the behavioral health provider network took place during 2015 (DY2). There was a concerted effort to rebuild the network which included supporting Federally Qualified Health Centers (FQHCs) with the expansion of their

[1] Based on member month figures according to the budget neutrality tables for DY1, DY2, and DY3.
[2] The baseline period is typically considered calendar year 2013, but may be SFY2013 or calendar year 2014 (DY1) depending on the measure and data availability from CY2013.
[3] This HEDIS measure is based on the Mental Health Value Set, which does not include diagnoses or services related to Substance Use Disorders.

service offerings to cover behavioral health services through support of obtaining additional required certifications to offer these specialized services. While some gaps in the network existed for a time resulting in service delays, the efforts by New Mexico and other stakeholders helped to quickly resolve these issues and reduce the concern of future service delays or access limitations.

- **Improving Care Coordination and Integration –** The Evaluation indicated general progress in both care coordination and integration activities. Improvements were noted in the percentage of members the managed care organizations (MCOs) were able to engage, the percentage of members for whom Health Risk Assessments (HRAs) were completed, the percentage of Level 2 members who received telephonic and in-person outreach, the percentage of members who had a BH service and also received outpatient ambulatory visits, and the Emergency Room (ER) visit rates among members with BH needs.

  There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

  Conversely, a higher percentage of LTSS members had ER visits, a lower percentage of members with schizophrenia or bipolar disorder received diabetes screening, a lower percentage of members with schizophrenia and diabetes received tests for diabetes monitoring.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care. There were improvements in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening ratios; increases in monitoring rates of Body Mass Index (BMI) for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across all five ambulatory care sensitive (ACS) measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable.

- **Reducing Expenditures and Shifting to Less Costly Services –** The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and Hospital Quality Improvement Incentive (HQII) pool amounts. The total cost of Centennial Care for DY1, DY2, and DY3 combined is below the budget neutrality limits as defined in the STCs[4] by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher level of care (LOC) Nursing Facility (NF) utilization to lower LOC NF utilization.

- **Increased Member Engagement** – There was a significant increase in the number of members enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately

[4] STCs 102, 104, and 111 define budget neutrality for the demonstration.

47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program. There are over 40 activities members can perform to earn rewards from adhering to refilling monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

Increased Member Satisfaction – The Evaluation found that member satisfaction results largely improved from the baseline to DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

Program Background

Managed care has been the primary service delivery system for Medicaid in the State of New Mexico (State) for more than a decade. The State began its managed care program for physical health, known as the Salud! program, in 1997, its managed care program for behavioral health began in 2005, and its Coordination of Long Term Services (CoLTS) program began in 2008. Prior to Centennial Care, New Mexico managed a variety of federal waivers that were administered through six (6) different managed care organizations (MCOs) and one Behavioral Health Statewide Entity (BHSE). New Mexico continues to offer a fee-for-service system for certain short-term eligibility groups and services, home and community-based services for Individuals with Intellectual Disabilities (IID) and Medically Fragile conditions, the Program of All Inclusive Care for the Elderly, Intermediate Care Facilities for Individuals with IID, and Native Americans who choose not to "opt in" to managed care.

In January 2014, New Mexico implemented Centennial Care, a Section 1115 demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS). Centennial Care offers Medicaid members an integrated model of care including physical health, behavioral health and long term services and supports. The State contracted with four MCOs to administer the Centennial Care program:

- Blue Cross Blue Shield (BCBS)
- Molina Healthcare (MHC)
- Presbyterian Health Plan (PHP)
- United Healthcare (UHC)

The CMS approved Special Terms and Conditions (STCs) outline the following goals:

1. Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, cost effectively in the right setting;

2. Ensure that the expenditures for care and services being provided are measured in terms of its quality and not solely by its quantity;

3. Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility or reducing provider rates; and

4. Streamline and modernize the Medicaid program in the State.

This report satisfies the requirements under Centennial Care STCs[5]. The Interim Report offers a more in-depth update to assess ongoing status of the Centennial Care waiver implementation. The Evaluation methodologies and results presented should be considered an ongoing analysis and are subject to change as the program matures and more information and data become available.

[5] STC 122: Interim Evaluation Report.

Evaluation Plan Design

Consistent with the STCs from CMS, Deloitte Consulting LLP (Deloitte) conducted this Evaluation to study HSD's performance operating the waiver program following the approved Evaluation Plan Design. This Interim Report covers program operations from January 1, 2014 through December 31, 2015 (DY2), with additional program data through December 31, 2016 (DY3) when available.

Program Goals and Hypotheses

The Evaluation Plan for Centennial Care set out four goals for the waiver, each with its own hypothesis and related research questions. Each research question had multiple performance measures to be assessed to determine the extent to which the waiver is achieving its goals. The goals and their corresponding hypotheses outlined in the Evaluation Plan are shown below:

Goal 1: Assure that Medicaid beneficiaries in the demonstration receive the right amount of care, delivered at the right time, in the right setting. The design of the program seeks to eliminate programmatic silos through the consolidation of several waiver programs.

> **Hypothesis 1:** Centennial Care's managed care design will deliver greater access in an appropriate and timely fashion.

Goal 2: Ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. This goal is guided by the principle that health care services improve health status most efficiently through coordinated, efficacious care. Centennial Care seeks to provide high quality services and reduce preventable adverse events.

> **Hypothesis 2:** Increased provision of care coordination will lead to improved health care outcomes and a reduction in adverse events.

Goal 3: Slow the growth rate of costs or "bend the cost curve" over time without cutting benefits or services, changing eligibility, or reducing provider rates. Measuring Centennial Care's progress toward this goal requires monitoring the impact of the expansion in Medicaid eligibility authorized under the Affordable Care Act (ACA). This goal seeks to examine whether improved care coordination results in a shift in spending towards more comprehensive services for individuals with chronic conditions and/or behavioral health needs and away from unnecessary and often costly service utilization by populations with lesser needs. Centennial Care's success in slowing cost growth by rewarding members who achieve certain health care goals will also need to be monitored.

> **Hypothesis 3:** The rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services.

Goal 4: Streamline and modernize the Medicaid program in the State. The consolidation of multiple waivers, benefits, and services into the Centennial Care program by itself will streamline New Mexico's Medicaid program. The hypothesis and research questions addressing this goal test whether this consolidation has substantive implications for the State's health care delivery system providers, enrollees, and the administration.

> **Hypothesis 4:** Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the State.

Approach

HSD engaged Deloitte to conduct the Evaluation of Centennial Care's impact on service delivery and integration through tracking and analysis of performance measures that address access to care, enrollment trends, care coordination, and changes in utilization and cost. The objective of the Centennial Care Evaluation Design Plan is to track performance of each Centennial Care evaluation measure over time against a baseline value.

For this Interim Report and for all Centennial Care demonstration reports going forward, each of these performance measures will be tracked against a baseline value measured either over calendar year 2013 prior to Centennial Care or over calendar year 2014 if pre-Centennial Care data was not available to establish a baseline value from calendar year 2013. In addition, the performance measures will be compared to other meaningful points of reference, including but not limited to:

- Measure values for prior demonstration years, such as progress in DY3 compared to DY2 and DY2 compared to DY1, to evaluate the progress of access to care, quality, and/or cost over time;
- PMPM budget neutrality limits as defined by the STCs from CMS, Section XIV: Monitoring budget neutrality for the Demonstration; and
- National average rates for health compliance, screening, and/or monitoring, such as average rates for standard Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures as published annually by the National Committee for Quality Assurance (NCQA) or as available from other sources[6].

This Interim Report includes detailed quantitative analysis of each performance measure under the Evaluation Plan Design. In the context of this report, discussions of changes in measure values between periods are based on the percent change (increase/decrease) which is calculated as [Current period measure value] / [Prior period measure value] – 1. Additional information related to measure definition and calculation methodology are provided in Appendix A.

For certain measures, hypothesis testing was performed using a two-proportion z-test to determine if a statistically significant change can be inferred. For additional information on the statistical test performed, see Appendix C.

Data Utilized

Consistent with HSD's approved Evaluation Design Plan, Deloitte conducted its Evaluation using a combination of State-provided reports including MCO reports, External Quality Review Organization (EQRO) reports, HSD reports, CMS-64 expenditures/computable cost reports, and special ad-hoc reports extracted from the Medicaid Management Information System (MMIS) and MCO ad-hoc reports. Additional detail on the data utilized for each measure has been provided in Appendix B.

[6] National benchmarks for CAHPS measures obtained through NCQA's Quality Compass (QC) tool referenced in this report uses data captured in calendar year 2014 for all qualified providers nationwide. In instances where QC benchmarks are not available, national benchmarks developed by Symphony Performance Health (SPH), a CMS-approved CAHPS survey vendor for a few MCOs, are provided as a point of reference. SPH benchmarks are based on data captured in calendar year 2015 for a subset of qualified providers nationwide.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Evaluation Limitations

Consistent with HSD's approved Evaluation Plan, Deloitte conducted its Evaluation using State-provided reports, including MCO reports, EQRO reports, HSD reports, and special ad-hoc reports from the MMIS and the MCOs.

Prior to January 1, 2014, HSD did systematically collect and analyze access to care, quality of care, and cost and utilization information for the legacy programs. However, in some cases, the legacy reports were not comparable to Centennial Care's reporting requirements. In other cases, Centennial Care's integration of services and changes in participating providers required changes in reporting. As an example, the level of detail required in reporting utilization by category of service changed dramatically between the legacy reports and Centennial Care. For some performance measures, this lack of consistency between the legacy programs and the new Centennial Care program impeded Deloitte's ability to create baseline metrics to directly compare improvements in access to care, quality of care, and cost and utilization attained by the new waiver program. In such cases, baselines were developed based on the best information available at the time, or Deloitte worked with HSD to revise the measure to accommodate the data available. Note that the details relevant to baseline development for each impacted measure are described in greater detail within Appendix A.

Additional limitations include:

- Certain measures do not include the Native American population that opted out of managed care as this information was not available in the data sources provided to support those measures.
- Due to the aggregate nature of collected data, various adjustment factors could not be applied. These factors include lag time in reporting (e.g. IBNR or data completion), fee schedule changes and/or benefit changes, demographic shifts (age/gender changes, category of eligibility enrollment changes), and changes in provider networks and MCO sub-capitated arrangements.
- Measures that track use of certain services may not accurately capture the use of these services for all possible sites of service. For example, immunizations or vaccines could be received in a walk-up clinic without charge that is outside the managed care network. We expect the impact to be relatively stable year to year with respect to the under reported utilization as the prevalence of alternate site type administration does not seem to fluctuate significantly.
- Where appropriate (e.g. utilization by category of service), measures were calculated on a per 1,000 basis using member month data to adjust for changes in population size. However, these data were not available for all measures nor for all baseline and demonstration year data to be adjusted consistently. Going forward, Deloitte will work with HSD to verify if additional data is available to allow for consistent application of this methodology across all appropriate measures.
- Similar to the above data limitation, analysis was not performed to quantify the impact of seasonality on certain measures where a partial year's data was used to establish the baseline.

- For the measure reporting the percentage of PCPs with open panels, the data submitted by MCOs does not include the number of additional patient slots available across the open panels. Such data would more precisely indicate available capacity in the system.
- To calculate HEDIS measures, plans may use two primary sources of data. Claims/encounter data is always used as a data source, but plans may also perform reviews of medical records to supplement their data for certain measures. When plans use solely claims/encounter data, it is referred to as an "administrative" method of calculating the numerator and denominator. When plans use both administrative data, as well as medical records, it is referred to as a "hybrid" method of data collection. Plans report their method of collection for each measure on its audited HEDIS report as "A" for administrative and "H" for hybrid. When calculating aggregate measure results (e.g. across all MCOs participating in Centennial Care) for HEDIS-based measures, the reporting methodology of the MCOs needed to be consistent. Therefore, there are measures where the aggregate results were calculated only with MCOs using the same HEDIS reporting methodology for that measure during a particular period, which are footnoted in the detailed measure results. This exclusion may skew results in certain periods.
- Due to the aggregate nature of some reports provided by the State, it was not always possible to determine the underlying cause of observed changes in measure values over time nor to test changes for statistical significance.
- For certain measures, data was not received from all four MCOs in all demonstration years. The aggregate results could potentially be skewed for these measures.
- DY1 data for the Centennial Care Rewards Program was limited and only available for a partial year due to an April 1 go-live date.
- Reports provided by participating MCOs had occasional data errors that were identified throughout the Evaluation process. Deloitte has worked with HSD to identify the errors and suggested requesting updated reports for future reporting cycles.

Evaluation Analysis Results

For listings of detailed definitions and evaluation methodologies for all measures, please refer to Appendix A.

Hypothesis 1

Centennial Care's managed care design will deliver greater access in an appropriate and timely fashion.

Centennial Care seeks to ensure that access to preventive care and services is assured for children, adolescents, and adults and that the use of preventive services increases over time, as preventive services may help to lower the utilization of more costly services incurred by members in the future as a result of chronic disease. Another goal is to assess members' health needs and risks in a timely manner, provide care planning and care coordination for members found to require support and access to care in order to prevent decline, crisis and unnecessary admissions. Hypothesis 1 assumes that the Centennial Care's managed care design will deliver greater access to care, in an appropriate and timely fashion.

The Evaluation found that access to care generally improved, while the timeliness with which services were delivered varied compared to the baseline. Overall, the MCOs care coordination activities have generally increased as plans were able to engage more members, and fewer refused care coordination services.

Research Question 1.A

Has access to care for all populations and services covered under the waiver, including physical health, behavioral health, and LTSS, improved under Centennial Care?

The Centennial Care waiver combines PH, BH, and LTSS within a single, consolidated waiver that establishes an integrated model of care. Prior to the waiver's implementation in 2014, these services were fragmented in separate waiver programs, with six different managed care contractors and one Behavioral Health Statewide Entity (BHSE).

The Evaluation is reviewing Centennial Care's impact on service delivery and integration through the analysis of 11 measures designed to address enrollment trends, access to care, and care settings. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, programmatic performance generally showed improved access to care. There were positive performance results when compared to the baseline in 7 out of 12 measures.

While a higher percentage of state population are enrolling in Centennial Care, and a greater percentage of Native Americans are participating in the program, New Mexico saw increases from the baseline to DY2 in members' access to key services in an appropriate care setting, including increased access to telemedicine and the utilization of new BH support services (which were not fully operational during DY1 and DY2). A higher percentage of members with a NF level of care (LOC) designation received care through the community, and a lower percentage of those members received care in NFs. Finally, a larger number of providers participated in Centennial Care in DY2 compared to DY1 and the provider-to-member ratio experienced a favorable decrease.

There was a decline in 5 out of 12 measures from the baseline to DY2. These results included a lower percentage of children and young adults received dental visits (although the rates across cohorts are higher than the national averages), a lower percentage of adult enrollees that utilized preventive or ambulatory services, a lower percentage of members had at least one visit to a Primary Care Provider (PCP), and a lower percentage of PCPs reported open panels in their practices (though the overall

percentage of open panels remained above 90%), and a lower percentage of members utilized overall mental health services (as indicated by their principal diagnosis). It should be noted that in 2015 (DY2), there was a significant transition with the NM behavioral health provider network with some gaps in the network existed for a time resulting in service delays.

Emerging trends for measures that have DY3 data available indicate a continuation of baseline to DY2 trends, including continued increases in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans participating in Centennial Care, and utilization of new BH support services. Available DY3 data also indicates stable percentages of members with NF LOC designation receiving care through HCBS and NFs compared to DY2. However, emerging DY3 information shows a continued decrease in the percentage of members having at least one visit to a PCP. DY3 data for these measures is through at least Q2, though some of the measures have full DY3 data.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 1 – Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups.

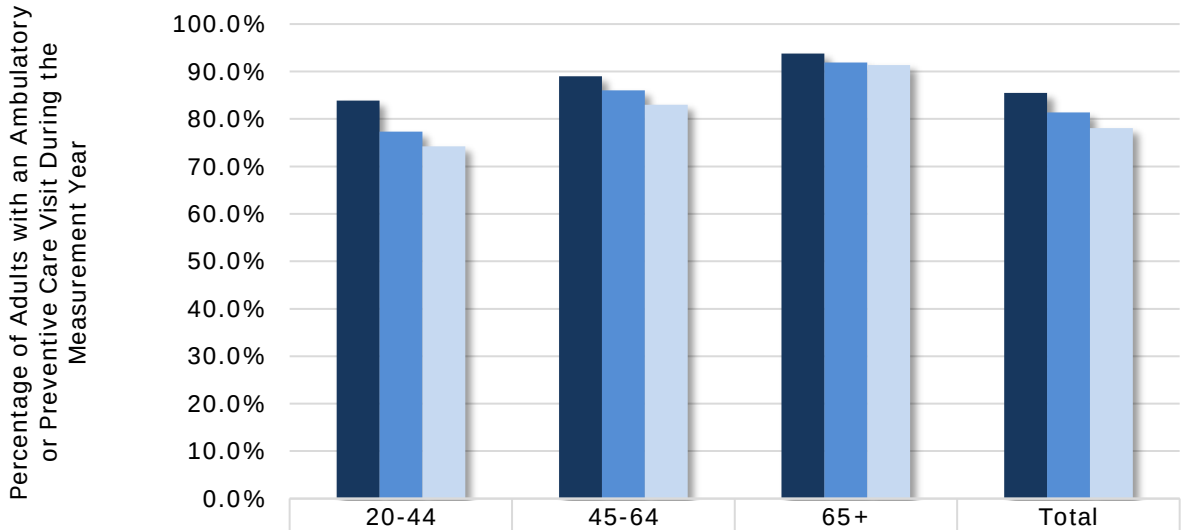
Exhibit 1 presents rates for the 2013 baseline, DY1, and DY2 for the measure Access to Ambulatory/Preventive Care. As illustrated, the rates for each of the three age cohorts as well as the aggregate rate experienced a decrease from DY1 to DY2. The largest decrease among the age cohorts was experienced in the 20-44 years of age cohort which decreased from 77.3% in DY1 to 74.2% in DY2 (a 4.0% change). This change was statistically significant at the 95% confidence level. All decreases apart from the decrease experienced in the 65+ years of age cohort were statistically significant, including the aggregate decrease of 4.1%.

Upon review of the individual MCO performance, PHP experienced the largest change in the aggregate rate (-5.1%) from DY1 to DY2 compared to BCBS, MHC, and UHC, which had changes of -0.3%, -4.3%, and -4.3% respectively.

The rates for each of the three age cohorts as well as the aggregate rate declined from the baseline to DY2. The aggregate rate declined 8.7%, which was statistically significant at the 95% confidence level. An 11.5% decrease in the 20-44 years of age cohort and a 6.8% decrease in the 45-64 years of age cohort were also statistically significant, while the decline in the 65+ years of age cohort was not statistically significant. All four MCOs experienced statistically significant decreases from the baseline to DY2 in their aggregate rate, the greatest of which was UHCs 15.0% decrease.

A national comparison rate could not be identified for this measure.

Exhibit 1 – Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups[7]



	20-44	45-64	65+	Total
2013 Baseline	83.9%	89.0%	93.8%	85.5%
DY1 Centennial Care	77.3%	86.1%	91.9%	81.4%
DY2 Centennial Care	74.2%	83.0%	91.4%	78.1%

[7] Source: MCO annual HEDIS reports for 2013 – 2015.

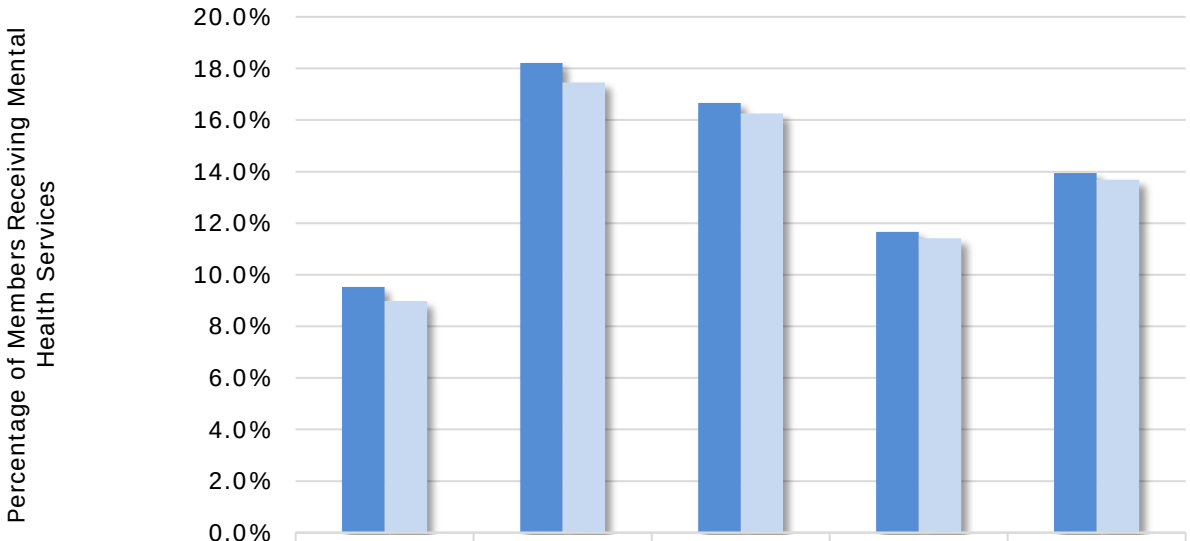
Measure 2 – Mental health services utilization (Members receiving any mental health service with mental health as the principal diagnosis).

Exhibit 2 presents rates for DY1 and DY2 for mental health services utilization. As illustrated, the rates for each of the four age cohorts as well as the aggregate rate experienced a decrease from DY1 to DY2. The largest decrease among the age cohort subcomponents was experienced in the 0-12 years of age cohort which decreased from 18.2% in DY1 to 17.5% in DY2 (a 5.7% change). This change was statistically significant at the 95% confidence level. All decreases apart from the decrease experienced in the 65+ years of age cohort were statistically significant, including the aggregate decrease of 1.8%.

The most significant decline in the aggregate rate from DY1 to DY2 among individual MCOs was experienced by BCBS (-12.3%), a decline that was statistically significant at the 95% confidence level. This was relatively larger than the changes experienced by MHC, PHP, and UHC, which were 2.8%, -1.2%, and -4.5%, respectively.

A national comparison rate could not be identified for this measure.

Exhibit 2 – Mental Health Services Utilization Aggregate[8]



	0-12	13-17	18-64	65+	Total
DY1 Centennial Care	9.5%	18.2%	16.7%	11.7%	13.9%
DY2 Centennial Care	9.0%	17.5%	16.3%	11.4%	13.7%

[8] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 3 – Telemedicine utilization (Number of telemedicine providers and telemedicine utilization).

Exhibit 3 presents results for the 2013 baseline, DY1, and DY2 for the measure Number of Telemedicine Providers and Telemedicine Utilization. As illustrated, utilization of telemedicine increased in both PH and BH subcomponents, as well as in aggregate. From DY1 to DY2, PH utilization experienced a 432.3% increase while BH experienced a 27.7% increase. Aggregate utilization increased by 47.5% from DY1 to DY2.

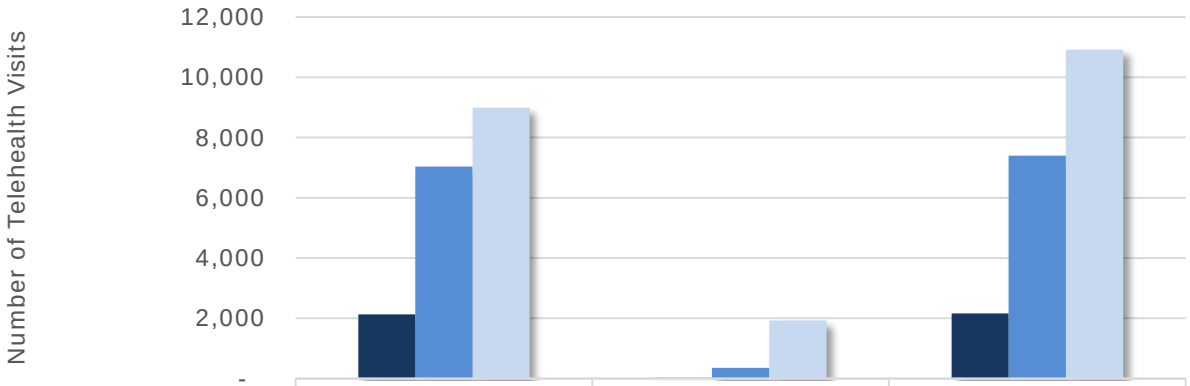
Aggregate utilization (both PH and BH) increased across all MCOs. UHC experienced the greatest increase (81.2%), while BCBS, MHC, and PHP increased by 72.5%, 48.7%, and 25.2%, respectively.

From the baseline to DY2, the aggregate utilization of telehealth services increased 405.3%. The PH utilization subcomponent increased by 6,544.8% while the BH utilization subcomponent increased by 321.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 3 – Telemedicine Utilization[9]



	Behavioral health	Physical health	Total
2013 Baseline	2,131	29	2,160
DY1 Centennial Care	7,039	362	7,401
DY2 Centennial Care	8,987	1,927	10,914

[9] Source: Ad hoc MCO reports 2013 - 2015.

Measure 4 and 5 – Number and percentage of people meeting nursing facility level of care who are in nursing facilities or are receiving HCBS.

With the implementation of Centennial Care, eligibility for HCBS does not require a waiver allocation ("slot") to access HCBS services if the member is eligible for full Medicaid and meets a NF LOC. Also, the personal care service (PCS) benefit was changed from being a state plan service to a component of the CB service package. Under the former Coordination of Long-Term Services (CoLTS) program, individuals who were Medicaid eligible could receive PCS under the state plan, and were required to wait for a waiver allocation in order to have access to the full array of CoLTS HCBS. Under Centennial Care, Medicaid members have access to all CB services that they are assessed to need, without an allocation, upon meeting the NF LOC criteria. Individuals who do not meet full Medicaid financial eligibility requirements will be allocated to a waiver "slot".

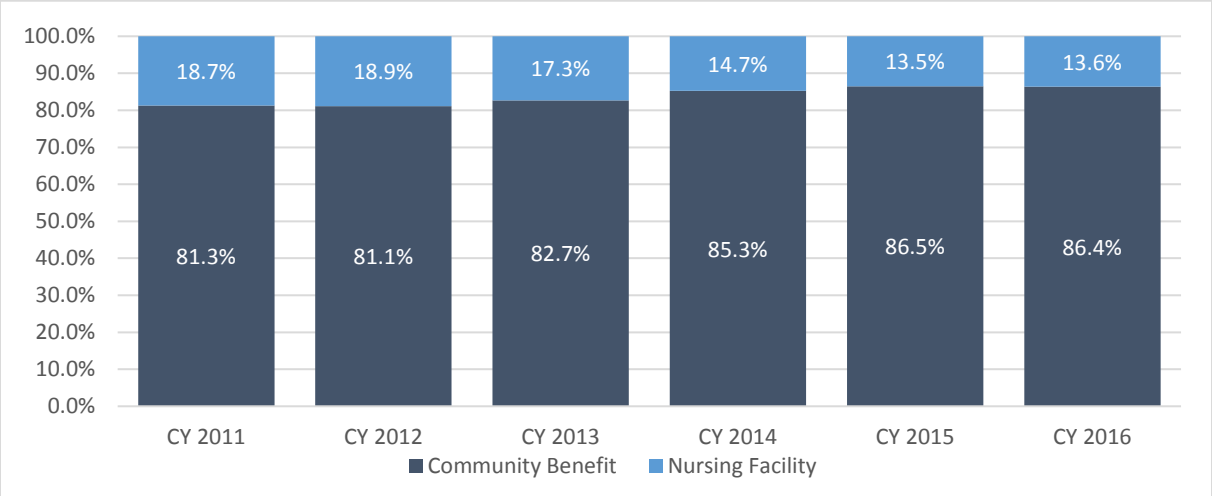
The number of unique members receiving HCBS increased from 24,015 to 29,799 (a 24.1% increase) from DY1 to DY3[10].

In overall performance of its LTSS program, New Mexico ranks in the second best quartile in the 2014 National State Long-Term Care Scorecard published by the AARP and the Commonwealth Fund. New Mexico's LTC system is especially strong in terms of:

- Affordability and access (top quartile)
- Choice of setting and provider (top quartile)
- Effective transitions across settings of care (second quartile)
- Community Reintegration/Rebalancing

Under Centennial Care, NM has continued to reintegrate members from nursing facilities into the community, with 86.4% of members in the long-term care program being served in the community in 2016, which is relatively consistent results with 2015 results.

Exhibit 4.a/5.a – Long Term Services and Supports Enrollment - Dual and Medicaid Only NF LOC Enrollment Proportion[11]

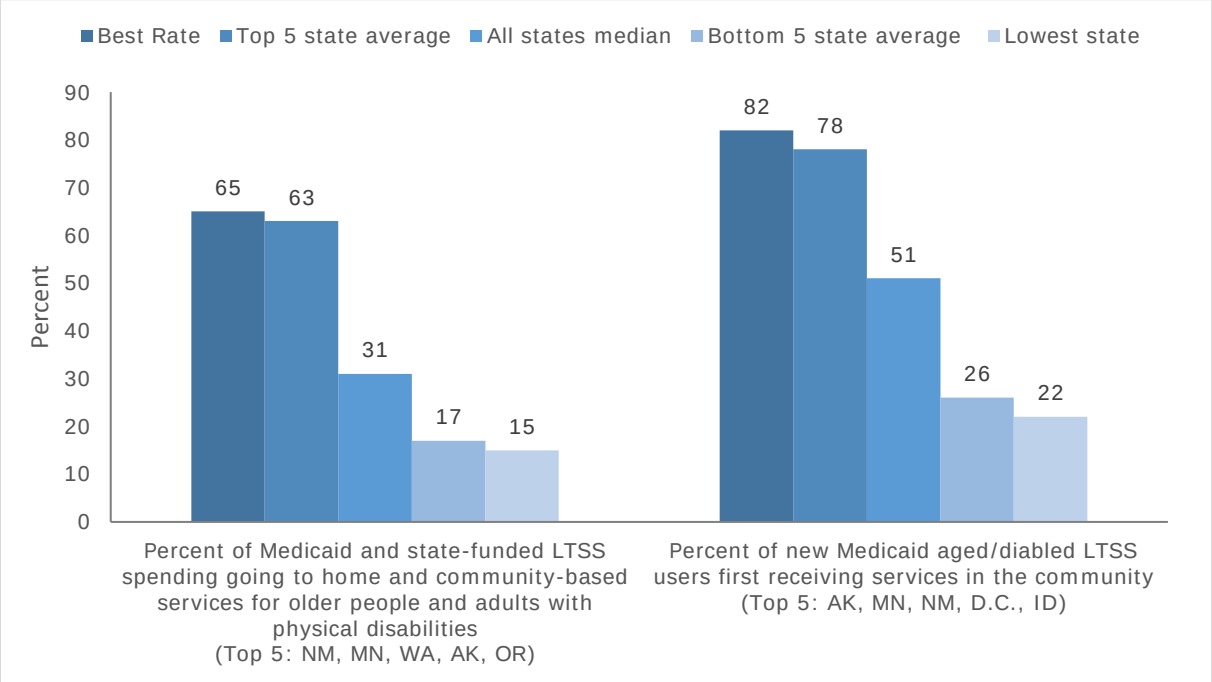


In the AARP's annual report for 2014, *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, New Mexico ranks first in the nation for

[10] Source: Mercer calculation based on MCO encounter data.
[11] Source: Ad hoc report developed by Mercer that analyzes distribution of member months for NF vs. community benefit. Note that Deloitte did not review the underlying data report that supports this exhibit.

spending more than 65 percent of its long-term care dollars on home and community-based services, as seen in Exhibit 4.b/5.b below.

Exhibit 4.b/5.b – National Ranking of New Mexico's HCBS Spending as a Percentage of LTSS Spending and Percentage of New Medicaid Users First Receiving Services in the Community



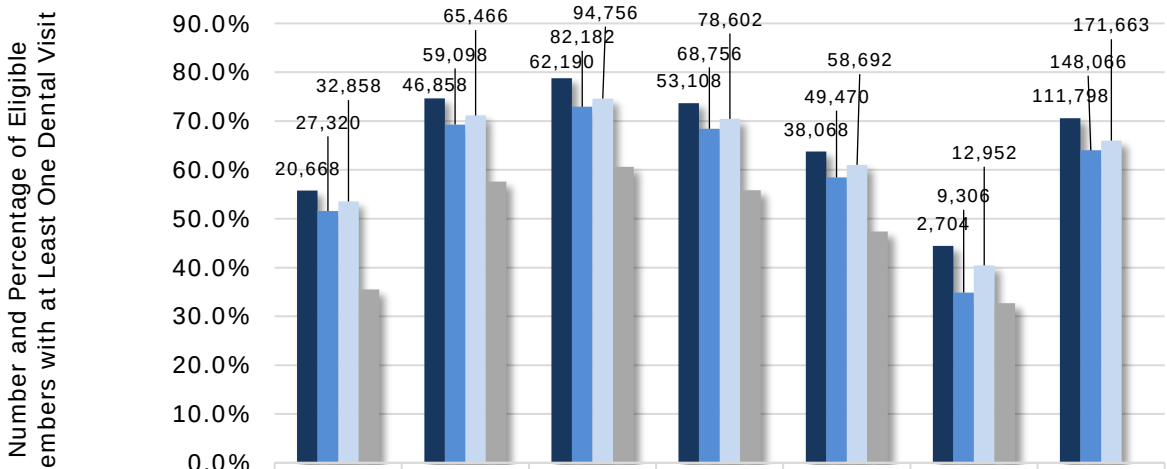
Measure 6 – Number and percentage of people with annual dental visit.

Exhibit 6 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the Number and Percentage of Members with an Annual Dental Visit. As illustrated, the aggregate rate has declined from 70.6% in the baseline to 66.0% in DY2 (a 6.5% change) which was statistically significant at the 95% confidence level. However, the most recent year-over-year change for the Centennial Care program resulted in a 3.1% increase from DY1 to DY2, which also was statistically significant at the 95% confidence level.

The largest change from DY1 to DY2 among the age cohorts was a 15.9% increase experienced by the adult cohort, ages 19-21. The adult cohort also experienced the greatest change from the baseline to DY2 (-9.0%). All cohort and aggregate changes from both the baseline to DY2 and from DY1 to DY2 were statistically significant at the 95% confidence level.

It should be noted that while the rates across the cohorts have decreased from the baseline to DY2, the DY2 rates across all age cohorts were higher than the national averages.

Exhibit 6 – Number and Percentage of Participants with Annual Dental Visits by Age Group[12]



	2-3	4-6	7-10	11-14	15-18	19-21	Total
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%	44.4%	70.6%
DY1 Centennial Care	51.6%	69.3%	72.9%	68.4%	58.5%	34.9%	64.0%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%	40.4%	66.0%
2015 National Avg	35.5%	57.6%	60.6%	55.8%	47.4%	32.7%	48.3%

[12] Source: MCO annual HEDIS reports for 2013 – 2015.

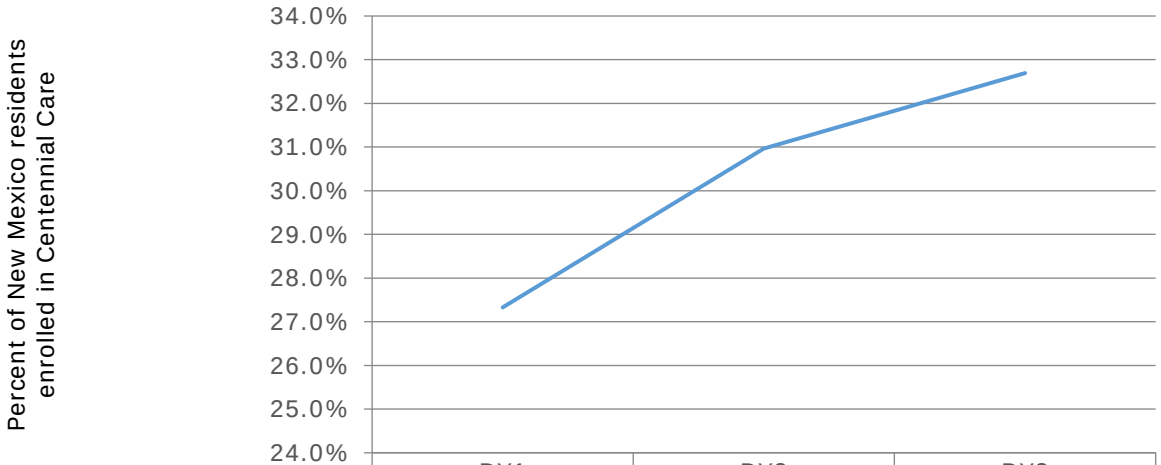
Measure 7 – Enrollment in Centennial Care as a percentage of state population.

Exhibit 7 presents rates for DY1, DY2, and DY3 for the percentage of the population enrolled in Centennial Care.

As illustrated, the percentage of New Mexicans enrolled in Centennial Care has increased from DY2 to DY3 by 5.6%. This year-over-year increase is consistent with trends since the program's inception, and the total program-to-date increase from DY1 to DY3 was 19.6% which was a statistically significant change.

A national comparison rate could not be identified for this measure.

Exhibit 7 – Percentage of State Population Enrolled in Centennial Care[13]



	DY1	DY2	DY3
Percentage of the population enrolled	27.3%	31.0%	32.7%

[13] Source: Mercer Dashboard reports for Centennial Care enrollment and United States Census Bureau annual state level population estimates.

Measure 8 – Number of Native Americans opting-in and opting-out of Centennial Care.

Exhibit 8 presents rates for DY1, DY2, and DY3 for the Number of Native Americans that Opt-out of Centennial Care.

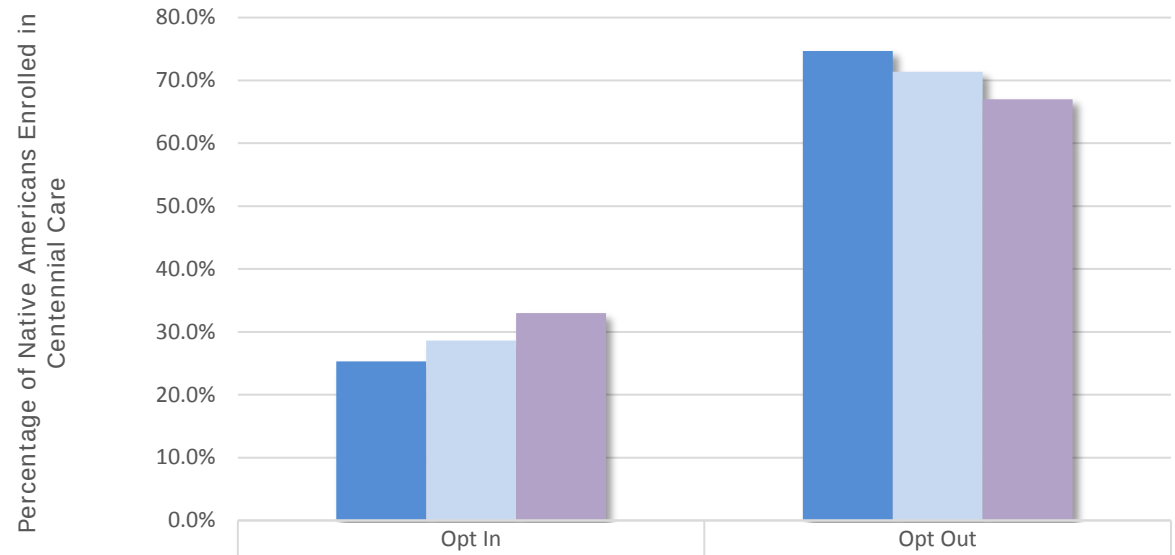
As illustrated, Native Americans' preference for Centennial Care grew as the opt-out rate declined from 71.4% to 67.0%, while the rate at which Native Americans opted-in increased from 28.6% to 33.0% from DY2 to DY3.

The change since Centennial Care's inception demonstrates a consistent story, as the rate at which Native Americans opted-in increased from 25.3% to 33.0% from DY1 to DY3. The opt-out rate dropped from 74.7% to 67.0% over the same period.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

A national comparison rate could not be identified for this measure.

Exhibit 8 – Percentage of Native Americans Opting-In and Opting-Out of Centennial Care[14]



	Opt In	Opt Out
DY1 Centennial Care	25.3%	74.7%
DY2 Centennial Care	28.6%	71.4%
DY3 Centennial Care	33.0%	67.0%

[14] Source: Native American Opt In reports for 2014 – 2016.

Measure 10 – Number and percentage of participants with BH conditions who accessed any of the three new BH services (BH respite, family support, and recovery).

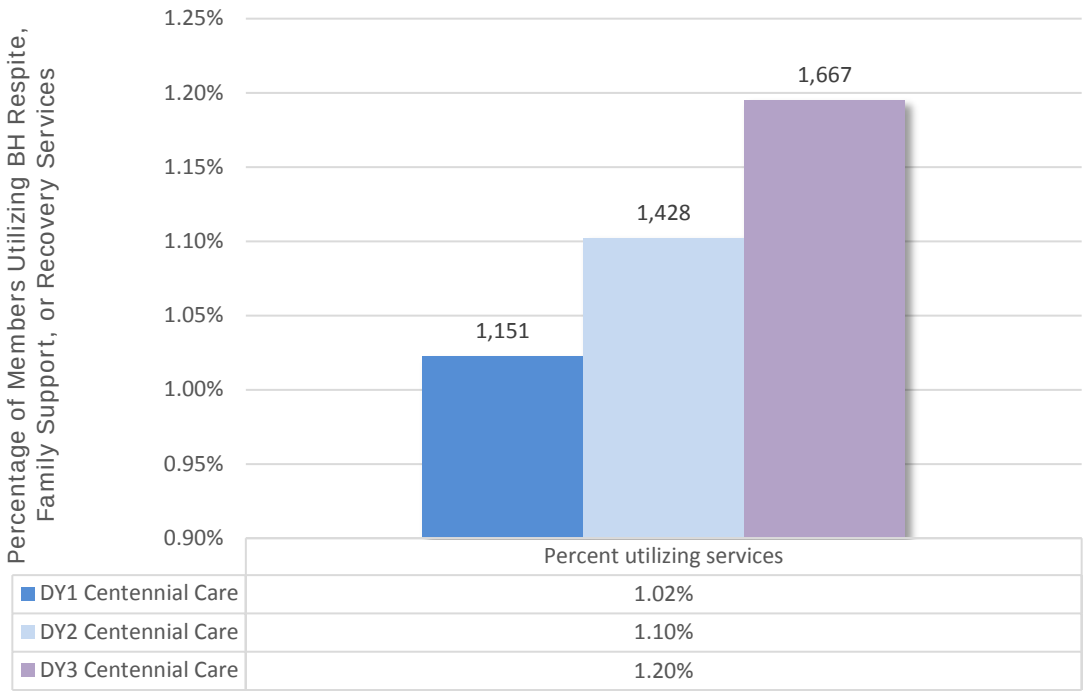
Exhibit 10 presents rates for DY1, DY2, and DY3 for the utilization of new BH services. The three new services were not fully operational in DY1 and DY2 and there are several considerations with respect to the results:

- The Family Support Services were not launched during this review period as the Family Certification program was being built to train qualified staff. In DY4, the certification will begin in January 2018 for families of children and for families of adults. The existing Certified Peer Support Worker certification will include a specialty training on providing this service.
- BH respite care is only available for parents of youth and there were instances of miscommunication among providers about existing respite services within the Community Benefit program compared to the new behavioral health respite.
- The Recovery Services were launched in 2014 in the group setting only and providers did not find it useful. In DY4, these services will be available individually for adults.

As illustrated, utilization of the new services increased from 1.10% in DY2 to 1.20% in DY3 (a change of 8.43%), which was not statistically significant. Year-over-year increases in the utilization of these services has been a consistent trend since the inception of Centennial Care, and the program-to-date increase from 1.02% in DY1 to 1.20% in DY3 (a 16.90% change), which was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 10 – Members Utilizing BH Respite, Family Support, and Recovery Services[15]



	Percent utilizing services
DY1 Centennial Care	1.02%
DY2 Centennial Care	1.10%
DY3 Centennial Care	1.20%

[15] Source: BH Clients with Respite, Family Support, Recovery Services MMIS reports for 2014 – 2016.

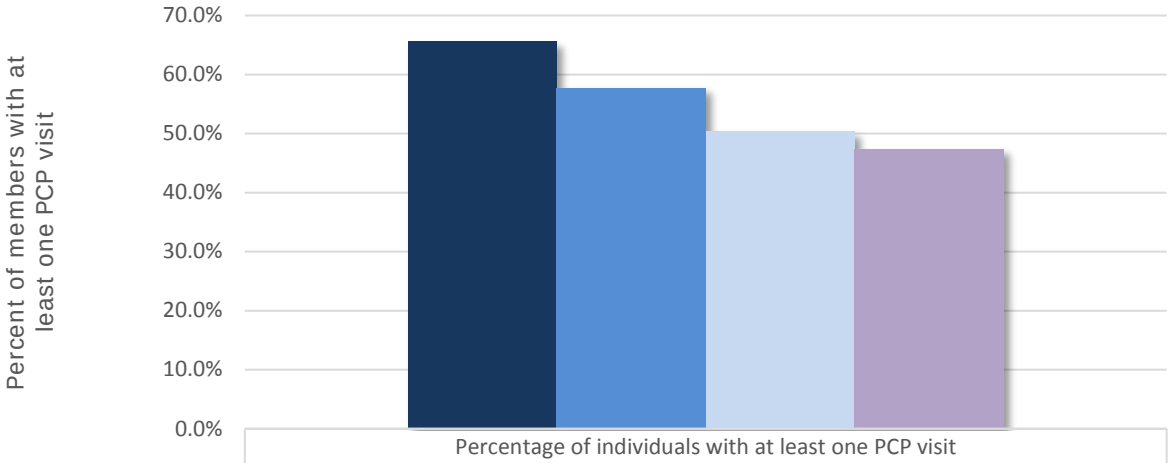
Measure 11 – Number and percentage of unduplicated participants with at least one PCP visit.

Exhibit 11 presents rates for DY1, DY2, and DY3 for the Access to PCP measure.

As illustrated, the percentage of members with at least one PCP visit declined from 50.4% in DY2 to 47.4% in DY3 (a 5.8% change), which was not statistically significant. This measure has demonstrated consistent decline for each year measured, and the total decline from 65.5% in the baseline to 47.4% in DY3, a 27.7% change. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 11 – Percentage of Members with at Least One PCP Visit[16]



	Percentage of individuals with at least one PCP visit
2013 Baseline	65.5%
DY1 Centennial Care	57.6%
DY2 Centennial Care	50.4%
DY3 Centennial Care	47.4%

[16] Source: PCP Visits MMIS reports for 2014 – 2016.

Measure 12 – Number/ratio of participating providers to enrollees.

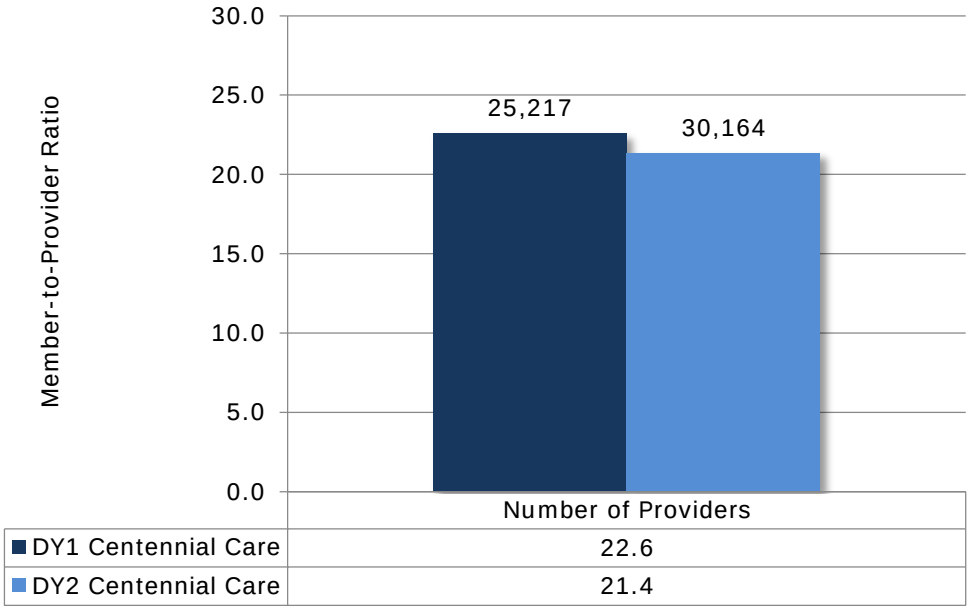
Exhibit 12 presents results for DY1 and DY2 for the number and ratio of providers to members. This measure was not reported previously due to the data source and reporting methodology undergoing refinements.

As illustrated, the ratio of providers to members experienced a favorable decrease from 22.6 in DY1 to 21.4 in DY2 (a 5.4% change). This decrease in the ratio was driven by a 19.6% increase in the number of providers participating in Centennial Care, which increased from approximately 25K in DY1 to approximately 30K in DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the timing that the data was made available for analysis.

Exhibit 12 – Number/Ratio of Participating Provider to Members



Measure 13 – Percentage of primary care providers with open panels.

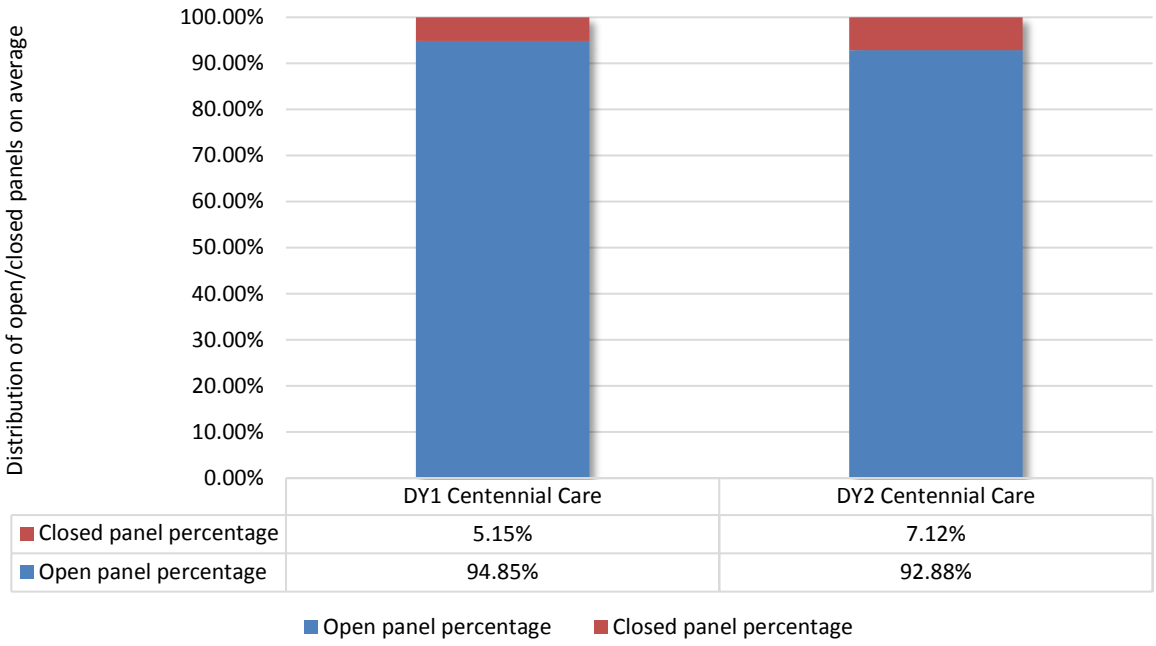
Exhibit 13 presents rates for DY1 and DY2 for PCPs with Open Panels. As illustrated, the percentage of open panels declined by 2.1% from DY1 to DY2. Conversely, the number of closed panels increased by 38.1% in this same interval. Despite these changes, the overall percentage of open panels remained above 90.0% and the percentage of closed panels remained below 10.0% for both years.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests relatively consistent results for both subcomponents as seen in DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 13 – Percent of PCPs by Open/Closed Panel Status[17]



	DY1 Centennial Care	DY2 Centennial Care
Closed panel percentage	5.15%	7.12%
Open panel percentage	94.85%	92.88%

[17] Source: MCO reports for 2014 – 2015 (HSD 3).

Research Question 1.B

Is access to care timely under Centennial Care?

The Evaluation is reviewing Centennial Care's impact on timely access to care through the analysis of 14 performance measures that specifically address geographic access to PCPs, adult, child, and adolescent preventive health/wellness services, prenatal and postpartum care, and follow-up after BH and Residential Treatment Center (RTC) services. For each measure, performance is tracked over time against a baseline value as well as on an annual basis. Overall through DY2 of Centennial Care, programmatic performance varied across performance measures.

Although the MCO geographic-based data showed very high percentage of members with access to PCPs in all county types (urban, rural and frontier), the member to PCP ratios increased from DY1 to DY2 especially in the rural and frontier counties. It is important to note that the large increase in the percentage of the state population enrolled in Centennial Care may have contributed to the increase in member to PCP ratio; and may have contributed to the lower percentage of members with at least one PCP visit and rates of other screenings and immunizations that are generally checked and provided during an annual PCP visit.

The only measure that demonstrated clear improvement was flu vaccination rates for adults, and emerging DY3 experience suggests consistent performance results as DY2.

Plan by plan comparisons were examined in place of aggregate rates for the measure Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life due to differences in data reporting methodologies across MCOs. Performance trends varied by MCOs for this measure. Additionally, the measures Initiation and Engagement of Alcohol and Other Drug Dependence Treatment showed mixed results as certain subcomponents improved while others declined.

Ten of the 14 measures showed decline in performance. Rates decreased for timely follow-up after leaving an RTC, timely follow-up after hospitalization for mental illness, childhood immunization, immunization for adolescents, adolescent well care visits (three of the four MCOs), timely prenatal and postpartum care, breast cancer screening for women, and cervical cancer screening for women. In addition, there were observed shifts from the highest frequency to lower frequencies of visits for Well-Child Visits in First Month of Life and Frequency of Ongoing Prenatal Care, which also indicate decline in performance.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 14 – Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC).

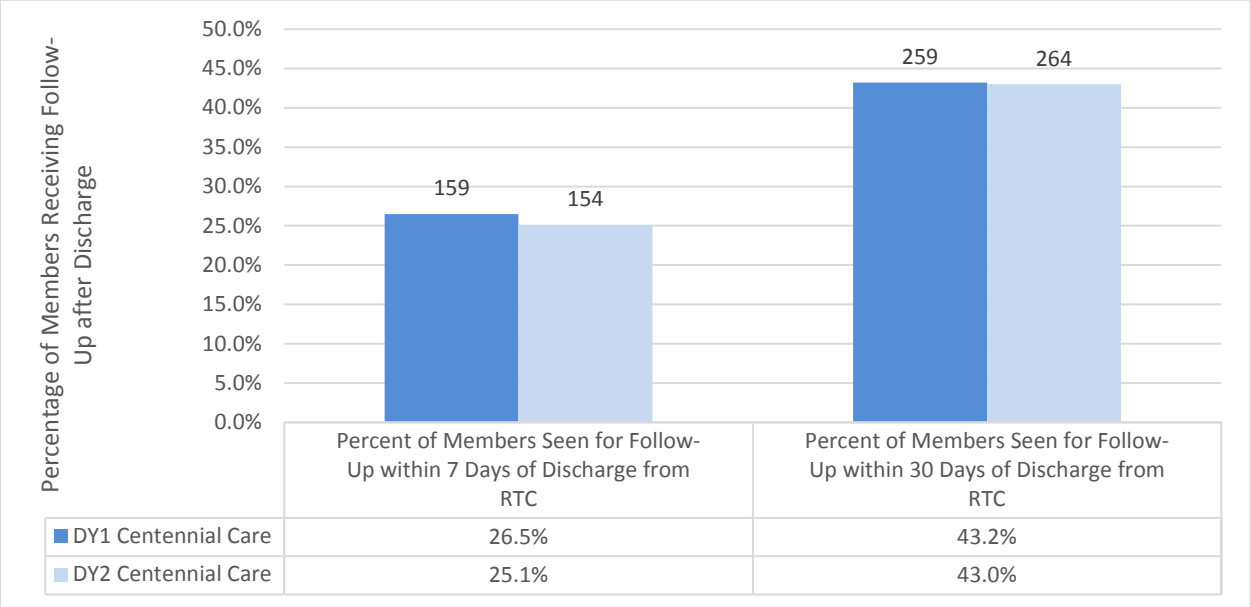
Exhibit 14 presents results for DY1 and DY2 for the Number and Percentage of Substance Use Disorder Participants with Follow-up 7 and 30 Days after leaving a RTC. RTCs serve the youth population under age 21 who are enrolled in Centennial Care.

As illustrated, the percentage of members with follow-up care after an RTC visit declined slightly for both the 7-day and 30-day subcomponents from DY1 to DY2. The 7-day follow-up percentage declined from 26.5% in DY1 to 25.1% in DY2 (a 5.2% change), and the 30-day follow-up rate declined from 43.2% in DY1 to 43.0% in DY2 (a 0.3% change). Neither of these changes were statistically significant.

Upon review of individual MCO performance of the 7-day follow-up subcomponent during the same period, MHC experienced the largest increase (82.8%) followed by UHC (40.3%), BCBS (-15.8%), and PHP (-37.0%). For the 30-day follow-up subcomponent, MHC experienced the largest increase (86.3%), followed by UHC (2.5%), BCBS (-11.7%), and PHP (-26.3%).

A national comparison could not be identified for this measure.

Exhibit 14 – Number and Percentage of Centennial Care Members Seen for a Follow-up with 7 and 30 Days after Discharge from an RTC[18]



	Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC
DY1 Centennial Care	26.5%	43.2%
DY2 Centennial Care	25.1%	43.0%

[18] Source: MCO reports for 2014 – 2015 (HSD 5).

Measure 15 – Number and percentage of BH participants with follow-up after hospitalization for mental illness.

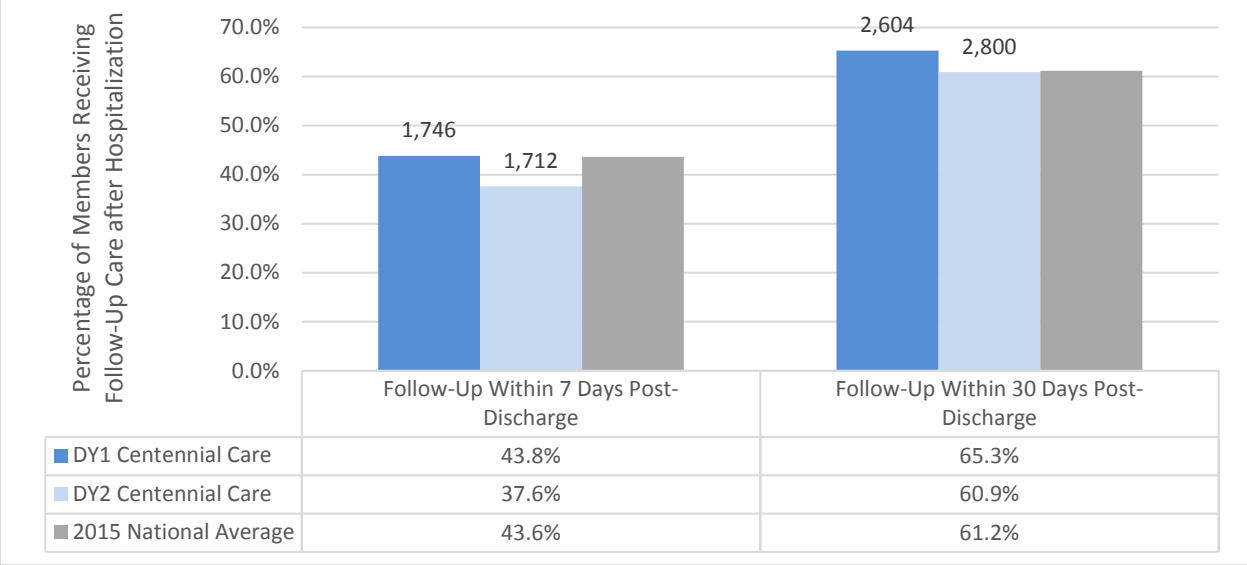
Exhibit 15 presents results for the percentage of members who were discharged after a hospitalization for mental illness and seen for follow-up care within 7 days and 30 days for DY1, DY2, and 2015 HEDIS Medicaid national averages.

As illustrated, the percentage of adults and children that had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner within 7 days and 30 days after their discharge declined (-14.2% and -6.9%, respectively) from DY1 to DY2. Both declines were statistically significant at the 95% confidence level. It is worth noting that the DY2 rate for a follow-up within 30 days subcomponent is within 0.3% of the 2015 national average rate.

The declines can largely be attributed to gaps in network coverage that occurred throughout DY2 with the closure of 7 BH provider locations in March, which impacted 2,357 members being served, and an additional closure of 12 BH provider locations in May, which impacted 3,567 members being served.

After the exit of these providers, HSD worked with the MCOs to close the network gap and rebuild the program services. Many members were moved to FQHCs which required additional certifications to administer the specialized BH services, and this delay may be a driver of the decreases that occurred from DY1 to DY2.

Exhibit 15 – Number and Percentage of Participants with Follow-up after Hospitalization for Mental Illness[19]



	Follow-Up Within 7 Days Post-Discharge	Follow-Up Within 30 Days Post-Discharge
DY1 Centennial Care	43.8%	65.3%
DY2 Centennial Care	37.6%	60.9%
2015 National Average	43.6%	61.2%

[19] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 16 – Childhood immunization status.

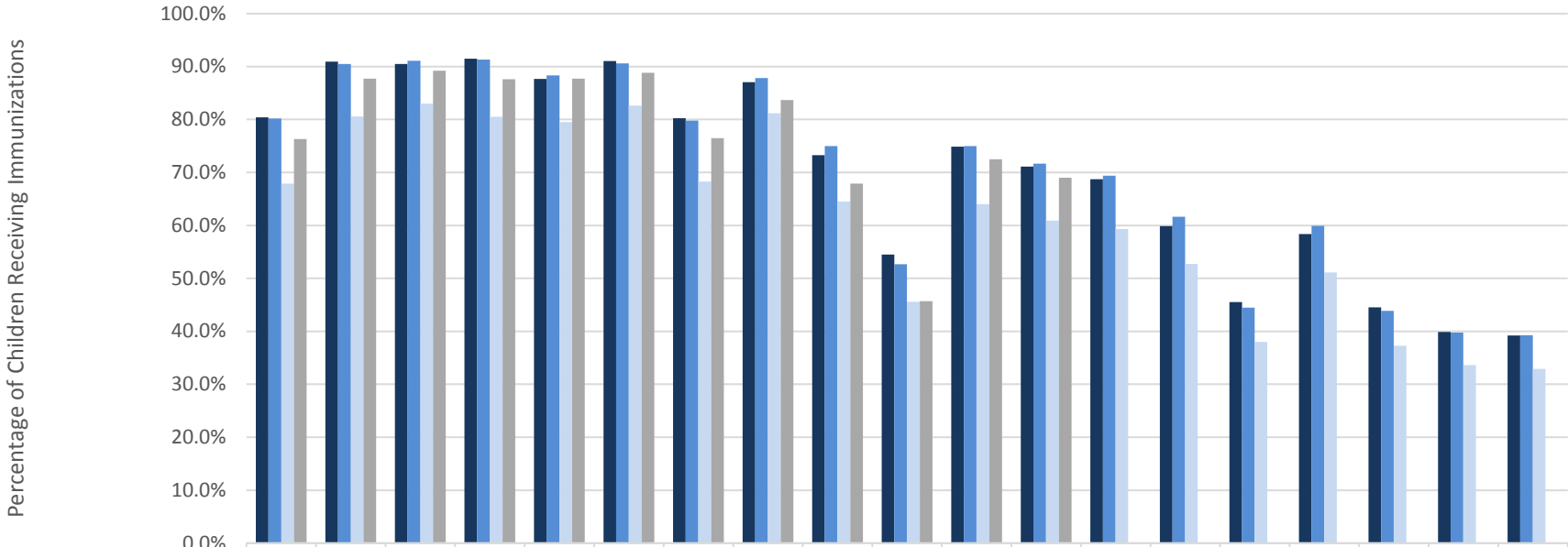
Exhibit 16 presents rates for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages for the 19 subcomponent rates and the aggregate rate for the Childhood Immunization Status measure. The evaluation provides results for 10 vaccines and 9 separate combination rates for three out of the four plans in the baseline and all four plans in DY1 and DY2.[20]

As the exhibit illustrates, rates for all 19 subcomponents declined from DY1 to DY2. The rate of decline across all subcomponents ranged from 7.5% to 16.1% and all declines in the rates were statistically significant at the 95% confidence level. Similarly, the rates for all 19 subcomponents declined from the baseline to DY2. The rate of decline ranged from 6.7% to 16.5% and all declines were statistically significant at the 95% confidence level. Additionally, all subcomponent rates for DY2 were below the corresponding 2015 national averages.

MHC experienced drops in all measures from the baseline to DY2, while other plans experienced varied results. However, not all changes from the baseline to DY2 for the individual plans (increases and declines) were statistically significant at the 95% confidence level. See Appendix C for more details regarding statistical significance for this measure.

[20] UHC reported "Not Reportable" (NR) in the baseline.

Exhibit 16 – Childhood Immunization Status[21]



	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	Rotavirus	Influenza	Combo 2	Combo 3	Combo 4	Combo 5	Combo 6	Combo 7	Combo 8	Combo 9	Combo 10
2013 Baseline	80.4%	90.9%	90.5%	91.5%	87.6%	91.0%	80.2%	87.1%	73.3%	54.5%	74.9%	71.1%	68.7%	59.9%	45.5%	58.4%	44.5%	39.9%	39.2%
DY1 Centennial Care	80.2%	90.5%	91.1%	91.3%	88.4%	90.6%	79.8%	87.9%	75.0%	52.7%	75.0%	71.7%	69.4%	61.6%	44.5%	59.9%	43.9%	39.8%	39.3%
DY2 Centennial Care	67.9%	80.6%	83.0%	80.5%	79.5%	82.6%	68.3%	81.2%	64.5%	45.6%	64.0%	60.9%	59.3%	52.7%	38.0%	51.1%	37.3%	33.6%	32.9%
2015 National Average	76.3%	87.7%	89.2%	87.6%	87.7%	88.8%	76.5%	83.7%	67.9%	45.7%	72.5%	69.0%							

[21] Source: MCO annual HEDIS reports for 2013-2015.

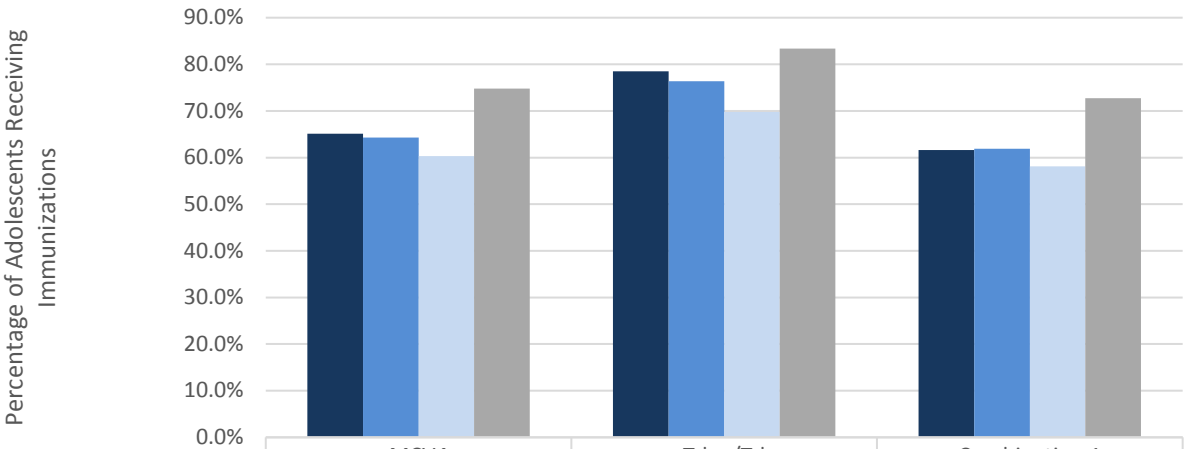
Measure 17 – Immunizations for Adolescents.

Exhibit 17.a presents rates for Immunizations for Adolescents for three plans the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages. The rates declined from DY1 to DY2 for meningococcal (MCV4), Tdap/Td, and the combined vaccine (Combination 1) by 6.3%, 8.6%, and 6.2% respectively. Only the 8.6% decline for Tdap/Td was statistically significant at the 95% confidence level.

Statistically significant drops in immunization rates for meningococcal (MCV4) vaccine (-7.3%) and Tdap/Td vaccines (-11.1%) occurred from the baseline to DY2. Combination 1 vaccination rates also declined from the baseline to DY2, but the change was not statistically significant.

The DY2 rates for all three subcomponents of immunizations were below the 2015 national average rates as depicted by Exhibit 17.a.

Exhibit 17.a – Immunizations for Adolescents (Three-Plan Aggregate)[22]

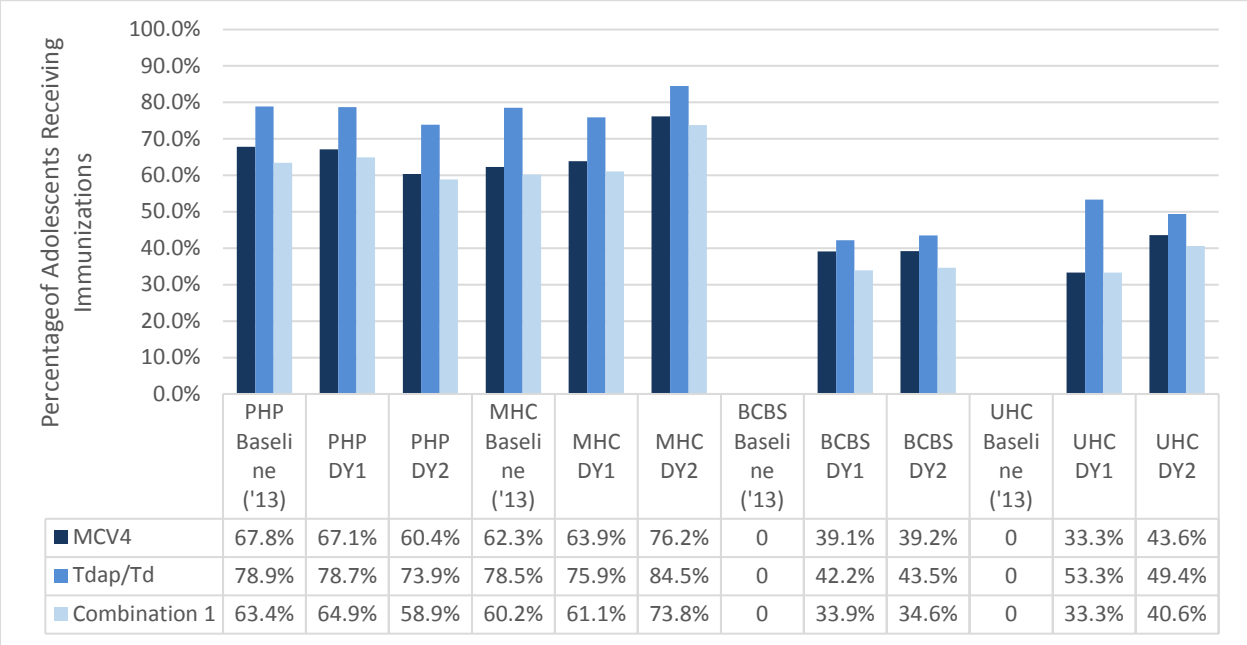


	MCV4	Tdap/Td	Combination 1
2013 Baseline	65.1%	78.5%	61.6%
DY1 Centennial Care	64.3%	76.4%	61.9%
DY2 Centennial Care	60.3%	69.8%	58.1%
2015 National Average	74.8%	83.4%	72.7%

Because of the inability to provide a four-plan aggregate rate, the evaluation also considered individual performance by each MCO across the three subcomponents of Immunizations for Adolescents. As illustrated in Exhibit 17.b, MHC experienced statistically significant increases in rates from the baseline to DY2 for MCV4 (22.3%), Tdap/Td (0.9%), and Combination 1 (22.7%), while PHP experienced slight drops in all subcomponents, although only the decline for MCV4 (-10.9%) was statistically significant at the 95% confidence level. Because UHC and BCBS did not report rates in the baseline, longitudinal comparison from the baseline to DY2 was not evaluated.

[22] Source: MCO annual HEDIS reports for 2013 – 2015. BCBS reported using the administrative method of data collection for all years while the other plans used the hybrid method. Therefore, BCBS was excluded from the aggregate results in all years. UHC did not report individually in the baseline due to a low denominator but their numerator and denominator results were included in the aggregate display.

Exhibit 17.b – Immunizations for Adolescents (Plan by Plan Rate)[23]



	PHP Baseline ('13)	PHP DY1	PHP DY2	MHC Baseline ('13)	MHC DY1	MHC DY2	BCBS Baseline ('13)	BCBS DY1	BCBS DY2	UHC Baseline ('13)	UHC DY1	UHC DY2
MCV4	67.8%	67.1%	60.4%	62.3%	63.9%	76.2%	0	39.1%	39.2%	0	33.3%	43.6%
Tdap/Td	78.9%	78.7%	73.9%	78.5%	75.9%	84.5%	0	42.2%	43.5%	0	53.3%	49.4%
Combination 1	63.4%	64.9%	58.9%	60.2%	61.1%	73.8%	0	33.9%	34.6%	0	33.3%	40.6%

[23] Source: MCO annual HEDIS reports for 2013 – 2015.

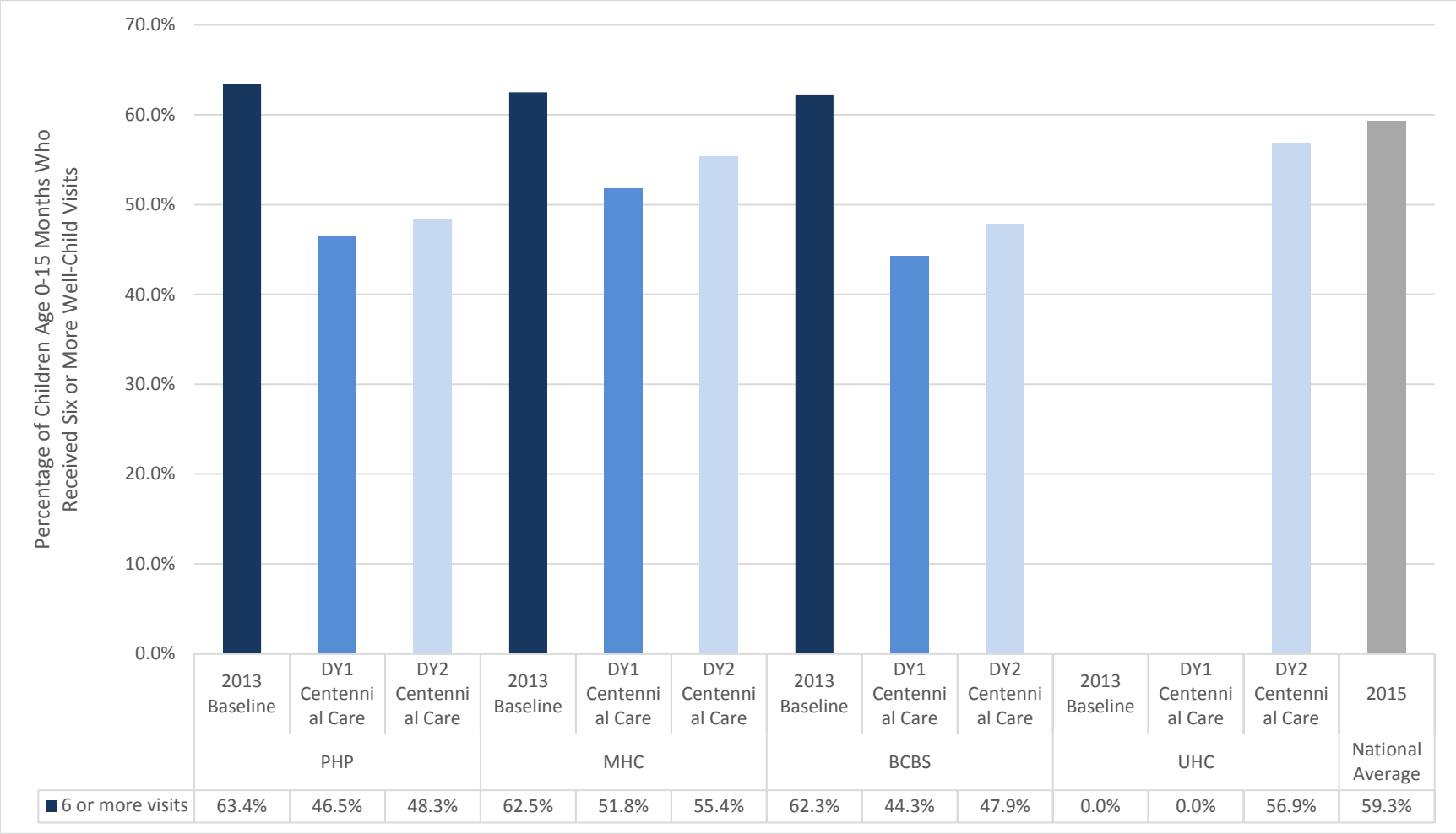
Measure 18 – Well-Child visits in first 15 months of life.

Exhibit 18 presents rates of six or more Well-Child Visits in First 15 Months of Life on seven subcomponents reporting the frequency of visits received by children 15 months and younger during the measurement year, from zero visits to six or more. The Evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed. The 2015 HEDIS Medicaid national average[24] for six or more visits was also included in Exhibit 18 for comparison purposes.

When evaluating plan-by-plan performance, all Centennial Care MCOs that reported experienced an improvement in the rate of six or more well-child visits from DY1 to DY2. However, all MCOs that reported experienced statistically significant declines from the baseline to DY1 and DY2.

[24] NCQA Quality Compass National Average for all lines of business provided by HSD

Exhibit 18 – Well-Child Visits in First 15 Months of Life (Plan-by-Plan Rates)[25]



	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care	2015 National Average
	PHP			MHC			BCBS			UHC			
6 or more visits	63.4%	46.5%	48.3%	62.5%	51.8%	55.4%	62.3%	44.3%	47.9%	0.0%	0.0%	56.9%	59.3%

[25] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in the baseline and DY1; PHP and BCBS reported rates under the Administrative methodology, while MHC report rates under the Hybrid methodology in DY1 and DY2. UHC reported under the Hybrid methodology in DY2. An aggregate rate was not calculated due to the different reporting methodologies.

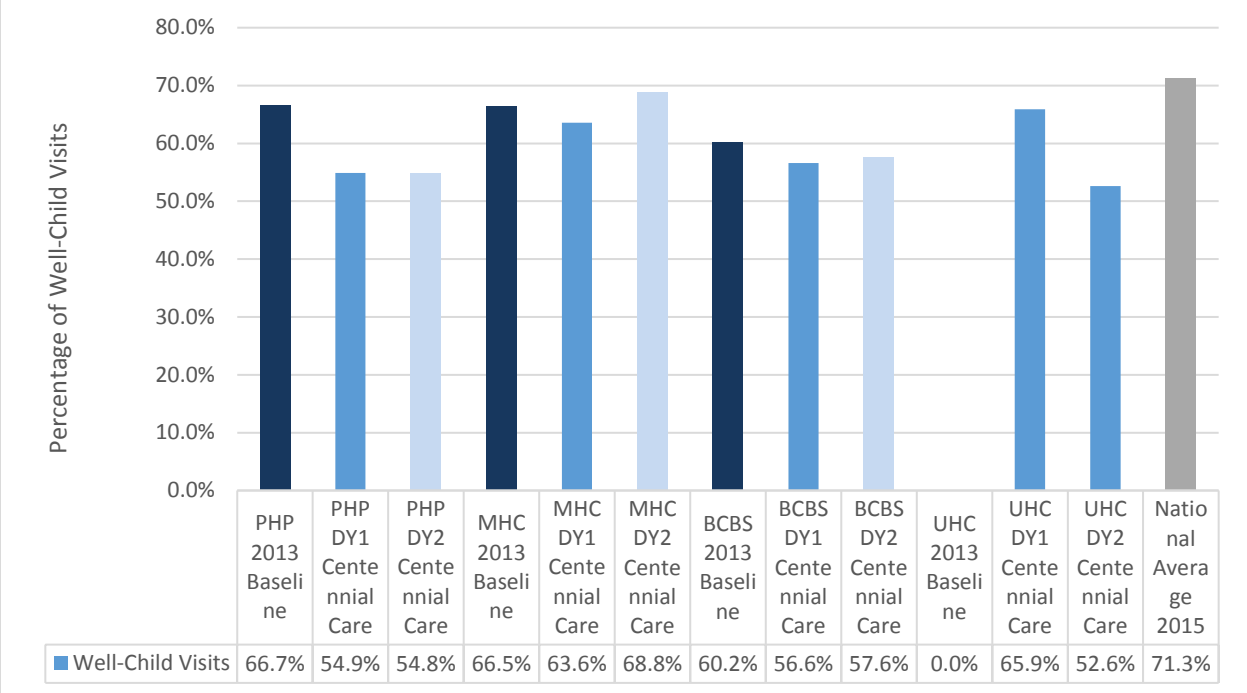
Measure 19 – Well-Child visits in third, fourth, fifth and sixth years of life.

Exhibit 19 presents rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life for the four Centennial Care MCOs from the baseline to DY2 as well as the 2015 HEDIS Medicaid national average. The Evaluation considered rates for the four MCOs on an individual basis; because of the varied methodologies plans used to report rates, an aggregate rate was not assessed.

As the exhibit below shows, MCO performance over time varied. For example, the three plans that reported baseline rates experienced declines from the baseline to DY1 ranging from 4.4% to 17.6% (only the 17.6% decline was statistically significant at the 95% confidence level). In DY2, two of the four plans experienced increases in the rate of visits from DY1. MHC experienced an 8.2% increase and BCBS a 1.7% increase; however, PHP and UHC both experienced declines of 0.2% and 20.3%, respectively. The UHC rate of change was statistically significant at the 95% confidence level. All MCOs fell below the 2015 national average of 71.3% in DY2.

Only PHP experienced a change in the rate of visits from the baseline to DY2 that was statistically significant at the 95% confidence level (-17.8%). The slight increase by MHC and decrease by BCBS during the same period were not statistically significant.

Exhibit 19 – Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Plan-by-Plan Rates)[26]



	PHP 2013 Baseline	PHP DY1 Centennial Care	PHP DY2 Centennial Care	MHC 2013 Baseline	MHC DY1 Centennial Care	MHC DY2 Centennial Care	BCBS 2013 Baseline	BCBS DY1 Centennial Care	BCBS DY2 Centennial Care	UHC 2013 Baseline	UHC DY1 Centennial Care	UHC DY2 Centennial Care	National Average 2015
Well-Child Visits	66.7%	54.9%	54.8%	66.5%	63.6%	68.8%	60.2%	56.6%	57.6%	0.0%	65.9%	52.6%	71.3%

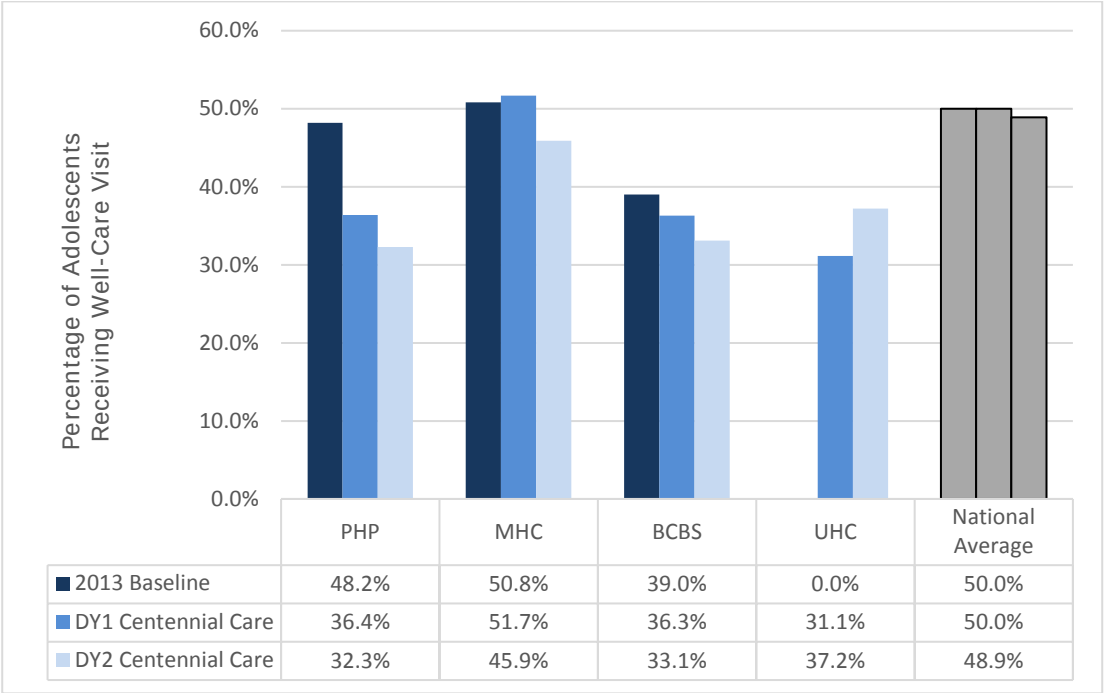
[26] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in the baseline. PHP and BCBS reported rates under the Administrative methodology in DY1 and DY2, while MHC report rates under the Hybrid methodology in DY1 and DY2. UHC reported under the Hybrid methodology in DY2. An aggregate rate was not calculated due to the different reporting methodologies.

Measure 20 – Adolescent well care visits.

Exhibit 20 presents rates for adolescents receiving at least one well care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year for the 2013 baseline, DY1, DY2. The Evaluation considered rates for the four MCOs on an individual basis; an aggregate rate was not assessed because of the varied methodologies plans used to report rates. The HEDIS Medicaid national averages for 2013, 2014, and 2015 were also included in Exhibit 20 for comparison purposes.

The performance of the Centennial Care MCOs on adolescent well care visits has been historically below the Medicaid national average, which hovers around 50.0%. The 2015 national average of 48.9% is depicted in the graph below. PHP and BCBS experienced consistent declines in adolescent well care visits from the baseline to DY1 and again from DY1 to DY2, both of which were statistically significant at the 95% confidence level. This resulted in a 33.0% decline from the baseline to DY2 for PHP and a 15.2% decline for BCBS. MHC had a slight increase from the baseline to DY1 and then experienced an 11.1% decline from DY1 to DY2, but neither was statistically significant. UHC did not report a rate in the baseline, but experienced a 19.5% increase in well care visits from DY1 to DY2, although it was not statistically significant.

Exhibit 20 – Adolescent Well Care Visits[27]



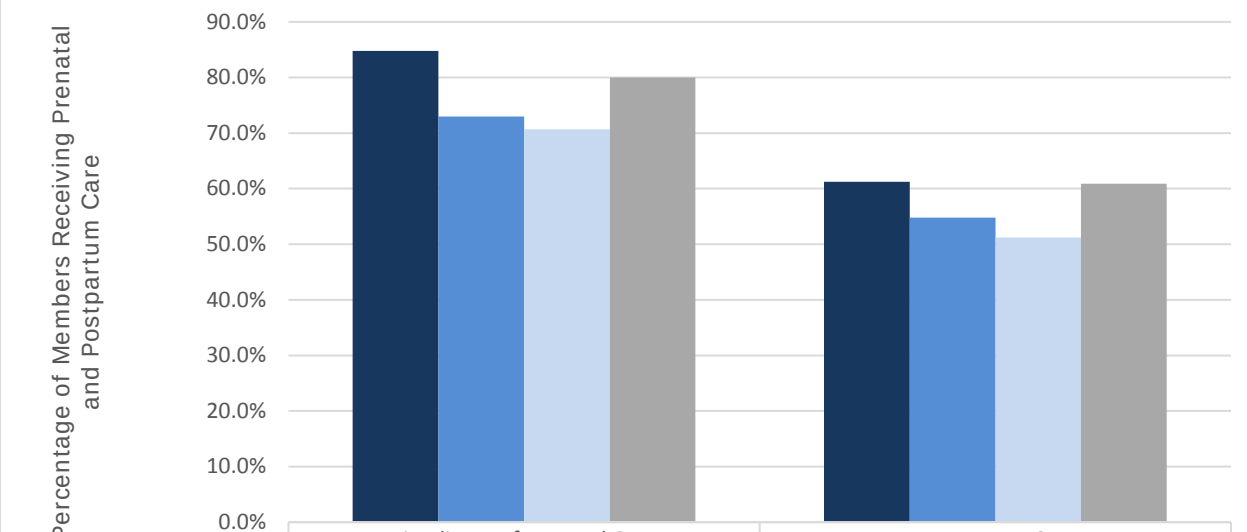
	PHP	MHC	BCBS	UHC	National Average
2013 Baseline	48.2%	50.8%	39.0%	0.0%	50.0%
DY1 Centennial Care	36.4%	51.7%	36.3%	31.1%	50.0%
DY2 Centennial Care	32.3%	45.9%	33.1%	37.2%	48.9%

[27] Source: MCO annual HEDIS reports for 2013 – 2015. UHCs' baseline denominator was less than 30, thus the rate is not included in the representation of individual MCO performance above. The non-reported rate (NR) is reflected as 0% in the graph above. PHP reported rates under the Administrative methodology in DY1 and DY2, BCBS reported under the Administrative methodology in DY1 – DY, while MHC and UHC reported under the Hybrid methodology. An aggregate rate was not calculated due to the different reporting methodologies.

Measure 21 – Prenatal and postpartum care.

Exhibit 21 presents rates of the timeliness of prenatal care and completion of postpartum care for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national averages. As illustrated, the rates have declined year-over-year for the last three years. The most significant year-over-year decline occurred between the baseline and DY1 for both timeliness of prenatal care (-13.9%) and postpartum care (-10.5%). While rates continued to drop from DY1 to DY2, the declines were less drastic at 3.2% for timeliness of prenatal care and 6.7% for postpartum care. Overall from the baseline to DY2, timeliness of prenatal care (-16.6%) and postpartum care (-16.5%) both decreased. Each year-over-year change was statistically significant at the 95% confidence level apart from the DY1 to DY2 change for timeliness of prenatal care.

Exhibit 21 – Prenatal and Postpartum Care[28]



	Timeliness of Prenatal Care	Postpartum Care
2013 Baseline	84.8%	61.3%
DY1 Centennial Care	73.0%	54.8%
DY2 Centennial Care	70.7%	51.2%
2015 National Average	80.0%	60.9%

[28] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 22 – Frequency of ongoing prenatal care.

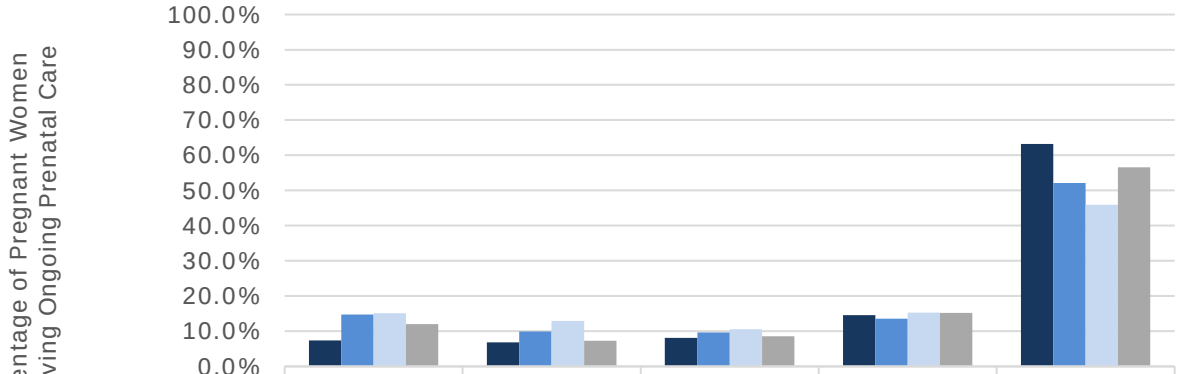
Exhibit 22 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the Frequency of Ongoing Prenatal Care measure. This measure parses the number of expected prenatal care visits into a distribution, represented by the different subcomponents. The number of expected visits are based on the recommendation that a woman with an uncomplicated pregnancy be examined every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation and weekly thereafter. Rates for members that received <21% of expected visits; 21–40% of expected visits; 41–60% of expected visits; 61–80% of expected visits; and ≥81% of expected visits were evaluated.

Three subcomponents had statistically significant rates of change from the baseline to DY1. The percentage of deliveries that received ≤21% of expected visits increased 100.1% indicating significant growth in deliveries that received less than adequate prenatal care. Deliveries that received 21-40% expected visits increased 45.2% and those received over 81% of expected prenatal visits decreased 17.6% demonstrating a shift towards less compliance with the measure from the baseline to DY1.

Performance from DY1 to DY2 showed a similar pattern toward an increase of deliveries receiving less than 80% of expected visits. The percentage of deliveries that received 21 – 40% expected visits increased 30.5%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.8%, both of which were statistically significant. Three subcomponents experienced increase in rates but were not statistically significant: deliveries that received under 21% (2.4%), deliveries receiving between 41 – 60% (10.5%), and deliveries receiving between 61 – 80% expected visits (12.9%).

When reviewing the experience from the baseline to DY2 holistically, there is an observed shift from the highest compliance, ≥81% of expected visits, to lower compliance rates, as members receiving <21%, 21–40%, 41-60%, and 61-80% of expected visits have increased from DY1 to DY2. The aggregate reported rate increased from the baseline to DY2 for four of the five subcomponents (excluding the ≥81% of expected visits subcomponent) and ranging from 5.7% to 104.9%. All increases apart from the 61–80% of expected visits subcomponent were statistically significant at the 95% confidence level. A statistically significant decrease of 27.3% was experienced for the subcomponent measuring ≥81% of expected visits.

Exhibit 22 – Frequency of Ongoing Prenatal Care[29]



	<21% of expected visits	21-40% of expected visits	41-60% of expected visits	61-80% of expected visits	81+% of expected visits
2013 Baseline	7.4%	6.8%	8.1%	14.5%	63.2%
DY1 Centennial Care	14.8%	9.9%	9.6%	13.6%	52.1%
DY2 Centennial Care	15.1%	13.0%	10.6%	15.3%	45.9%
2015 National Avg	12.0%	7.3%	8.6%	15.2%	56.6%

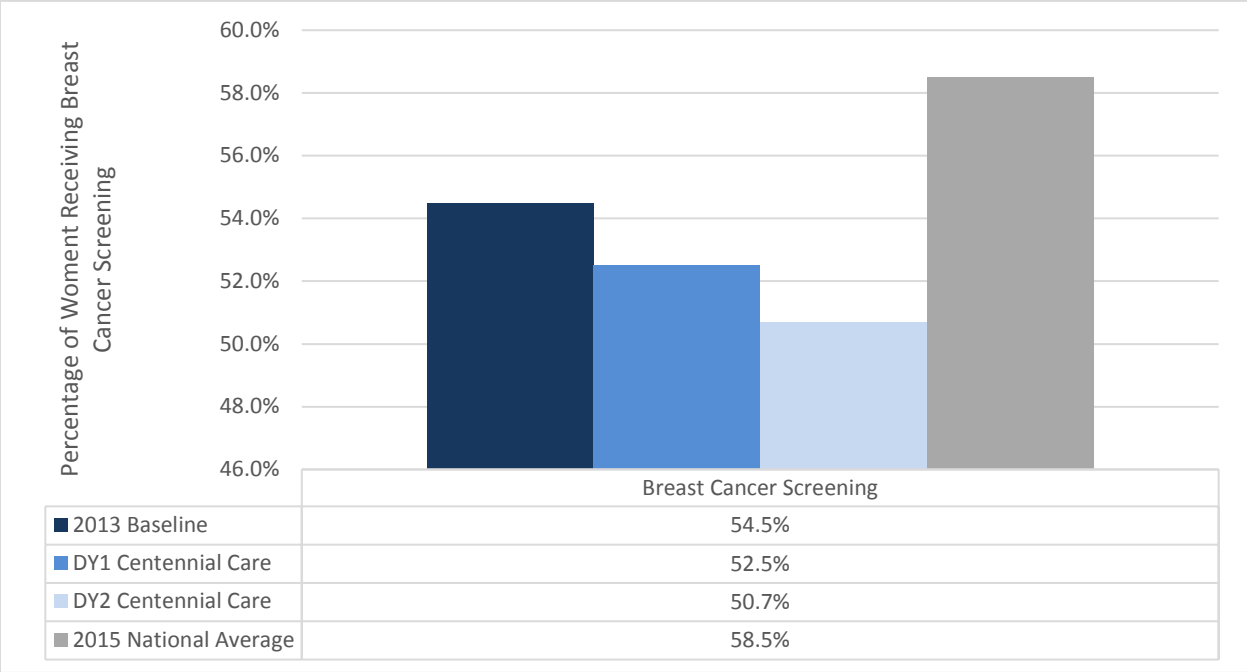
[29] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 23 – Breast cancer screening for women.

Exhibit 23 presents rates for Breast Cancer Screening for Women for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. As illustrated, there was a decline in the aggregate calculated rate from DY1 to DY2 (-3.3%) and a decline from the baseline to DY2 (-6.9%) that were statistically significant at the 95% confidence level. The DY2 rate was nearly eight percentage points below the national average.

PHP and UHC experienced sharp declines of 9.0% and 17.3%, respectively, from the baseline to DY1, which brought down the aggregate DY1 average. The DY2 aggregate average was brought down by declines in the PHP rate (-10.7%) and the MHC rate (-11.1%). These year-over-year changes were statistically significant at the 95% confidence level.

Exhibit 23 – Breast Cancer Screening for Women[30]



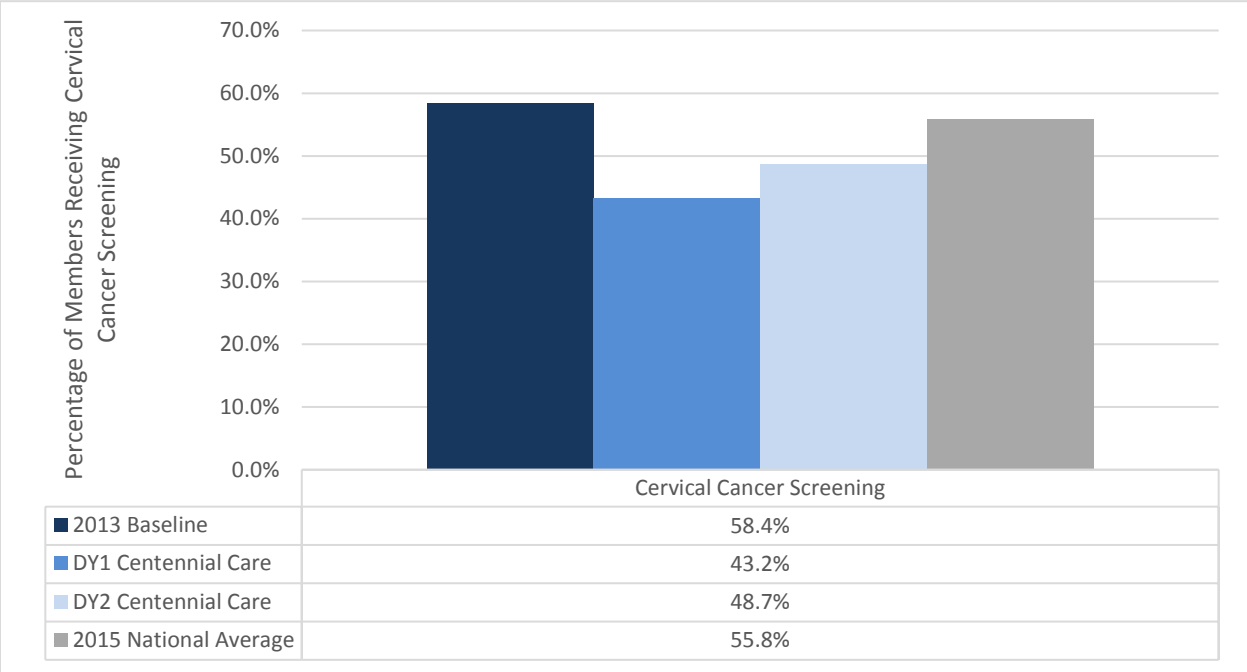
	Breast Cancer Screening
2013 Baseline	54.5%
DY1 Centennial Care	52.5%
DY2 Centennial Care	50.7%
2015 National Average	58.5%

[30] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 24 – Cervical cancer screening for women.

Exhibit 24 presents rates for Cervical Cancer Screening for Women for the 2013 baseline, DY1, DY2, and 2015 HEDIS Medicaid national average. As illustrated, the performance on the rate of screenings has declined from the baseline to DY2 by 16.6%, which was a statistically significant change at the 95% confidence level. It is important to note that the rate improved from DY1 to DY2 by 12.7%, which was also statistically significant and may indicate an upward trend in performance in future demonstration years.

Exhibit 24 – Cervical Cancer Screening for Women[31]



	Cervical Cancer Screening
2013 Baseline	58.4%
DY1 Centennial Care	43.2%
DY2 Centennial Care	48.7%
2015 National Average	55.8%

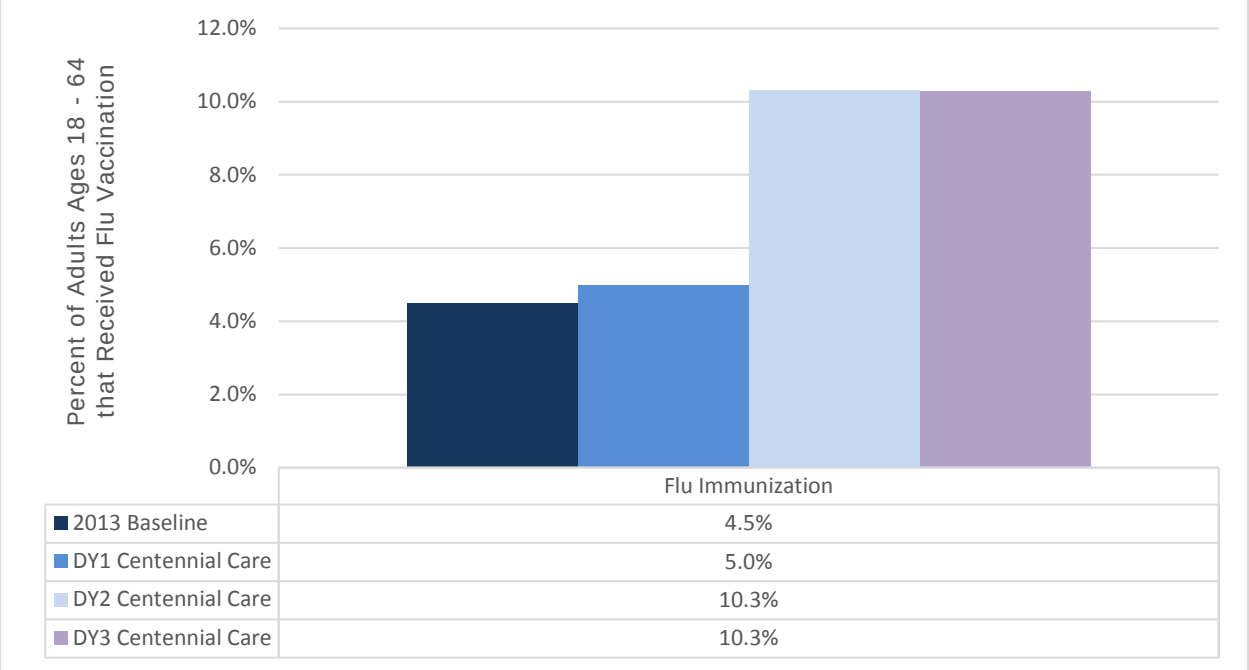
[31] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 25 – Flu vaccinations for adults.

Exhibit 25 presents results for the 2013 baseline, DY1, DY2, and DY3 of the Flu Vaccinations for Adults measure. As illustrated, the rate of immunizations was consistent from DY2 to DY3, but has increased substantially from 4.5% in the baseline to 10.3% in DY3 (a 128.7% change) which was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 25 – Flu Vaccinations for Adults[32]



	Flu Immunization
2013 Baseline	4.5%
DY1 Centennial Care	5.0%
DY2 Centennial Care	10.3%
DY3 Centennial Care	10.3%

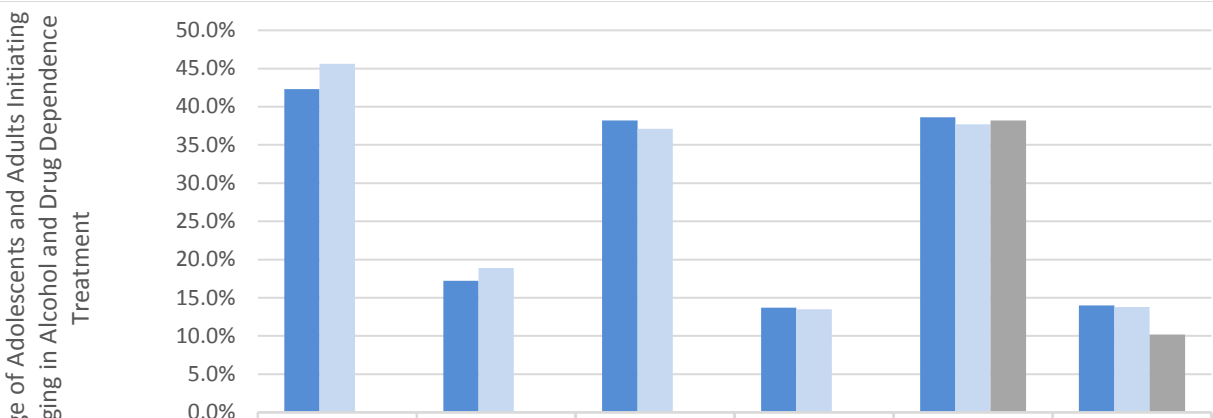
[32] Source: Flu vaccination MMIS reports for 2013 – 2016.

Measure 26 – Initiation and engagement of alcohol and other drug (AOD) dependence treatment.

Exhibit 26.a presents rates of Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment for DY1, DY2, and 2015 HEDIS Medicaid national averages for two age cohorts and the total population for three of the four MCOs.

MCO performance for members 13-17 years of age cohort on both initiation and engagement of AOD increased from DY1 to DY2 by 7.7% and 9.8%, respectively. Rates for members 18+ years of age cohort and the all-age cohort declined from DY1 to DY2 for both initiation (-2.9% and -2.4% respectively) and engagement (-1.6% and -1.2% respectively), although the DY2 results for engagement was higher than the 2015 national average. Only the 2.9% decline in initiation rate for members 18+ years of age cohort was statistically significant at the 95% confidence level.

Exhibit 26.a – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment[33]

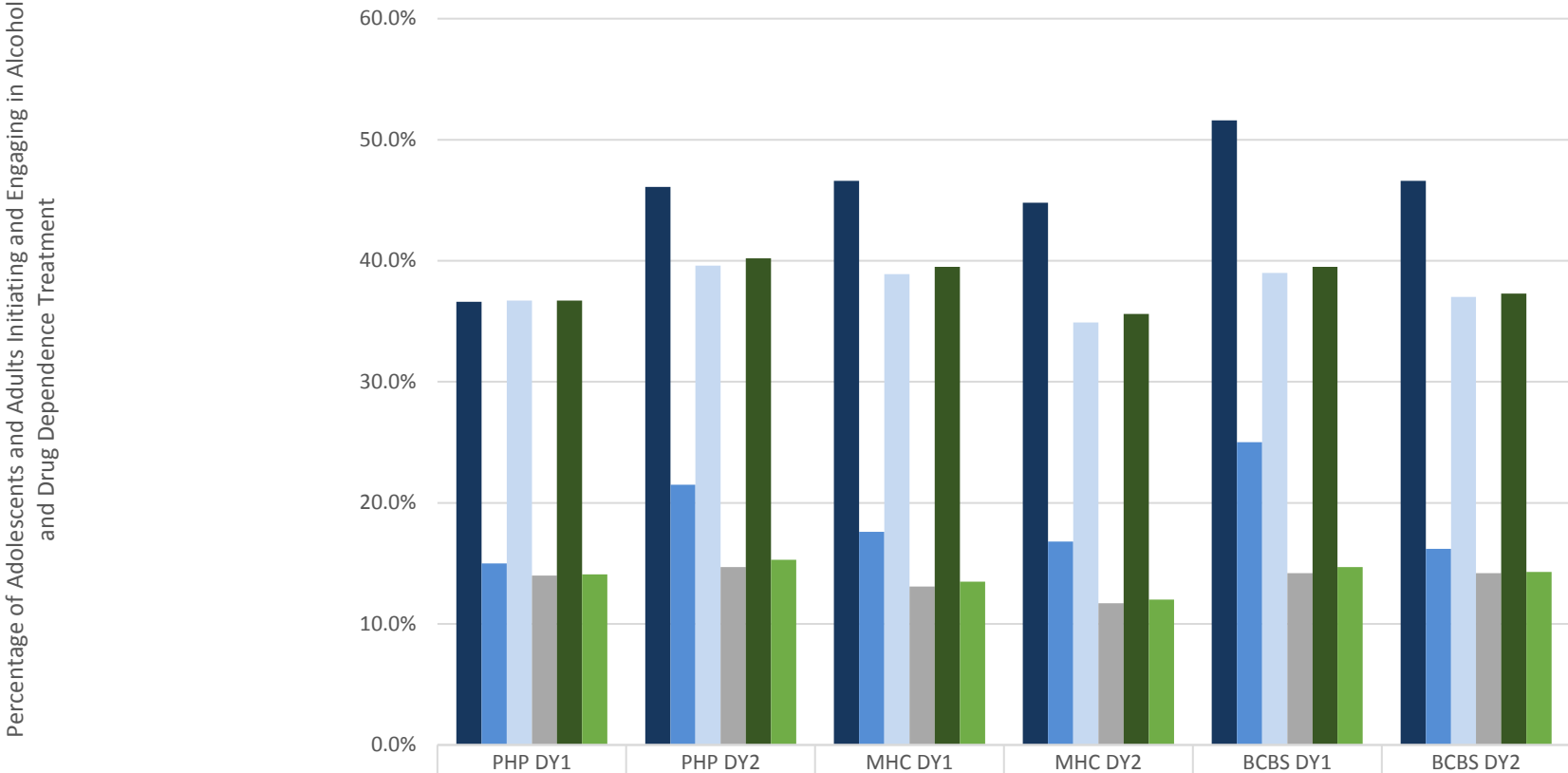


	13-17 years		18+ years		Total	
	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment	Initiation of AOD Treatment	Engagement of AOD Treatment
DY1 Centennial Care	42.3%	17.2%	38.2%	13.7%	38.6%	14.0%
DY2 Centennial Care	45.6%	18.9%	37.1%	13.5%	37.7%	13.8%
2015 National Average					38.2%	10.2%

Exhibit 26.b below demonstrates individual MCO performance on the Initiation and Engagement of AOD. PHP was the only MCO to have positive increases from DY1 to DY2 for all subcomponents. PHP experienced double-digit increases in both initiation and engagement of AOD for adolescents aged 13-17 (25.9% and 43.2%, respectively), both of which were statistically significant at the 95% confidence level. Conversely, MHC and BCBS experienced statistically significant declines from DY1 to DY2. MHC's rate of initiation of AOD treatment in adults aged 18 and older decreased 10.2% and the rate of engagement decreased by 10.7% from DY1 to DY2. BCBS's rate of engagement in AOD treatment in adolescents declined by 35.3%.

[33] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in DY1 and DY2.

Exhibit 26.b. – Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (Plan by Plan Rates)[34]



	PHP DY1	PHP DY2	MHC DY1	MHC DY2	BCBS DY1	BCBS DY2
13-17 years Initiation of AOD Treatment	36.6%	46.1%	46.6%	44.8%	51.6%	46.6%
13-17 years Engagement of AOD Treatment	15.0%	21.5%	17.6%	16.8%	25.0%	16.2%
18+ years Initiation of AOD Treatment	36.7%	39.6%	38.9%	34.9%	39.0%	37.0%
18+ years Engagement of AOD Treatment	14.0%	14.7%	13.1%	11.7%	14.2%	14.2%
Total Initiation of AOD Treatment	36.7%	40.2%	39.5%	35.6%	39.5%	37.3%
Total Engagement of AOD Treatment	14.1%	15.3%	13.5%	12.0%	14.7%	14.3%

[34] Source: MCO annual HEDIS reports for 2013 – 2015. UHC reported "Not Reportable" (NR) in DY1 and DY2.

Measure 27 – Geographic access measures.

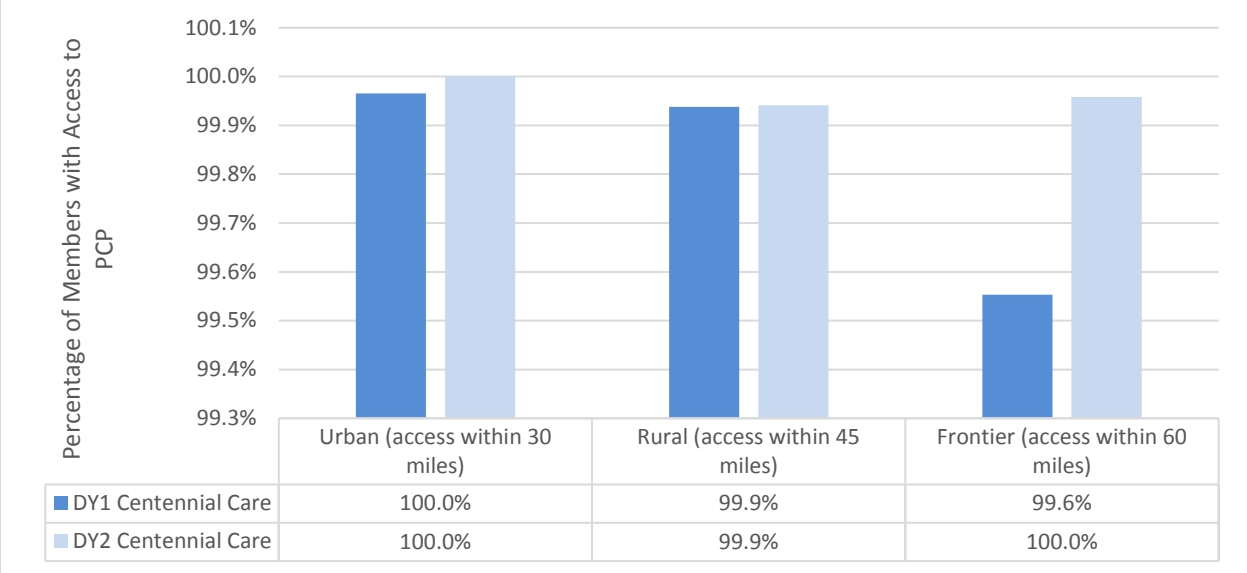
Geographic Access Measures is a general measure developed by HSD as a way to evaluate access to primary and specialty care for Centennial Care members across the State of New Mexico. Monitoring the networks of providers contracted by HSD assures its Medicaid beneficiaries are within a reasonable driving distance of providers and that there is an adequate number of providers to deliver care for Medicaid members.

HSD has developed standards for measuring geographic-based access to care which MCOs reported by quarter based on three county types:

- Urban Counties = 90% of members have access to a PCP within 30 miles
- Rural Counties = 90% of members have access to a PCP within 45 miles
- Frontier Counties = 90% of members have access to a PCP within 60 miles

Exhibit 27.a demonstrates the percentage of members with access to PCPs in each county type. As illustrated, all MCOs met the requirement for accessibility across counties in both performance years. Accessibility of PCPs in urban and rural counties remained steady while accessibility in frontier counties increased to 100.0% from DY1 to DY2.

Exhibit 27.a – Percentage of Members with Access to PCPs[35]

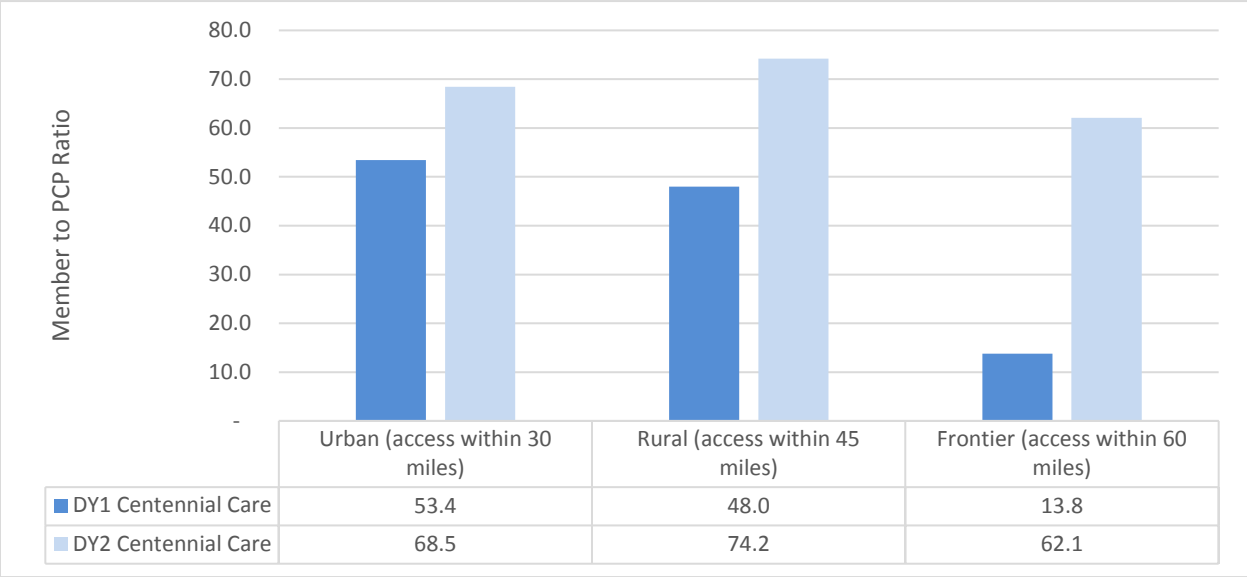


	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	100.0%	99.9%	99.6%
DY2 Centennial Care	100.0%	99.9%	100.0%

[35] Source: MCO reports for 2014 – 2015 (HSD 55).

Exhibit 27.b presents results for DY1 and DY2 of member to PCP ratios by county type. While HSD defines requirements for mileage access to PCPs, it does not have requirements for the ratio of members to providers by county type. As illustrated, member to PCP ratios increased in all county types from DY1 to DY2, the increases were 28.1%, 54.6%, and 350.4% for urban, rural, and frontier, respectively. These increases are not desired as a smaller member to provider ratio usually indicates better accessibility.

Exhibit 27.b – Members to PCP Ratio[36]



	Urban (access within 30 miles)	Rural (access within 45 miles)	Frontier (access within 60 miles)
DY1 Centennial Care	53.4	48.0	13.8
DY2 Centennial Care	68.5	74.2	62.1

[36] Source: MCO reports for 2014 – 2015 (HSD 55).

Research Question 1.C

Are care coordination activities meeting the goals of the right amount of care delivered at the right time in the right setting?

The Centennial Care waiver aims to integrate management of PH, BH, and LTSS benefits and services with the assumption that aligned benefits and incentives to coordinate care and services will produce improved outcomes. MCOs are responsible for assessing their members' health risks and service needs, determining care coordination levels, developing comprehensive care plans, and providing outreach and service coordination based on that level.

The Evaluation is reviewing Centennial Care's impact on care coordination through the analysis of nine performance measures that assess MCO activities to increase member engagement in the program, understand member health risks, stratify members into care coordination levels, and perform member outreach via telephone or in-person visits. In addition, Research Question 1.C attempts to understand the success of care coordination activities provided to HCBS beneficiaries.

Overall through DY3 of the Centennial Care program, the rate of care coordination activities has generally increased among MCOs, plans were able to engage a greater percentage of members, and fewer members refused care coordination services.

Five of nine measures saw improvement in the rate of activities performed for members from the baseline to DY2 despite a trend of increasing participants in Care Coordination Levels 2 and 3; those included completing HRAs, performing outreach to members in care coordination Level 2 and Level 3, engaging members for care coordination, and reducing instances of members refusing care coordination services.

Performance on one measure declined since the baseline including the percentage of members who transitioned from a NF into the community.

Three measures showed mixed results where each measure contains two subcomponents measuring performance for transition members and new members. For these measures, one subcomponent showed improvement while the other declined. These measures include members who were assigned care coordination Level 2 and Level 3 that had a Comprehensive Needs Assessment (CNA), and providing Care Coordination level assignment packages within contract timeframes.

It should be noted that in DY2 and DY3, PHP did not report data on several subcomponents related to activities provided to transition members (HRAs, CNAs, CCPs); these members were not considered in the numerator or the denominator of rates. Therefore, it is not expected to have impacted aggregate results.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 28 – Number and percentage of members with Health Risk Assessments (HRAs) completed within contract timeframes.

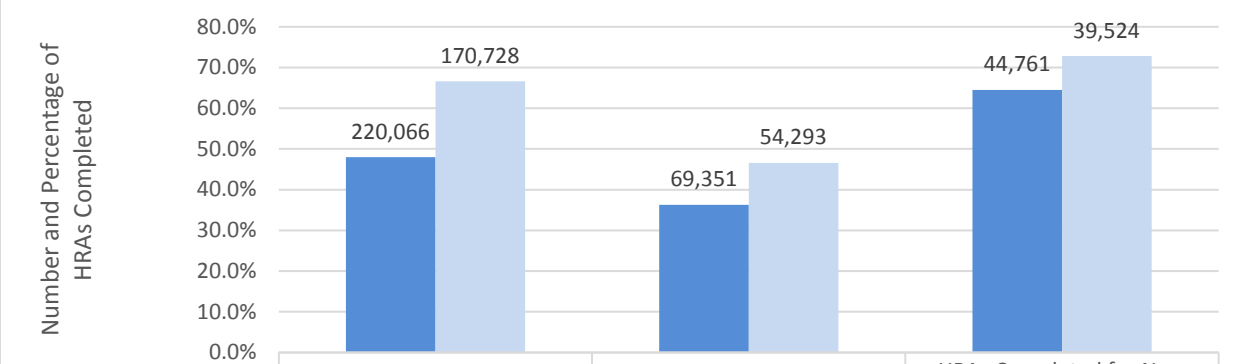
Exhibit 28 presents the results for DY1 and DY2 for the three subcomponents reflecting completed HRAs for transition and new members. Results of the number and percentage of HRAs completed within contract timeframes for transition and new members, as well as HRAs completed within 30 days of enrollment for new members are described below. From DY1 to DY2 the percentage of HRAs completed for transition members increased from 48.0% to 66.6% (a 38.8% increase) and the percentage of HRAs completed for new members increased from 36.3% to 46.6% (a 28.5% increase). Similarly, HRAs completed within 30 days of enrollment for new members increased from 64.5% to 72.8% (a 12.8% increase) from DY1 to DY2.

Upon review of the individual MCO performance over the same time period, BCBS experienced a 52.6% improvement in their individual rates of HRAs completed for transition members from DY1 to DY2, while UHC and MHC experienced increases of 27.6% and 22.3% respectively.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 28 – Number and Percentage of Members with HRAs Completed within Contract Timeframes[37]



	HRAs Completed for Transition Members	HRAs Completed for New Members (completed this quarter)	HRAs Completed for New Members (completed within 30 calendar days of enrollment)
DY1 Centennial Care	48.0%	36.3%	64.5%
DY2 Centennial Care	66.6%	46.6%	72.8%

[37] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 29 – Number and percentage of those provided care coordination level assignment within 10 calendar days of HRA (participants who received a care coordination designation and assignment of care coordinator within contract timeframes).

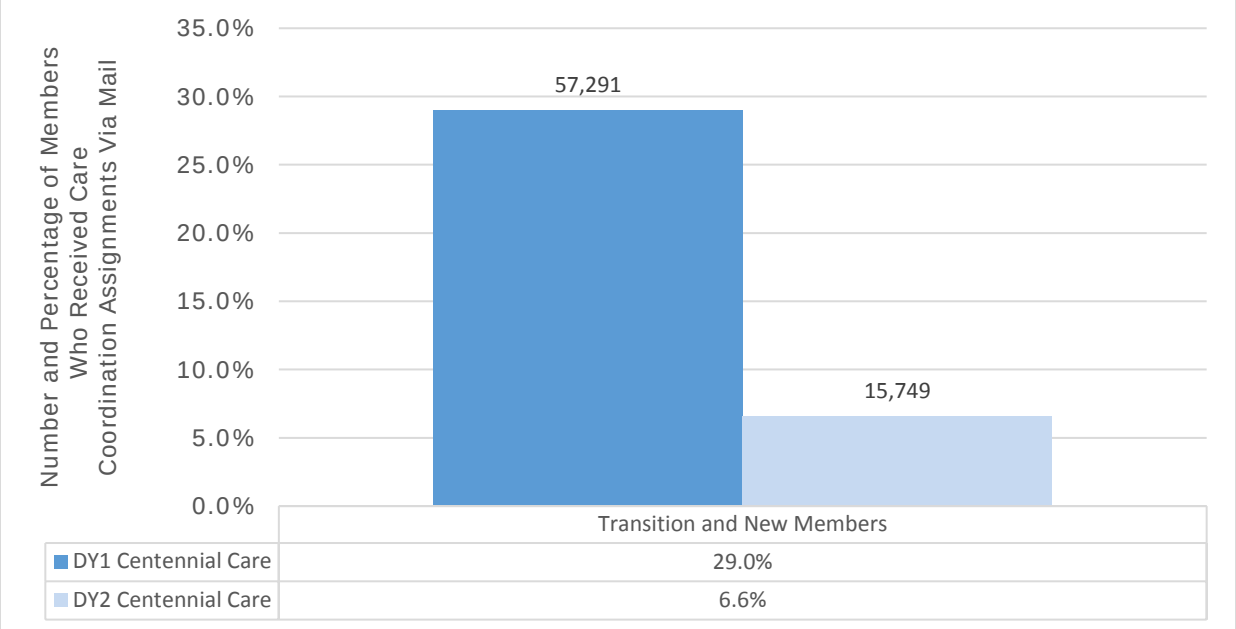
Exhibit 29 below presents results for DY1 and DY2 for the Number of Medicaid Members who were Provided Care Coordination Level Assignments within 10 Calendar Days of an HRA. This definition is being used by HSD as an alternative for "the number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes" since HSD Report 6 does not contain those specific data points. Furthermore, it should be noted that HSD Report 6 only captures data on the number of CCL assignments that MCOs sent to members via mail and does not include the sharing of CCL information verbally which MCOs are allowed to do. Appendix A provides more detail on the definition and methodology used to calculate this measure.

As illustrated, the percentage of members provided care coordination level assignments via mail trended downward from DY1 to DY2. This is somewhat expected, as CCL assignment information was sent via mail most frequently to members transitioning into Centennial Care from the legacy programs and those transitions occurred early in DY1 .

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 29 – Number and Percentage of those Provided Care Coordination Level Assignment Via Mail within 10 Calendar Days of HRA[38]



[38] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 30 – Number and percentage of participants in care coordination Level 2 based on the Comprehensive Needs Assessment (number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes).

Exhibit 30 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 2 based on the Comprehensive Needs Assessment. The data elements required to measure the activity reflected in the Evaluation Plan (number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes) were not included in the HSD Report 6. Therefore, an alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Report 6, and the measure name was updated to "Number and Percentage of Level 2 Assignments Based on the CNA."

Results for both transition and new members are calculated using the number of Level 2 assignments made based on CNA answers, as a percentage of CNAs completed. The measure does not reflect performance of the Centennial Care MCOs, but instead reflects the needs of the population and resulting stratification into one of two higher care levels (Level 2 and Level 3)[39].

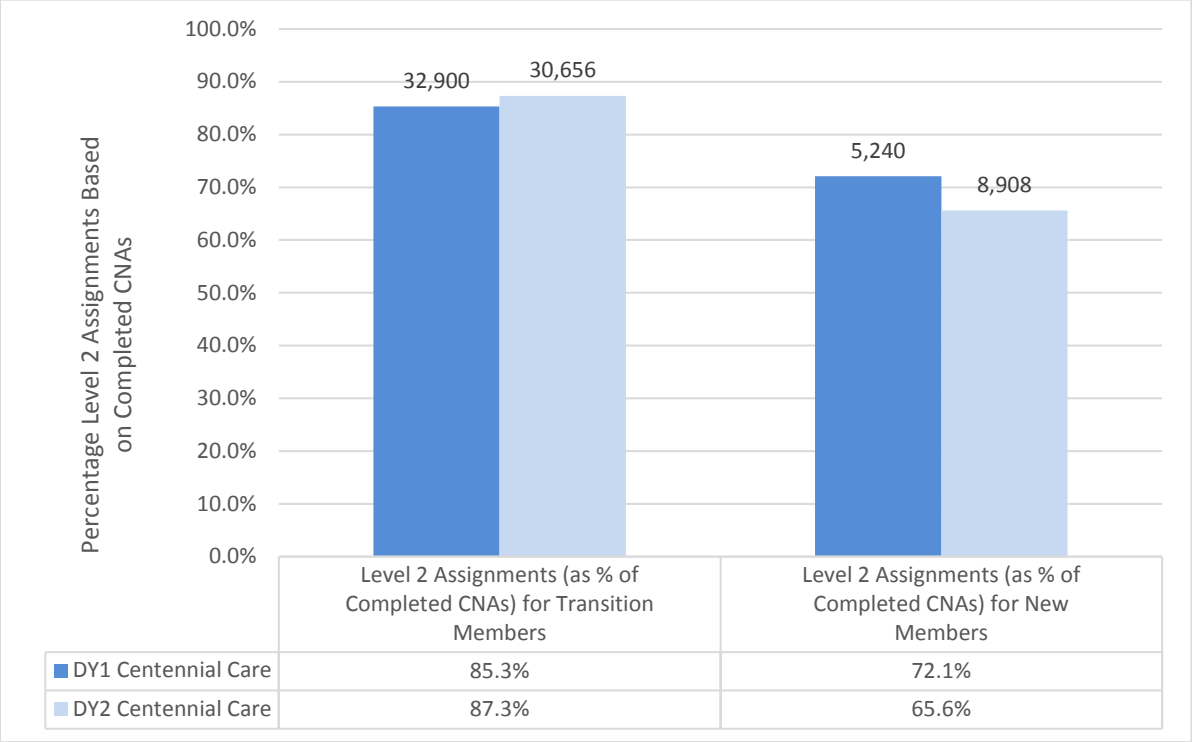
As Exhibit 30 illustrates, the percentage of transition members reported by three of the four MCOs that were assigned to Level 2 from DY1 to DY2 remained relatively consistent, staying between 85.3% and 87.3%. By comparison, a lower percentage of new Medicaid members were assigned to Level 2 and the percentage of Level 2 assignments decreased from 72.1% to 65.6% (a 9.0% decline) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

[39] In DY3, HSD indicated that members will only be stratified into two levels. Level 1 is no longer considered a Care Coordination Level that is measured.

Exhibit 30 – Number and Percentage of Participants in Care Coordination Level 2 Based on the Comprehensive Needs Assessment [40]



	Level 2 Assignments (as % of Completed CNAs) for Transition Members	Level 2 Assignments (as % of Completed CNAs) for New Members
DY1 Centennial Care	85.3%	72.1%
DY2 Centennial Care	87.3%	65.6%

[40] Source: MCO reports for 2014 – 2016 (HSD 6). PHP did not report on transition members in DY2.

Measure 31 –Number and percentage of participants in care coordination Level 3 based on the Comprehensive Needs Assessment (number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes).

Exhibit 31 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 3 based on the Comprehensive Needs Assessment. The data elements required to measure the activity reflected in the Evaluation Plan (number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes) were not included in the HSD Report 6 report. Therefore, an alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Report 6, and the measure name was updated to "Number and Percentage of Level 3 Assignments Based on the CNA."

Results for both transition and new members are calculated using the number of Level 3 assignments made based on CNA answers, as a percentage of CNAs completed. The measure does not reflect performance of the Centennial Care MCOs, but instead reflects the needs of the population and resulting stratification into one of two levels (Level 2 and Level 3 are possible)[41].

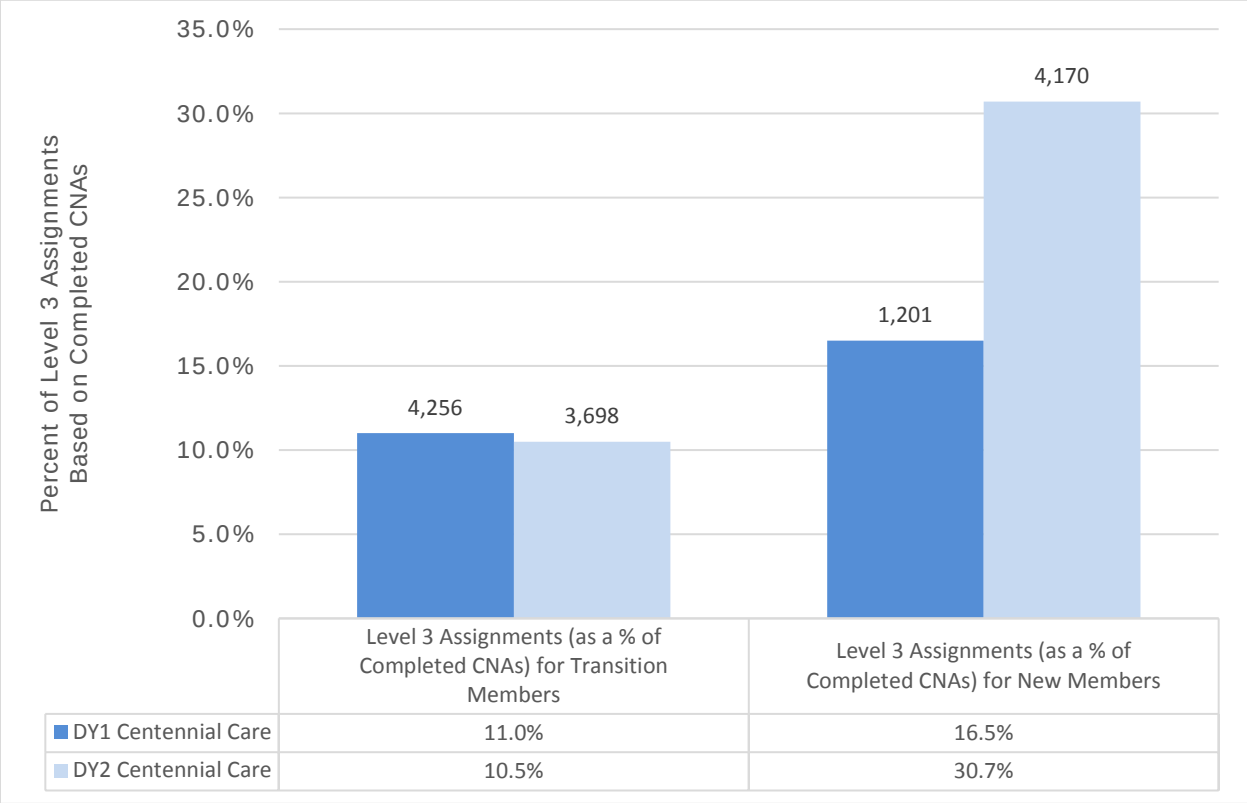
As Exhibit 31 illustrates, the percentage of new members who were assigned to Level 3 was greater than the percentage of transition members assigned to Level 3. The percentage of transition members assigned to Level 3 remained fairly level from DY1 to DY2 (11.0% and 10.5% respectively). Conversely, the percentage of new members assigned to Level 3 grew significantly year-over-year, increasing from 16.5% in DY1 to 30.7% in DY2 (a 85.9% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

[41] In DY3, HSD indicated that members will only be stratified into two levels. Level 1 is no longer a Care Coordination Level.

Exhibit 31 – Number and Percentage of Participants in Care Coordination Level 3 Based on the Comprehensive Needs Assessment[42]



[42] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 32 – Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes.

Exhibit 32 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 2 who received in-person visits at least twice a year (semi-annual) and telephone contact during the quarter.

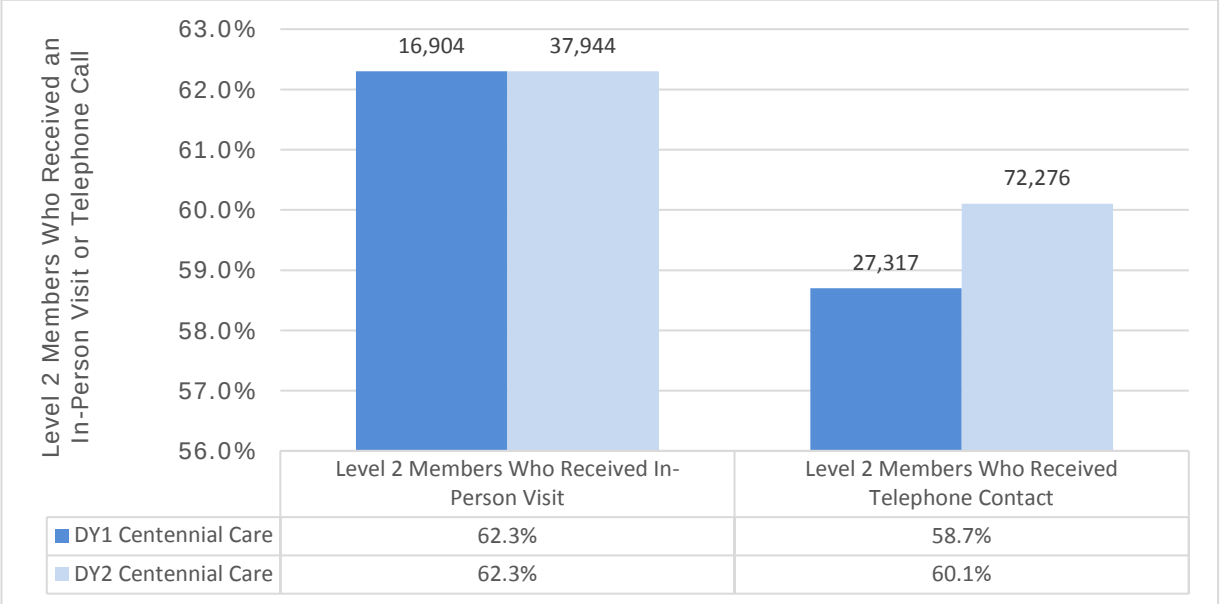
As illustrated, the percentage of Level 2 members who received in-person visits remained steady from DY1 to DY2. Members who received quarterly phone contact increased slightly year-over-year between DY1 and DY2.

Upon review of the individual MCOs, performance in both activities provided to Level 2 members demonstrated relatively consistent patterns of over time, with the exception of BCBS. BCBSs performance declined for both activities from DY1 to DY2 (-30.7% for in-person, -13.2% for telephone).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 32 – Number and Percentage of Participants in Care Coordination Level 2 Who Received In-Person Visits and Telephone Contact [43]



[43] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 33 – Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes.

Exhibit 33 below presents results for DY1 and DY2 for the number and percentage of participants in care coordination Level 3 who received a quarterly in-person visit and those who received monthly telephone contact.

As illustrated, the percentage of Level 3 members who received quarterly in-person visits remained relatively consistent from DY1 to DY2. The percentage of Level 3 members who received monthly phone contact increased from 54.3% to 61.7% (a 13.6% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 33 – Number and Percentage of Participants in Care Coordination Level 3 who Received In-Person Visits and Telephone Contact within Contract Timeframes[44]

	Level 3 Members Who Received In-Person Visit	Level 3 Members Who Received Telephone Contact
DY1 Centennial Care	59.3%	54.3%
DY2 Centennial Care	59.3%	61.7%

[44] Source: MCO reports for 2014 – 2016 (HSD 6).

Measure 34 – Number and percentage of participants the MCO is unable to engage for care coordination (number and percentage of participants the MCO is unable to locate for care coordination).

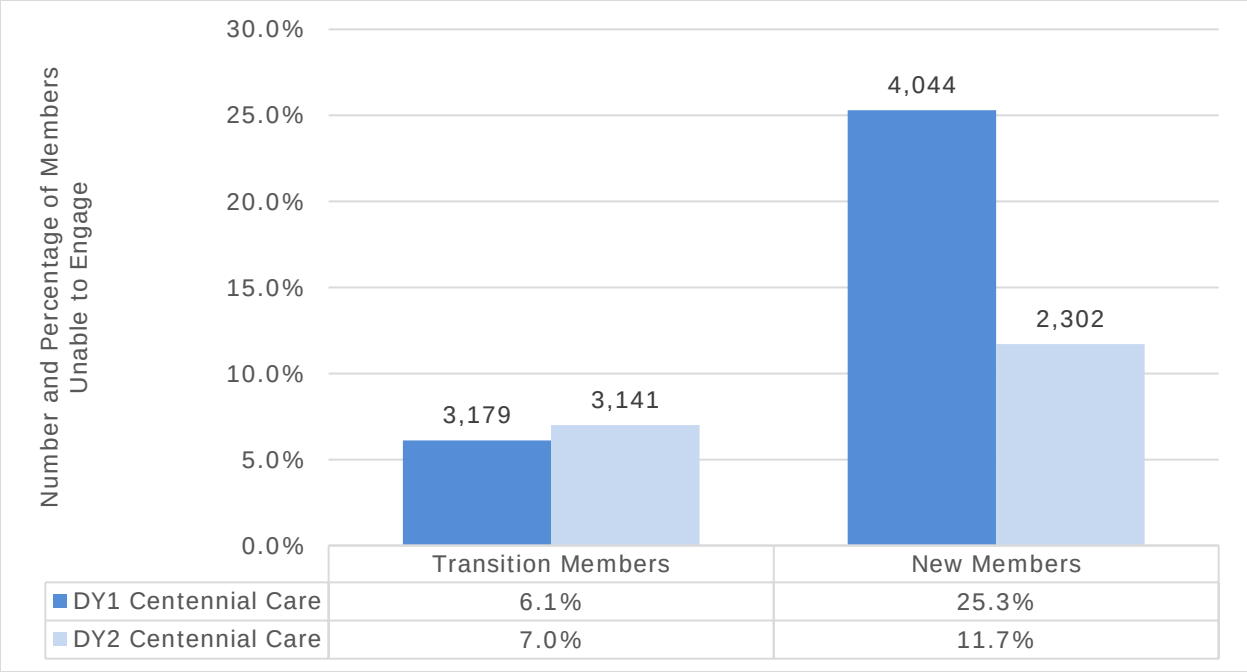
Exhibit 34 below presents results for DY1 and DY2 for the number and percentage of participants for whom a CNA is required, but the MCO is unable to engage the member. The data element specifically citing "unable to locate for care coordination" was not included in HSD Report 6, therefore, the number of transition and new Medicaid members for whom a CNA was required but the MCO was "unable to engage" is used. A reduction in the percentage of members for whom the MCOs were unable to engage indicates a positive trend in the ability of MCOs to find and contact members.

As illustrated, the percentage of transition members MCOs were unable to engage in care coordination was relatively consistent from DY1 to DY2. The percentage of new members the MCOs were unable to engage experienced a favorable decline from 25.3% to 11.7% (a 53.9% change) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 34 – Number and Percentage of Participants the MCO is Unable to Engage for Care Coordination[45]



[45] Source: MCO reports for 2014 – 2016 (HSD 6). PHP did not report information on transition members in DY2.

Measure 35 - Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS).

Exhibit 35 presents rates for DY1 and DY2 of the number and percentage of members who have transitioned between NF LOC and the community to use HCBS. There are two subcomponents reported: those members who left a NF and moved to the community to use HCBS and those who were in the community, but were readmitted into a NF.

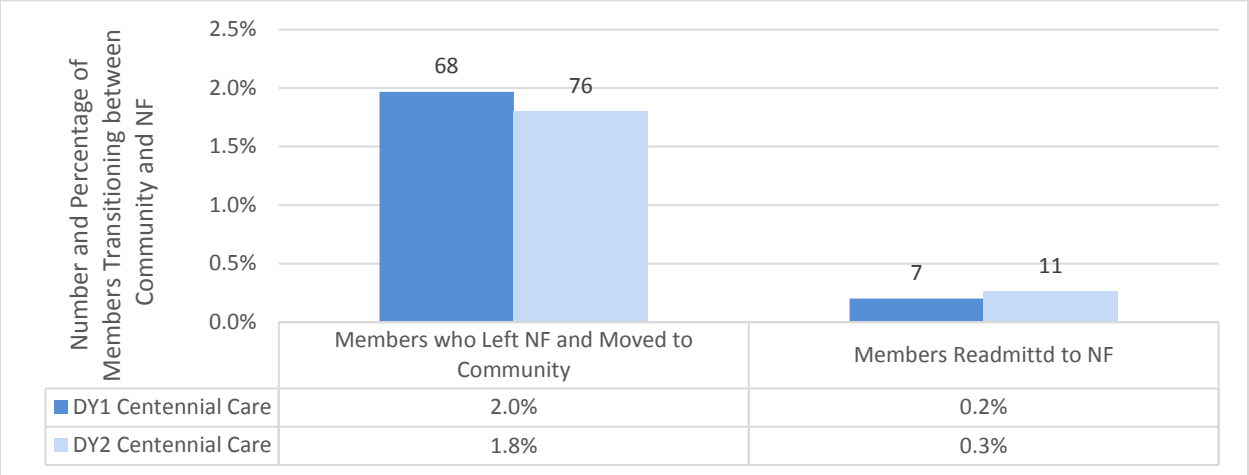
As illustrated, the rate of members moving from a NF into the community declined from 2.0% to 1.8% (an 8.5% change) from DY1 to DY2. The percentage of members who were readmitted into a NF increased from 0.2% to 0.3% (a 28.6% change) over the same period. It must be noted that the overall percentages of members transitioning between care settings is quite small, and a slightly higher percentage are transitioning from NF to the community as opposed to from the community to a NF. None of these changes were statistically significant.

Individual plan performance on this measure was varied. For example, PHP improved the percentage of members who transferred from a NF to the community from 2.5% in DY1 to 4.8% in DY2 (a 93.4% change) and experienced only a slight increase (from 0.0% to 0.3%) in the percentage of NF readmissions. MHC and UHC both experienced decreases in the percentage of members leaving a NF for community care; MHC decreased from 4.8% in DY1 and 3.5% in DY2 (a 27.2% change) and UHC decreased from 1.1% in DY1 to 0.9% in DY2 (a 19.9% change). None of these changes were statistically significant.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests that the percentage of members readmitted to a NF will remain relatively consistent and the percentage of members leaving NF for community care may increase slightly.

A national comparison rate could not be identified for this measure.

Exhibit 35 – Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)[46]



[46] Source: MCO reports for 2014 – 2015 (HSD 7).

Measure 36 – Number and percentage of participants who refused care coordination.

Exhibit 36 below presents rates for DY1 and DY2 for the number and percentage of participants who refused care coordination. The specific data element required to measure this activity was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members who "refused a CNA," based on the assumption that if the member refused the process to screen for care coordination, then they would also refuse to participate in care coordination. A declining percentage of members who refused care coordination indicates a positive trend in the ability for MCOs to engage members in specialized programs.

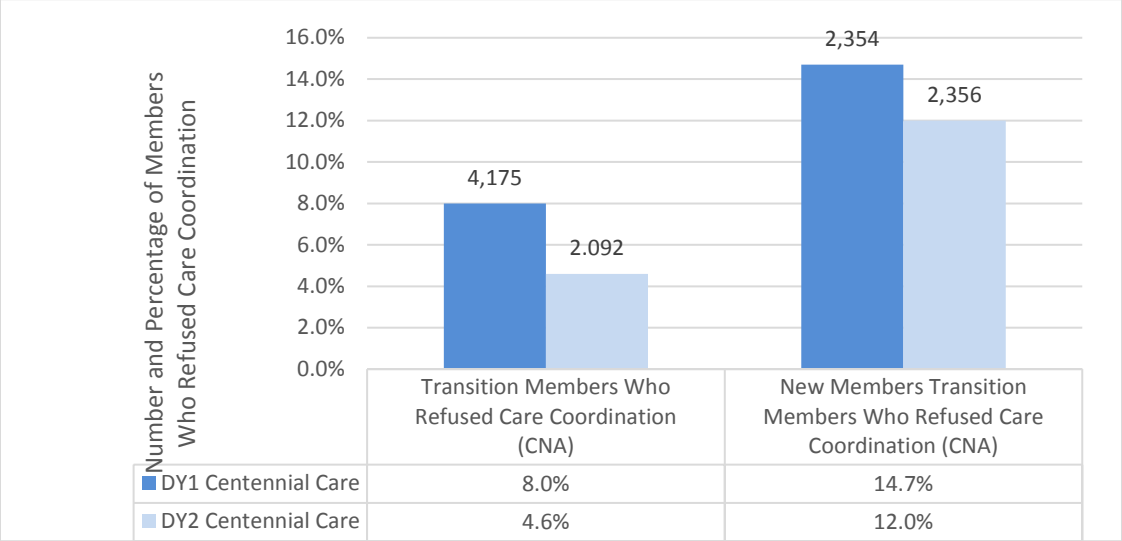
As illustrated, the percentage of both transition and new members who refused a CNA, thereby refusing care coordination services, declined from DY1 to DY2. Overall, the percentage of transition members who refused care coordination declined from 8.0% in DY1 to 4.6% in DY2 (a 42.2% change) and a decline in the percentage of new members refusing care coordination from 14.7% in DY1 to 12.0% in DY2 (a 19.0% change), meaning a greater percentage of members are accepting care coordination over time.

BCBS, one of the three plans that reported transition member activities in DY2, experienced a decline from 15.0% to 12.1% (a 19.5% change) in the percentage of refusals from DY1 to DY2. PHP, MHC, and BCBS experienced declining percentages of refusals for new members over the same period, indicating improved performance.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 36 – Number and Percentage of Participants who Refused Care Coordination[47]



	Transition Members Who Refused Care Coordination (CNA)	New Members Transition Members Who Refused Care Coordination (CNA)
DY1 Centennial Care	8.0%	14.7%
DY2 Centennial Care	4.6%	12.0%

[47] Source: MCO reports for 2014 – 2016 (HSD 6).

Hypothesis 2

Increased provision of care coordination will lead to improved care outcomes and a reduction in adverse events.

One of Centennial Care's goals is to ensure that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. This goal is guided by the principle that health care services improve health status most efficiently through coordinated, efficacious care. Centennial Care seeks to provide high quality services and reduce preventable adverse events.

The Evaluation found that enhanced care coordination under Centennial Care is resulting in improved care outcomes for needed services and is generally meeting waiver goals to improve quality.

Research Question 2.A

To what extent has quality of care improved due to the implementation of the Centennial Care program for Medicaid/CHIP beneficiaries in New Mexico?

The Centennial Care waiver provides some new and enhanced benefits, in addition to traditional Medicaid State Plan benefits, including care coordination, a comprehensive community benefit that includes personal care and HCBS, new BH services integrated with traditional PH services, and a member rewards program intended to incentivize individuals to participate in state-defined activities that promote healthy behaviors. Prior to the waiver's implementation in 2014, these services were fragmented into multiple waiver programs, with six managed care contractors and one BHSE.

The Evaluation is reviewing Centennial Care's impact on quality of care through analysis of 17 measures that address adult, child and adolescent screenings, ACS conditions, avoidable ER visits, adverse events (i.e., critical incidents, fall risk management), BH inpatient admissions and nursing facility acuity transitions. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs continue to improve quality of care as noted in the findings for the assigned performance measures. There were positive performance results across measures and within various subcomponents of measures, with rates improving in 10 out of 17 measures.

New Mexico saw improvement from the baseline[48] to DY2 in several subcomponents of EPSDT screening ratios; slight increases in monitoring rates of BMI for adults, children and adolescents; increases in asthma medication management among most cohorts; increases in antidepressant medication management; a positive shift from higher NF acuity to lower NF acuity; and increased fall risk intervention.

There were also improvements in hospital admission rates and ER visit rates. There were reductions in hospital admission rates across most ACS measures (i.e., short and long term diabetes, asthma in younger adults and Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults, and hypertension) across both time periods (i.e., DY1 to DY2 and the baseline to DY2). Finally, there was a decline in the percentage of ER visits that were potentially avoidable from DY1 to DY2. Downward trends for these measures are considered desirable.

On the other hand, there was a decline in performance across measures and within various subcomponents of measures in 5 out of 17 measures compared to the baseline. These measures include asthma medication ratios, smoking and tobacco use cessation rates, annual patient monitoring

[48] The baseline period is typically considered calendar year 2013, but may be SFY2013 or calendar year 2014 (DY1) depending on the measure and data availability from CY2013.

for persistent medications, inpatient admissions to psychiatric hospitals and RTCs, and a slight unfavorable increase in pediatric asthma admissions.

Two measures experienced mixed results with data through DY2; for critical incident reporting, there were decreases in half of the critical incidents categories but increases in the other categories across the three cohorts. For comprehensive diabetes care, there were improvements in 3 of 6 subcomponents from the baseline to DY2.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

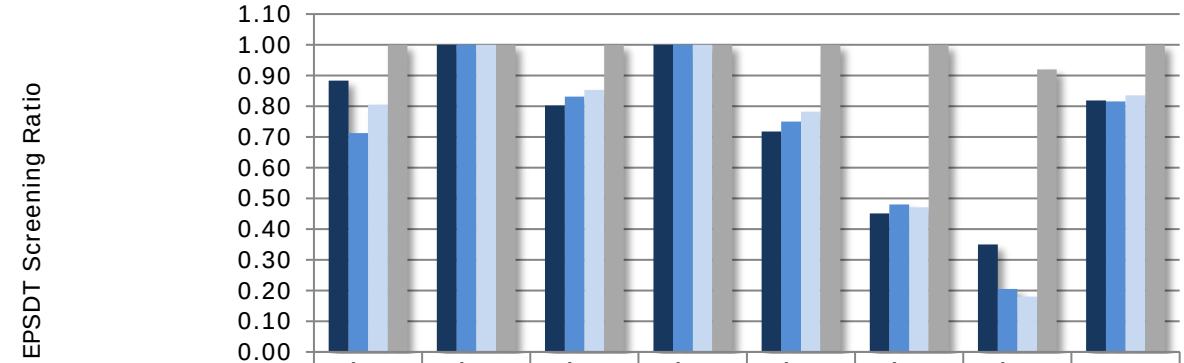
Measure 37 – EPSDT screening ratio.

Exhibit 37 presents results for the FFY 2013 baseline, FFY 2014, FFY 2015, and the EPSDT FFY 2015 national average[49] for the seven age cohorts and the aggregate rate for the measure EPSDT Screening Ratio. As illustrated, the screening ratios improved from FFY 2014 to FFY 2015 for the <1 age cohort (13.0%), 3-5 age cohort (2.6%), 10-14 age cohort (4.3%), and the aggregate (2.4%). The ratios declined for members in the 15-18 age cohort (-1.8%) and the 19-20 age cohort (-12.2%). The ratios stayed the same for the 1-2 age cohort and the 6-9 age cohort.

Screening ratios improved from the FFY 2013 baseline to FFY 2015 for the 3-5 age cohort (6.3%), the 10-14 age cohort (8.9%), the 15-18 age cohort (4.5%), and in the aggregate (2.0%). Two age cohorts declined from the FFY 2013 baseline to FFY 2015: <1 (-8.8%) and 19-20 (-48.5%). During this same time period, there was no change in the 1-2 age cohort and the 6-9 age cohort.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 37 – EPSDT Screening Ratio[50]



	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20	Total
FFY 2013 Baseline	0.88	1.00	0.80	1.00	0.72	0.45	0.35	0.82
FFY 2014	0.71	1.00	0.83	1.00	0.75	0.48	0.21	0.82
FFY 2015	0.81	1.00	0.85	1.00	0.78	0.47	0.18	0.84
FFY 2015 National Avg	1.00	1.00	1.00	1.00	1.00	1.00	0.92	1.00

[49] Source: CMS-416 Annual EPSDT Participation Report (National) Federal Fiscal Year 2016.
[50] Source: CMS-416 Reports for Federal Fiscal Years 2013 – 2015.

Measure 38 – Annual monitoring for patients on persistent medication.

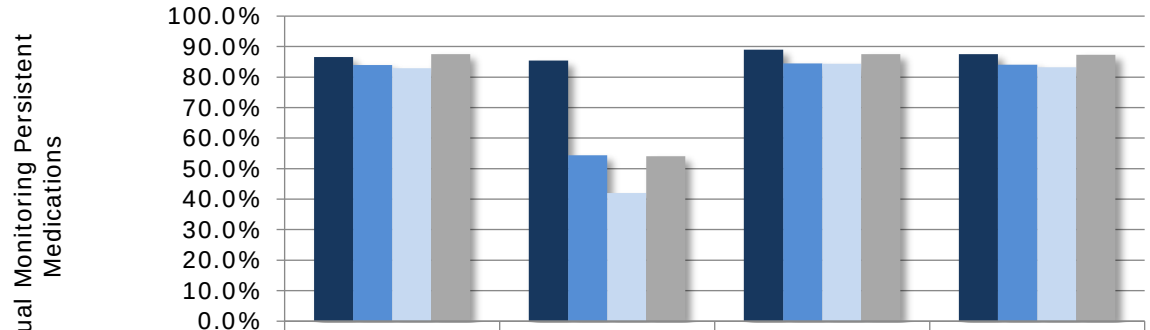
Exhibit 38 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the three subcomponent rates and the aggregate rate for the measure Annual Monitoring for Patients on Persistent Medication.

All three subcomponents and the aggregate rate declined from DY1 to DY2. The declines in angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (-1.2%) and the aggregate rate (-0.9%) were statistically significant at the 95% confidence level. The largest decline was in the digoxin rate (-22.8%), although this change was not statistically significant at the 95% confidence level.

Upon review of the individual MCO performance for the ACE inhibitors or ARBs subcomponent, BCBS experienced the steepest decline (-2.8%) from DY1 to DY2 compared to MHC, PHP, and UHC, which had declines of 0.6%, 0.5%, and 1.9% respectively. Similarly, for the aggregate rate, BCBS had the steepest decline (-2.5%) from DY1 to DY2 compared to MHC and UHC, which had declines of 0.3% and 2.1% respectively. PHP experienced a 0.1% increase in the aggregate rate from DY1 to DY2.

Across all four MCOs, all three subcomponents and the aggregate rate declined from the baseline to DY2. The digoxin subcomponent experienced the steepest decline (-50.9%), while the ACE inhibitors (or ARBs) and diuretics had declines of 4.2% and 5.3% respectively. The aggregate rate declined by 4.9%. All declines were statistically significant at the 95% confidence level.

Exhibit 38 – Annual Monitoring for Patients on Persistent Medications[51]



	ACE Inhibitors or ARBs	Digoxin	Diuretics	Total
2013 Baseline	86.6%	85.4%	89.0%	87.5%
DY1 Centennial Care	83.9%	54.3%	84.5%	84.0%
DY2 Centennial Care	82.9%	42.0%	84.3%	83.3%
2015 National Avg	87.5%	54.1%	87.5%	87.3%

[51] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 39 – Medication management for people with asthma (50% compliance).

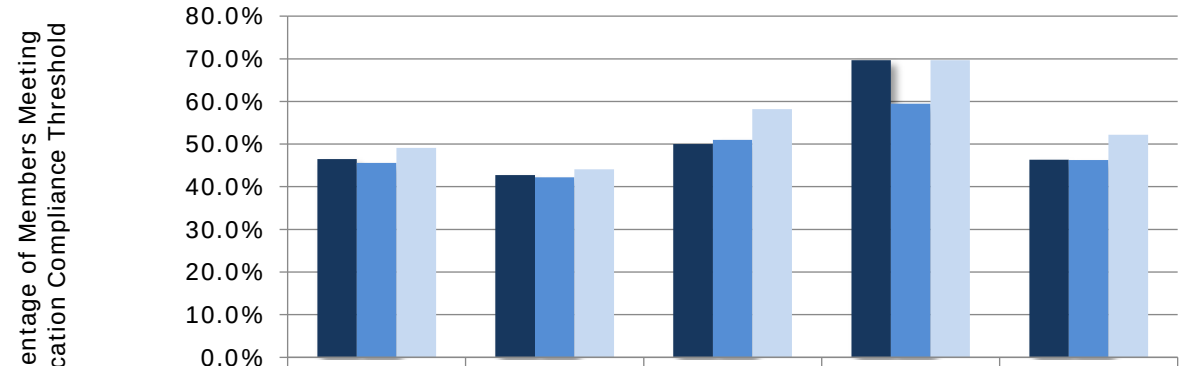
Exhibit 39 presents rates for the 2013 baseline, DY1, and DY2 for the four age cohorts and the aggregate rate for the measure Medication Management for People with Asthma. As illustrated, rates increased in all four age cohorts and in the aggregate from DY1 to DY2. The largest increases at the cohort level were among members 51-64 years of age cohort (17.2%), followed by members 19-50 years of age cohort (14.1%). The aggregate rate increased by 12.8%. These changes were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from DY1 to DY2 for the 5-11 years of age cohort, PHPs increase (17.4%) was statistically significant at the 95% confidence level, while BCBSs increase (2.8%) and MHCs change (0.0%) were not. During this same period, two plans had a decline for the 12-18 year of age cohort: BCBS (-25.8%) and MHC (-6.1%) while one plan reported an increase: PHP (20.4%). PHPs increase was statistically significant at the 95% confidence level. UHC did not have sufficient data to report. As it relates to the 19-50 years of age cohort, three plans had sufficient data to calculate rates and the rates all increased: MHC (17.3%), PHP (16.8%), and BCBS (7.8%). The MHC and PHP increases were statistically significant at the 95% confidence level. For the 51-64 years of age cohort, MHCs increase (25.6%) was statistically significant at the 95% confidence level while the other two plans that reported on this age cohort was not: PHP (27.7%) and UHC (6.9%). For the aggregate rates, no changes were statistically significant at the 95% confidence level.

Three of the four age cohorts and the aggregate increased from the baseline to DY2. The largest improvements at the cohort level were among members 19-50 years of age (16.3%) followed by members 5-11 years of age (5.6%) and members 12-18 years of age (3.2%). The aggregate rate increased by 12.7%. The changes in the 19-50 years of age cohort and the aggregate rate were statistically significant at the 95% confidence level. Upon review of the individual MCO performance from the baseline to DY2, PHP had increases in the 5-11, 12-18, and 19-50 years of age cohort that were statistically significant at the 95% confidence level. No changes were statistically significant at the 95% confidence level for the 51-64 years of age cohort or the aggregate rate.

A national comparison rate could not be identified for this measure.

Exhibit 39 – Medication Management for People with Asthma[52]



	5-11 years 50%	12-18 years 50%	19-50 years 50%	51-64 years 50%	Total 50%
2013 Baseline	46.5%	42.7%	50.0%	69.7%	46.3%
DY1 Centennial Care	45.6%	42.2%	51.0%	59.4%	46.3%
DY2 Centennial Care	49.1%	44.1%	58.2%	69.6%	52.2%

[52] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 40 – Asthma medication ratio.

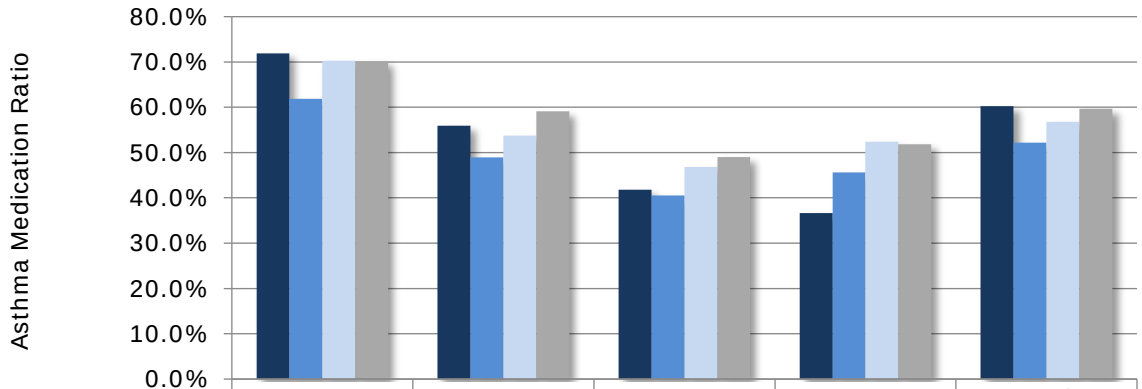
Exhibit 40 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the four age cohorts and the aggregate rate for the measure Asthma Medication Ratio. As illustrated, all age cohorts and the aggregate rate increased from DY1 to DY2. The largest improvement was among members 19-50 years of age (15.4%), followed by increases in the 5-11 age cohort (13.5%), and the 12-18 cohort (9.9%), all of which were statistically significant at the 95% confidence level. The change in the aggregate rate (8.7%) was also statistically significant. The increase in the 51-54 age cohort (14.8%) was not statistically significant.

Upon review of the individual MCO performance from DY1 to DY2 for the 5-11 age cohort, MHC experienced the largest increase (22.5%) followed by PHP (8.1%) and BCBS (6.1%). Both MHC and PHPs rates were statistically significant at the 95% confidence level. UHC did not have sufficient data to report. Similarly, for the 19-50 age cohort, PHP had a statistically significant increase (27.8%) from DY1 to DY2 compared to BCBS, MHC, and UHC, which had changes of -9.8%, 12.4%, and -9.2%, respectively. As it relates to the 51-64 age cohort, three plans had sufficient data to calculate rates. MHC had a statistically significant increase (45.4%) compared to MHC and UHC, which had changes of 3.6% and -6.0%. For the aggregate rate, MHC had a statistically significant increase (15.5%) compared to BCBS, PHP, and UHC, which had changes of 3.3%, 5.24%, and -3.5%.

Two of the four age cohorts experienced increases in rates from the baseline to DY2: 19-50 (11.9%) and 51-64 (43.0%). The increases were statistically significant at the 95% confidence level. The remaining two age cohorts (5-11 and 12-18) declined slightly from the baseline to DY2, though the changes were not statistically significant. The aggregate decline was 5.7%, which was statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from the baseline to DY2 for the 5-11 age cohort, both BCBS and PHP had statistically significant declines (-22.5% and -6.1%) while MHC had a statistically significant increase (7.9%). UHC did not have sufficient data to report. For the 19-50 age cohort, PHP had a statistically significant increase (19.9%) compared to the increases for MHC (14.5%) and UHC (15.5%). On the other hand, BCBS had a statistically significant decline (-28.6%). As it relates to the 51-64 age cohort, three plans had sufficient data to calculate rates. Both MHC and PHP had statistically significant increases (66.2% and 46.6%) while UHC did not (13.6%). BCBS and PHP experienced statistically significant declines in the aggregate rate, decreasing 24.0% and 8.6% respectively. Both MHC and UHC experienced increases though the changes were not statistically significant at the 95% confidence level.

Exhibit 40 – Asthma Medication Ratio[53]



	5-11 years	12-18 years	19-50 years	51-64 years	Total
2013 Baseline	71.9%	55.9%	41.8%	36.6%	60.2%
DY1 Centennial Care	61.9%	48.9%	40.6%	45.6%	52.2%
DY2 Centennial Care	70.2%	53.8%	46.8%	52.4%	56.8%
2015 National Avg	70.1%	59.1%	49.0%	51.8%	59.7%

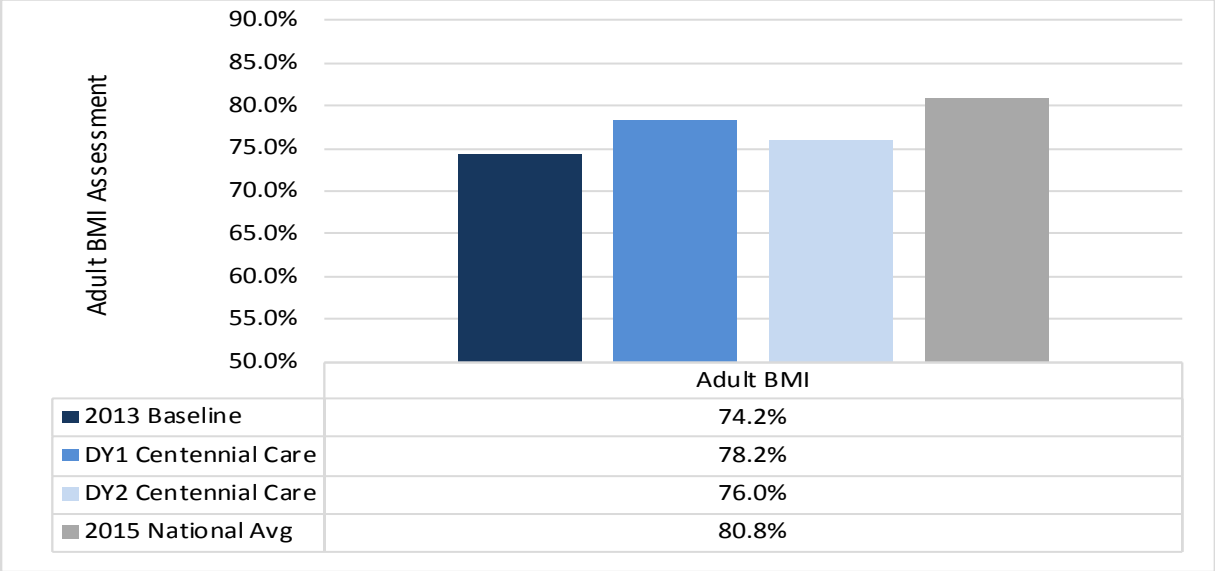
[53] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 41 – Adult BMI assessment and weight assessment for children/adolescents.

Exhibit 41.a presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Adult BMI Assessment. As illustrated, the rate decreased modestly from DY1 to DY2 (2.8%), but it was not statistically significant at the 95% confidence level. Upon review of the individual MCO performance, MHC's rate increased (7.0%) while the other MCO rates declined: BCBS (-9.0%), PHP (-0.5%), and UHC (-3.8%). Only BCBS's decline was statistically significant at the 95% confidence level.

The rate increased from the baseline to DY2 (2.4%) but this was not statistically significant at the 95% confidence level. Upon review of the individual MCO performance, the largest increase from the baseline to DY2 among MCOs was PHP (14.4%), which was statistically significant at the 95% confidence level, compared to changes for BCBS (0.6%), MHC (-1.7%), and UHC (0.2%).

Exhibit 41.a – Adult BMI Assessment[54]



	Adult BMI
2013 Baseline	74.2%
DY1 Centennial Care	78.2%
DY2 Centennial Care	76.0%
2015 National Avg	80.8%

Exhibit 41.b presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the three subcomponents included in the measure Weight Assessment for Children/Adolescents. As illustrated, BMI percentile had a positive increase from DY1 to DY2 of 21.0%, which was statistically significant at the 95% confidence level. The other two rates declined from DY1 to DY2: counseling for nutrition (-5.1%) and counseling for physical activity (-1.4%). The declines were not statistically significant.

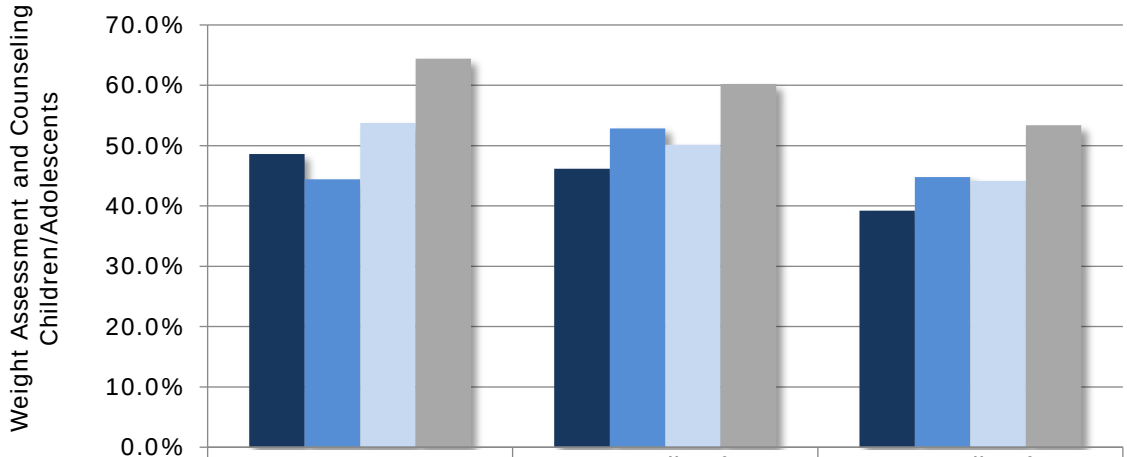
Upon review of the individual MCO performance for the BMI percentile from DY1 to DY2, MHC experienced the largest increase (51.6%), followed by PHP (45.1%). These improvements were statistically significant at the 95% confidence level. During this same period, BCBS exhibited the largest decline in rate for counseling for nutrition (-22.8%), which was statistically significant at the 95% confidence level. As it relates to counseling for physical activity, UHC had a large increase during this same time period (30.5%), which was statistically significant at the 95% confidence level.

There were improvements in all three subcomponents from the baseline to DY2. The largest improvement was in the rate for counseling for physical activity (12.5%), followed by BMI percentile (10.5%), and then counseling for nutrition (8.6%). The increases in all three rates were statistically

[54] Source: MCO annual HEDIS reports for 2013 – 2015.

significant at the 95% confidence level. Upon review of the individual MCO performance, the largest increase from the baseline to DY2 among MCOs was in PHP's BMI assessment rate (70.5%), which was statistically significant at the 95% confidence level.

Exhibit 41.b – Weight Assessment for Children/Adolescents[55]



	BMI Percentile	Counseling for Nutrition	Counseling for Physical Activity
2013 Baseline	48.6%	46.2%	39.2%
DY1 Centennial Care	44.4%	52.9%	44.8%
DY2 Centennial Care	53.7%	50.1%	44.1%
2015 National Avg	64.4%	60.2%	53.4%

[55] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 42 – Comprehensive diabetes care.

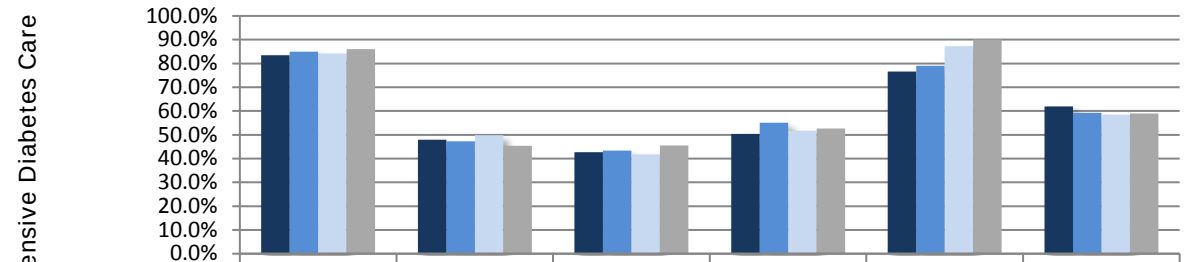
Exhibit 42 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national averages for the six subcomponents included in Comprehensive Diabetes Care. As illustrated, one of six rates had a positive increase from DY1 to DY2: medical attention for nephropathy (10.4%). The change in the rate for medical attention for nephropathy was statistically significant at the 95% confidence level.

Four subcomponents (HbA1c testing, HbA1c poor control >9.0%, eye exam, and blood pressure control) declined from DY1 to DY2 but only one decrease (eye exam) was statistically significant at the 95% confidence level. Upon review of individual MCO performance for the eye exam measure, BCBS experienced the steepest decline (-11.9%) from DY1 to DY2 compared to MHC, PHP, and UHC, which had declines of 3.5%, 3.5%, and 4.1% respectively.

The last subcomponent (HbA1c poor control >9.0%) had an unfavorable increase from DY1 to DY2.

Three of six of the subcomponents (HbA1c testing, eye exam, and medical attention for nephropathy) improved from the baseline to DY2. The largest improvement was in the rate for medical attention for nephropathy, increasing by 14.0%, which was statistically significant at the 95% confidence level. Two subcomponents declined from the baseline to DY2 (HbA1c poor control <8.0% and blood pressure control) but only blood pressure control was statistically significant at the 95% confidence level. One of the six subcomponents (HbA1c poor control >9.0%) had an unfavorable increase from the baseline to DY2.

Exhibit 42 – Comprehensive Diabetes Care[56]



	HbA1c Testing	HbA1c Poor Control (>9.0%)	HbA1c Control (<8.0%)	Eye Exam	Medical Attention for Nephropathy	Blood Pressure Controlled <140/90 mm Hg
2013 Baseline	83.5%	47.9%	42.7%	50.4%	76.6%	62.0%
DY1 Centennial Care	85.0%	47.2%	43.4%	55.0%	79.1%	59.3%
DY2 Centennial Care	84.1%	49.8%	41.8%	51.8%	87.3%	58.4%
2015 National Avg	86.0%	45.4%	45.5%	52.7%	90.0%	59.0%

[56] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 43.a – Ambulatory care sensitive diabetes long-term complications admission rates.

Exhibit 43.a presents results for the baseline, DY1, and DY2 for Ambulatory Care Sensitive Diabetes Long Term Complications Admission Rates. As illustrated, there was an improvement in performance resulting in a 14.1% decrease in the rate per 100,000 with admissions due to long term complications from diabetes from DY1 to DY2.

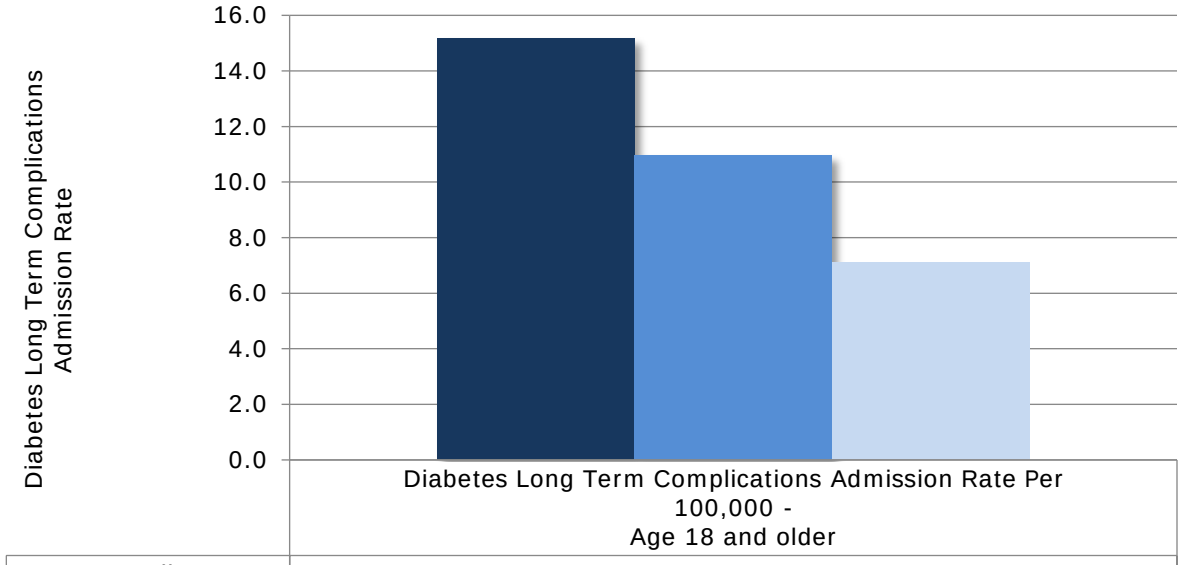
Upon review of the individual MCO performance during the same time period, there was improvement in performance, resulting in a decrease in the rate per 100,000 for admissions due to long term complications from diabetes, for all MCOs: BCBS (-22.7%), MHC (-0.4%), PHP (-10.6%), and UHC (-19.1%).

There was also an improvement in performance resulting in a 38.0% decrease in the rate per 100,000 with admissions due to long term complications from diabetes from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 43.a – Diabetes Long Term Complications Admissions Rate[57]



[57] Source: ACS MMIS reports.

Measure 43.b – Ambulatory care sensitive diabetes short-term complications admission rates.

Exhibit 43.b presents results for DY1 and DY2 for Ambulatory Care Sensitive Diabetes Short Term Complications Admission Rates. As illustrated, there was an improvement in performance resulting in a 22.0% decrease in the rate per 100,000 for members 18-64 years of age with admissions due to short term complications from diabetes from DY1 to DY2. For members 65 years of age and older, the performance decreased resulting in an 8.6% increase in the rate per 100,000.

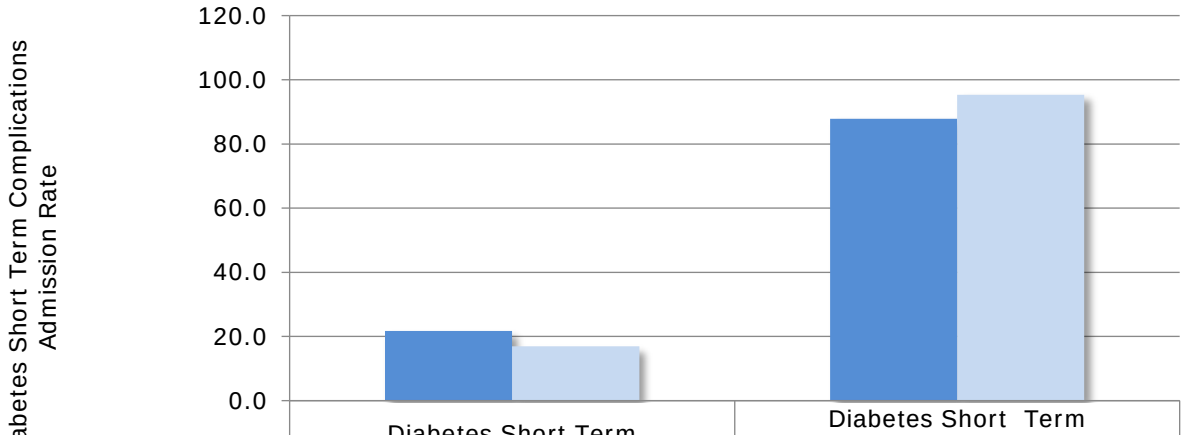
There was an improvement in individual MCO performance over the same time period for three MCOs, resulting in a decrease in rate per 100,000 for admissions of 18-64 year olds due to short term complications from diabetes: BCBS (-15.3%), MHC (-30.2%), and UHC (-39.6%). PHP experienced a 4.1% increase in rate per 100,000, which was a decline in performance. For members 65 years of age and older, performance improved for UHC (-0.1%) and declined for BCBS, MHC, and PHP who experienced increases in rates of 76.1%, 825.9%, and 1,204.8%, respectively.

Although BCBS, MHC, and PHP experienced increases in their rates, it should be noted that their admission rate per 100,000 were in the range of 8–40, while UHC's rate per 100,000 was nearly 250 in DY2 and significantly pulled up the average in both DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 43.b – Diabetes Short Term Complications Admissions Rate[58]



	Diabetes Short Term Complications Admission Rate 18-64 years	Diabetes Short Term Complications Admission Rate 65+ years
DY1 Centennial Care	21.7	87.8
DY2 Centennial Care	17.0	95.3

[58] Source: Centennial Care Diabetes Inpatient Encounters (PQI) reports and MMIS reports.

Measure 44 – ACS admission rates for COPD or asthma in older adults; asthma in younger adults.

Exhibit 44.a presents results for the 2013 baseline, DY1, and DY2 for ACS Admission Rates for Asthma in Younger Adults. As illustrated, there was improvement in performance resulting in a 23.8% decrease in the asthma admission rate per 100,000 for members 18-39 years of age from DY1 to DY2.

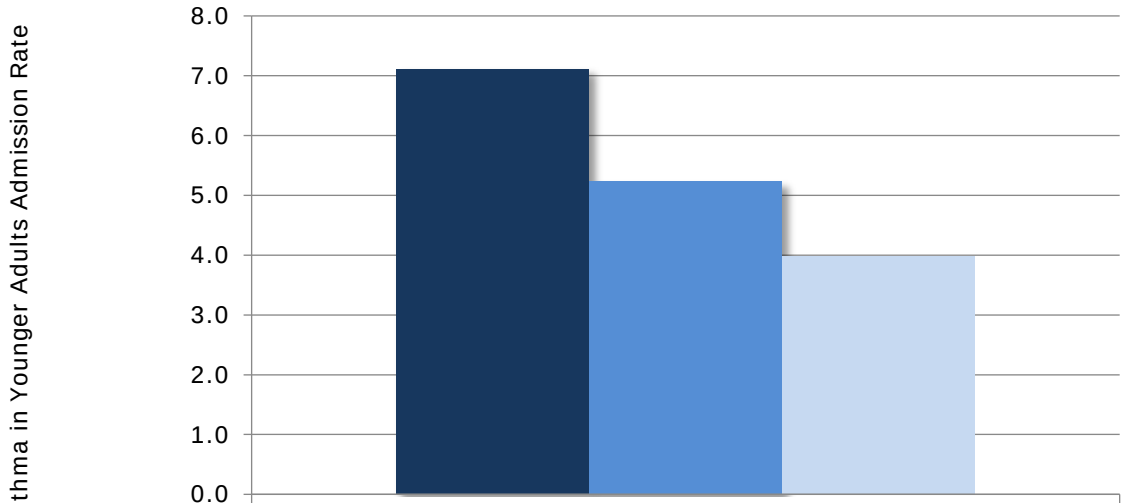
Upon review of the individual MCO performance over the same time period, there were no outliers noted.

There were similar results analyzing changes from the baseline to DY2, where there was an improvement in performance resulting in a 44.0% decline in the rate per 100,000.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 44.a – Asthma in Younger Adults Admission Rate[59]



	Asthma in Younger Adults Admission Rate Per 100,000 - Ages 18 to 39
Baseline	7.1
DY1 Centennial Care	5.2
DY2 Centennial Care	4.0

Exhibit 44.b presents results for the 2013 baseline, DY1, and DY2 for ACS Admission Rates for COPD or Asthma in Older Adults. As illustrated, there was an improvement in performance resulting in a 38.4% decline in the COPD or asthma admission rate per 100,000 for members 40-64 years of age from DY1 to DY2. Similarly, there was an improvement in performance resulting in a 19.6% decline in the COPD or asthma admission rate per 100,000 for members aged 65+ over the same time period.

Upon review of the individual MCO performance over the same time period, there were no outliers noted in the admission rates for members 40-64 years of age. Conversely, for members age 65+,

[59] Source: ACS MMIS reports.

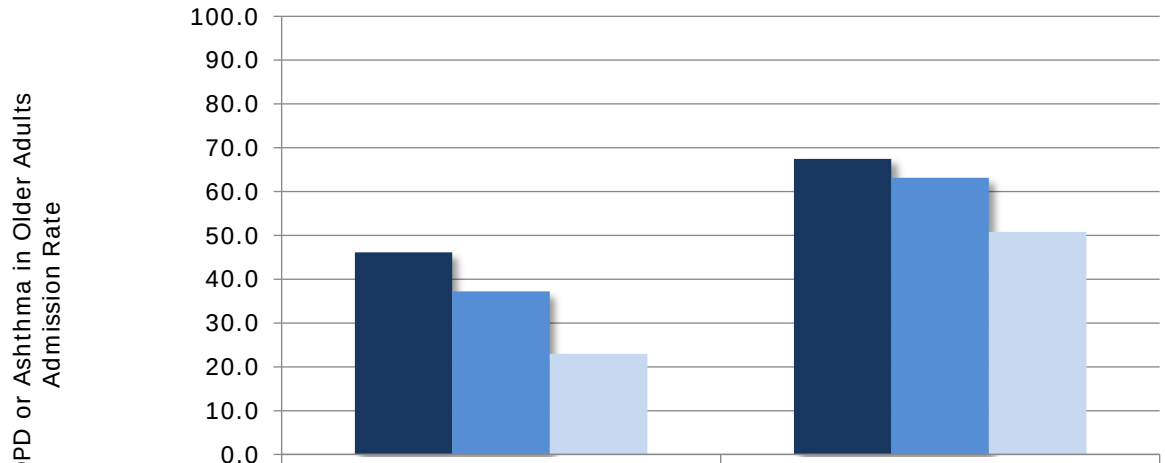
COPD or asthma admission rates declined for MHC (-12.9%), PHP (-56.7%), and UHC (-33.7%) while the rate increased for BCBS (621.4%).

There was an improvement in performance in the COPD or asthma admission rates per 100,000 for members 40-64 years of age (-50.2%) and for members aged 65+ (-24.7%) from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 44.b – COPD or Asthma in Older Adults Admission Rate[60]



	COPD or Ashthma in Older Adults Admission Rate Per 100,000 - Ages 40-64	COPD or Ashthma in Older Adults Admission Rate Per 100,000 - Age 65+
Baseline	46.1	67.5
DY1 Centennial Care	37.2	63.2
DY2 Centennial Care	23.0	50.8

[60] Source: ACS MMIS reports.

Measure 45 – Ambulatory care sensitive admission rates for hypertension.

Exhibit 45 presents results for the 2013 baseline, DY1, and DY2 for Ambulatory Care Sensitive Admission Rates for Hypertension. As illustrated, there was an improvement in performance resulting in a 0.6% decrease in the rate per 100,000 for members with admissions due to hypertension from DY1 to DY2.

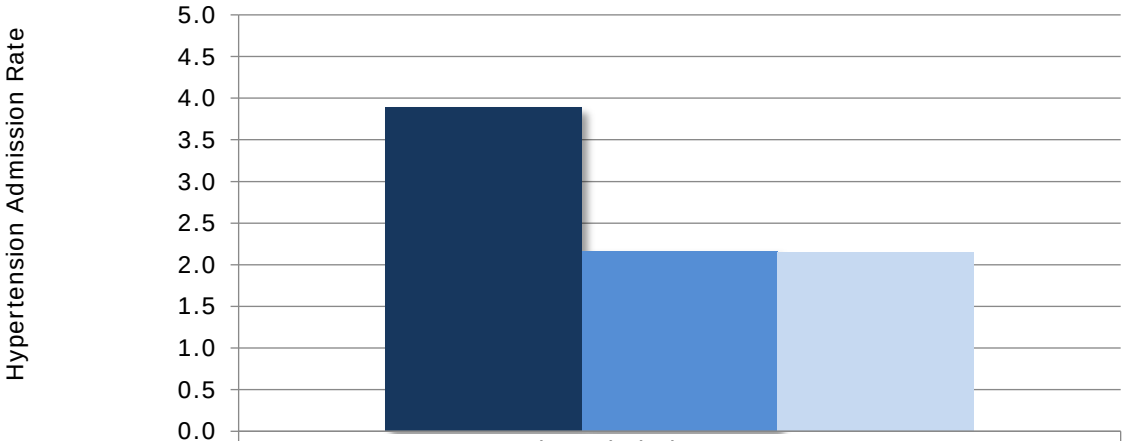
There was an improvement in individual MCO performance over the same time period for two of the MCOs, resulting in a decrease in rate per 100,000 for members with admissions due hypertension: MHC (-28.5%) and UHC (-31.4%). BCBS experienced a 31.2% increase and PHP experienced a 93.3% increase in the rate per 100,000, which was a decline in performance.

From the baseline to DY2, there was an improvement in performance resulting in a 44.6% decrease in the rate per 100,000 with admissions due to hypertension.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 45 – Hypertension Admissions Rate[61]



	Hypertension Admission Rate Per 100,000 - Ages 18 and Older
Baseline	3.9
DY1 Centennial Care	2.2
DY2 Centennial Care	2.2

[61] Source: ACS MMIS reports.

Measure 46 – ACS admission rates for pediatric asthma.

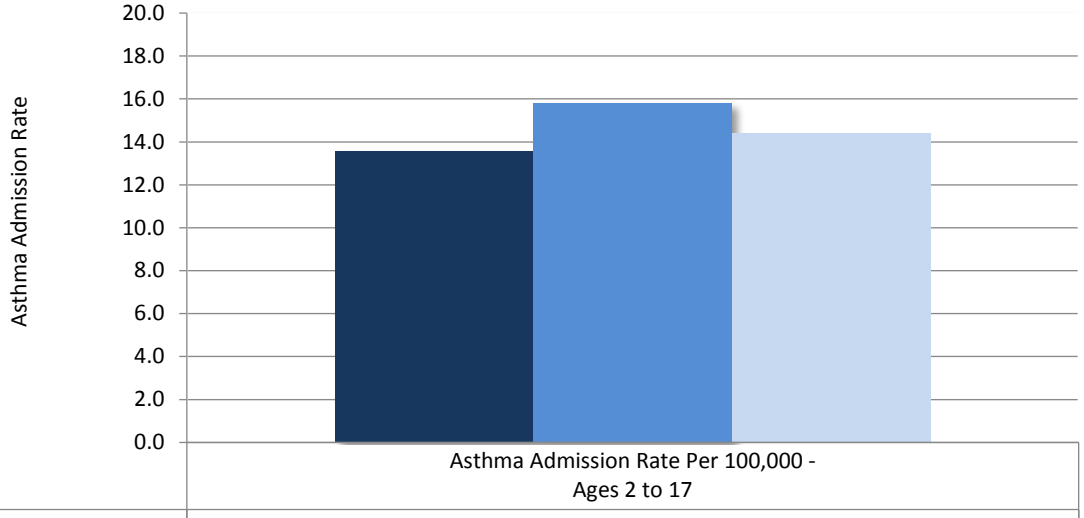
Exhibit 46 presents rates for the 2013 baseline, DY1, and DY2 for the ACS Pediatric Asthma Admission measure for members 2 through 17 years of age. Similar to other admission rate measures, this is an inverse measure where a decreasing rate represents an improvement in performance. As illustrated, there was an improvement in performance resulting in an 8.8% decrease in the in the rate per 100,000 with admissions for pediatric asthma from DY1 to DY2.

There was a decline in performance resulting in a 6.3% increase from the baseline to DY2. Upon review of individual MCO performance during this same time period, MHC experienced the steepest decline at 31.0% compared to UHC's decline of 12.9%. Both BCBS and PHP experienced increases over this same time period.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 46 – ACS Admissions Rate for Pediatric Asthma Aggregate[62]



	Asthma Admission Rate Per 100,000 - Ages 2 to 17
2013 Baseline	13.6
DY1 Centennial Care	15.8
DY2 Centennial Care	14.4

[62] A downward trend for this measure is considered an improvement as an annual reduction in admission rates is desirable. Source: ACS MMIS reports.

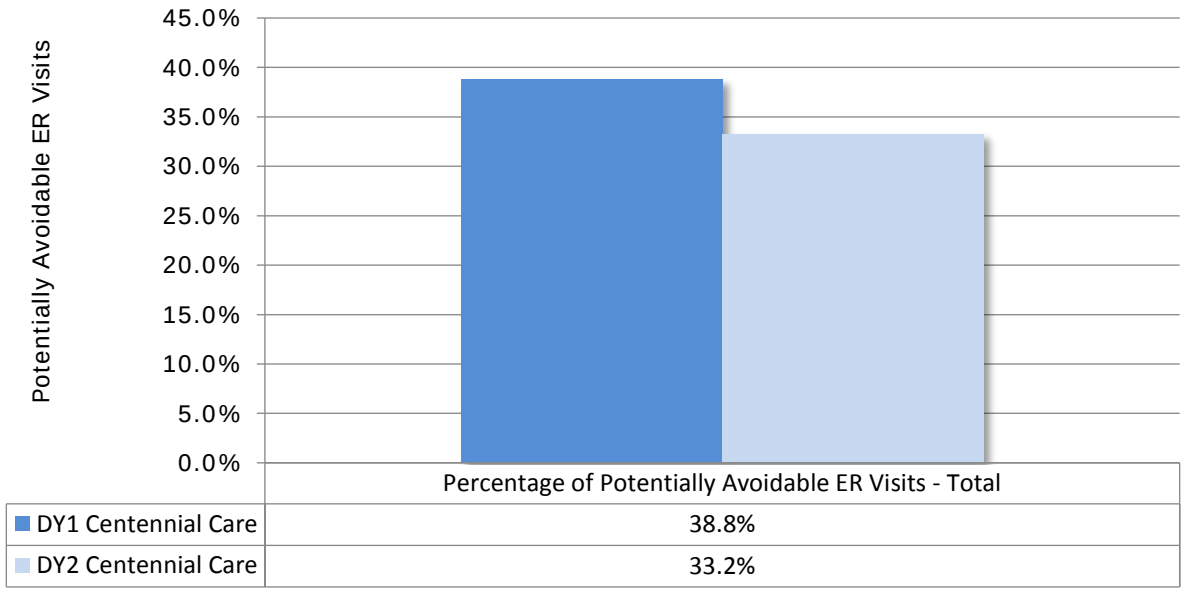
Measure 47 – Number and percentage of potentially avoidable ER visits.

Exhibit 47.a presents results for DY1 and DY2 for the Percentage of Unduplicated Members with a Potentially Avoidable ER Visits. As illustrated, there was a 14.4% decline in the percentage of unduplicated members with a potentially avoidable ER visit out of the total number of ER visits from DY1 to DY2. This is an improvement despite the total ER usage increased between DY1 and DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 47.a – Percentage of Members with Potentially Avoidable ER Visits[63]



	Percentage of Potentially Avoidable ER Visits - Total
DY1 Centennial Care	38.8%
DY2 Centennial Care	33.2%

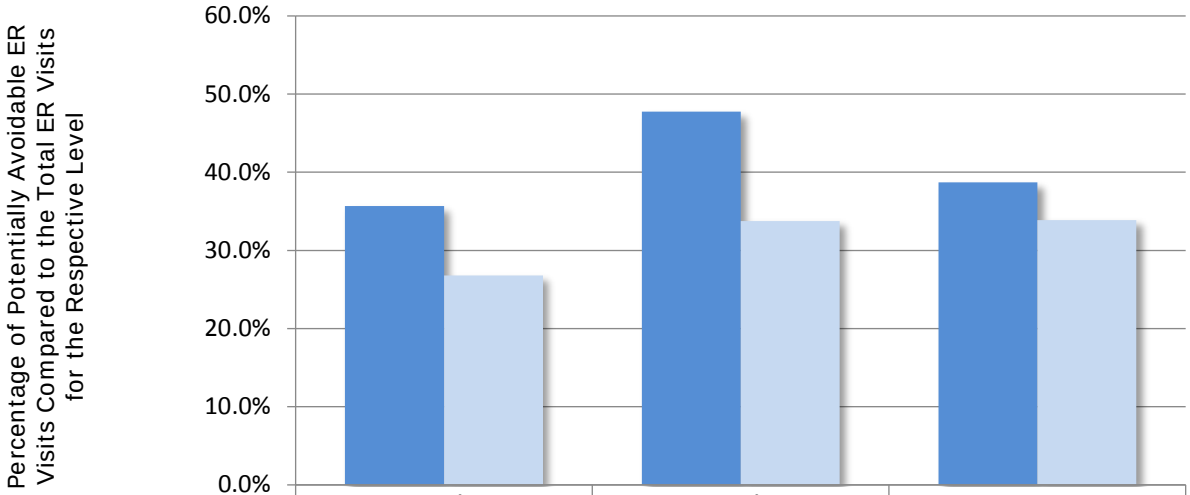
[63] Source: MCO reports for 2014 – 2015 (HSD 40).

Exhibit 47.b presents results for DY1 and DY2 for the Percentage of Unduplicated Members with Non-Emergent ER Visits by Care Coordination Level Out of the Total Number of ER Visits by Level. As illustrated, there were reductions in non-emergent ER visits in Care Coordination Level 2 (-24.9%), Level 3 (-29.4%), and members with no care coordination level (-12.4%) from DY1 to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 47.b – Percentage of Members with Potentially Avoidable ER Visits Out of the Total Number of ER Visits by Care Coordination Level[64]

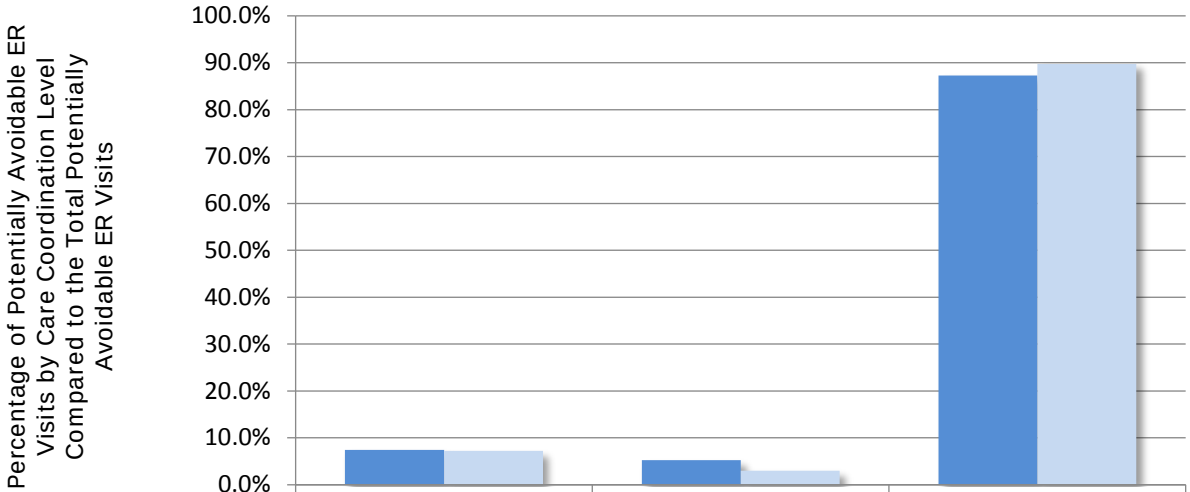


	Level 2	Level 3	No CCL
DY1 Centennial Care	35.7%	47.8%	38.7%
DY2 Centennial Care	26.8%	33.7%	33.9%

[64] Source: MCO reports for 2014 – 2015 (HSD 40).

Exhibit 47.c presents results for DY1 and DY2 for Potentially Avoidable ER Visits by Care Coordination Level. As illustrated, there were reductions in potentially avoidable ER visits in Care Coordination Level 2 (-2.4%) and Level 3 (-42.3%). The percentage for members with no Care Coordination Level increased by 2.8%.

Exhibit 47.c – Percentage of Members with Potentially Avoidable ER Visits by Care Coordination Level Out of the Total Number of Non-Emergent ER Visits[65]



	Level 2	Level 3	No CCL
DY1 Centennial Care	7.4%	5.3%	87.3%
DY2 Centennial Care	7.3%	3.0%	89.7%

[65] Source: MCO reports for 2014 – 2015 (HSD 40).

Measure 48 – Medical assistance with smoking and tobacco use cessation.

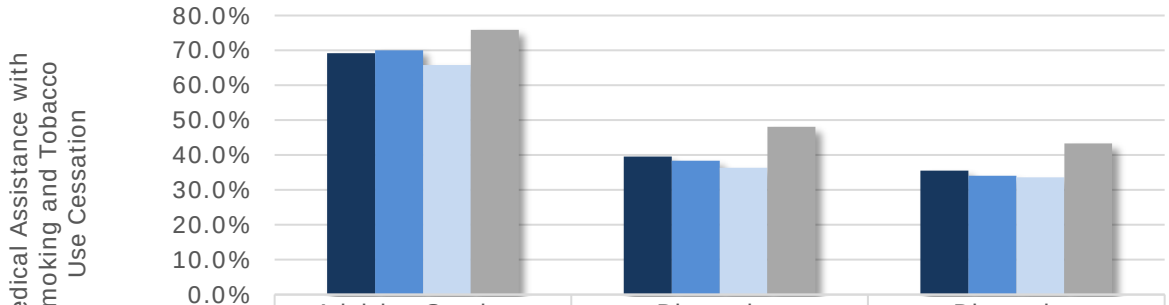
Exhibit 48 presents results for the baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the three subcomponents for the Medical Assistance with Tobacco Use Cessation measure. As illustrated, the rate of members who received advice to quit declined by 6.1% from DY1 and DY2. There was a 5.2% decline in the rate of members who discussed or were recommended cessation medications and a 1.3% decline in the rate of members who discussed cessation strategies during the same time period. Upon review of the individual MCO performance, there was a large improvement in the discussion of cessation strategies subcomponent from DY1 to DY2 for PHP (9.5%) compared to declines for BCBS (-1.0%), MHC (-2.4%), and UHC (-7.8%), though these three MCOs maintained higher rates in DY2 compared to PHP. There were no significant outliers across any of the MCOs for the advising smokers and tobaccos users to quit subcomponent and the discussing cessation medications subcomponent.

The rates for all three subcomponents fell from the baseline to DY2. The largest decline was in the rate of members who discussed or were recommended cessation medications (-8.2%) followed by the rate of members who discussed cessation strategies (-5.5%) and the rate of members who received advice to quit (-4.9%).

Upon review of the individual MCO performance, MHC had improvements in the advising smokers and tobaccos users to quit subcomponent from the baseline to DY2 for MHC (10.8%) though there were declines across all other MCOs: BCBS (-15.5%), PHP (-5.7%), and UHC (-8.2%). Similarly, there was improvement in the discussing of cessation medications subcomponent from the baseline to DY2 for MHC (12.7%) though there were declines across all other MCOs: BCBS (-14.6%), PHP (-12.8%), and UHC (-15.9%). MHC's rate also improved for the discussing cessation medications subcomponent (16.8%) compared to the declines across the other MCOs from the baseline to DY2: BCBS (-15.4%), PHP (-3.15%), and UHC (-16.9%).

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 48 – Medical Assistance with Smoking and Tobacco Use Cessation[66]



	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
2013 Baseline	69.2%	39.6%	35.5%
DY1 Centennial Care	70.0%	38.4%	34.0%
DY2 Centennial Care	65.8%	36.4%	33.6%
2015 National Avg	75.9%	48.1%	43.3%

[66] Source: MCO CAHPS reports for 2013 – 2015.

Measure 49.a – Number of critical incidents by reporting category – Centennial Care.

Exhibit 49.a presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for Centennial Care. As illustrated, in four categories there were increases in percentage of critical incidents reported from DY1 to DY2: Emergency Services (2.9%), Death (8.5%), Neglect (13.9%), and Missing/Elopement (37.4%). During the same time period, there were declines in the percentage of critical incident reports for Abuse (-26.8%), Exploitation (-23.6%), Law Enforcement (-8.7%), and Environmental Hazard (-6.8%).

Upon review of the individual MCO performance from DY1 and DY2, UHC experienced declines in four reporting categories: Abuse (-26.7%), Environmental Hazard (-6.3%), Exploitation (-29.1%), and Law Enforcement (-20.6%), and PHP had declines in two reporting categories: Abuse (-12.6%) and Neglect (-31.3%). BCBS had one reporting category, Law Enforcement, which remained constant. All other rates for the MCOs increased from DY1 to DY2.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests that Emergency Services, Death, and Neglect will continue to be the most frequently reported incident categories.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.a – Critical Incidents by Reporting Category: Centennial Care Total[67]

Critical Incident Type	Centennial Care - DY1		Centennial Care - DY2		DY1 - DY2 % Change
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	
Abuse	958	9.8%	875	7.2%	-26.8%
Death	1,058	10.8%	1,432	11.8%	8.5%
Natural/Expected	886	83.7%	1,246	87.0%	3.9%
Unexpected	164	15.5%	169	11.8%	-23.9%
Homicide	5	0.5%	5	0.3%	-26.1%
Suicide	3	0.3%	13	0.9%	220.2%
Emergency Services	5,710	58.5%	7,326	60.2%	2.9%
Environmental Hazard	179	1.8%	208	1.7%	-6.8%
Exploitation	463	4.7%	441	3.6%	-23.6%
Law Enforcement	448	4.6%	510	4.2%	-8.7%
Missing/Elopement	94	1.0%	161	1.3%	37.4%
Neglect	853	8.7%	1,211	9.9%	13.9%
Total Number of Critical Incidents	**9,763**		**12,164**		

Measure 49.b – Number of critical incidents by reporting category – behavioral health.

[67] Source: MCO Critical Incident Reports.

Exhibit 49.b presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for the Behavioral Health subcomponent. As illustrated, there were declines in four of the eight reporting categories: Abuse, which was the category with the second largest number of reported incidents (-36.3%), Environmental Hazard (-100.0%), Law Enforcement (-8.1%), and Missing/Elopement (-33.5%). The remaining four categories had increases in percentage of critical incident reports: Emergency Services, the category with the largest number of reports (38.9%), Death (46.5%), Exploitation (73.6%), and Neglect (0.03%).

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend appears consistent with the results from DY1 to DY2. The categories of Abuse, Law Enforcement, Missing/Elopement, and Neglect declined while the remaining four categories (Death, Emergency Services, Environmental Hazard, and Exploitation) continue to trend upward.

A plan by plan comparison on BH sub category was not performed as this data was only available in the aggregate.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.b – Critical Incident Reports for Centennial Care: Behavioral Health [68]

Critical Incident Type	Behavioral Health - DY1		Behavioral Health - DY2		DY1 - DY2 % Change
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	
Abuse	304	33.3%	223	21.2%	-36.3%
Death	32	3.5%	54	5.1%	46.5%
Natural/Expected	20	62.5%	30	55.6%	-11.1%
Unexpected	10	31.3%	21	38.9%	24.4%
Homicide	1	3.1%	1	1.9%	-40.7%
Suicide	1	3.1%	2	3.7%	18.5%
Emergency Services	310	34.0%	496	47.1%	38.9%
Environmental Hazard	6	0.7%	0	0.0%	-100.0%
Exploitation	7	0.8%	14	1.3%	73.6%
Law Enforcement	135	14.8%	143	13.6%	-8.1%
Missing/Elopement	60	6.6%	46	4.4%	-33.5%
Neglect	59	6.5%	68	6.5%	0.0%
Total Number of Critical Incidents	**913**		**1,044**		

Measure 49.c – Number of critical incidents by reporting category – self-direction.

Exhibit 49.c presents results for DY1 and DY2 for the Number of Critical Incidents by Reporting Category for the Self-Direction subcomponent. As illustrated, four of the eight reporting

[68] Source: MCO Critical Incident Reports.

categories declined in the percentage of critical incident reports: Abuse (-2.5%), Death (-20.5%), Exploitation (-7.8%), and Neglect (-54.6%). The reporting category with the largest number of critical incident reports, Emergency Services, increased by 6.9% from DY1 to DY2. The remaining three categories had increases in the percentage of critical incident reports: Environmental Hazards (4.9%), Law Enforcement (34.8%), and Missing/Elopement increased from 0.4% to 1.3%, a 267.0% change.

For DY3, data was only available for the first two quarters of the measurement year. The emerging trend suggests a decrease in the percentage of critical incident reports for Death, Environmental Hazard, Exploitation, Law Enforcement, and Missing/Elopement. Data suggests that Emergency Services may continue as the category with the most critical incident reports.

A plan by plan comparison on the self-directed sub category was not performed as this data was only available in the aggregate.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the dependent nature of the data.

Exhibit 49.c – Critical Incident Reports for Centennial Care: Self-Direction[69]

Measure	Self-Direction - DY1		Self-Direction - DY2		
	# Members	Centennial Care Percent per Incident Type	# Members	Centennial Care Percent per Incident Type	DY1 - DY2 % Change
Abuse	71	8.5%	44	8.2%	-2.5%
Death	95	11.3%	48	9.0%	-20.5%
Natural/Expected	81	85.3%	43	89.6%	5.1%
Unexpected	13	13.7%	4	8.3%	-39.1%
Homicide	0	0.0%	0	0.0%	0.0%
Suicide	1	1.1%	1	2.1%	97.9%
Emergency Services	521	62.0%	354	66.3%	6.9%
Environmental Hazard	12	1.4%	8	1.5%	4.9%
Exploitation	58	6.9%	34	6.4%	-7.8%
Law Enforcement	28	3.3%	24	4.5%	34.8%
Missing/Elopement	3	0.4%	7	1.3%	267.0%
Neglect	52	6.2%	15	2.8%	-54.6%
Total Number of Critical Incidents	**840**		**534**		

[69] Source: MCO Critical Incident Reports.

Measure 50 – Antidepressant medication management.

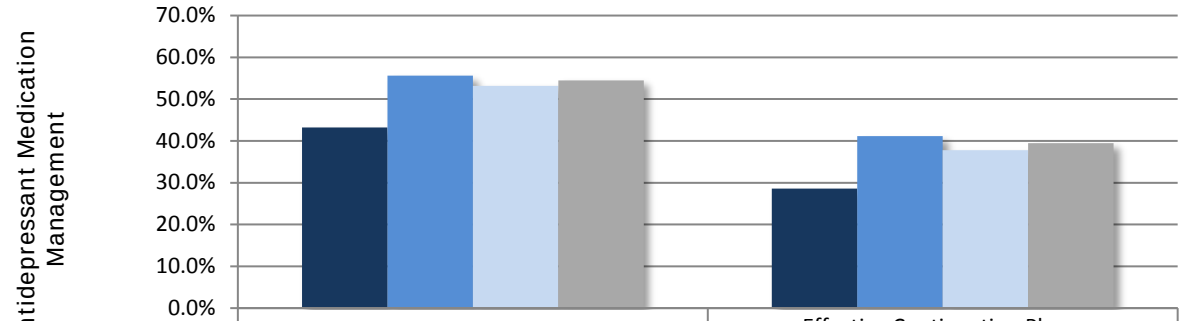
Exhibit 50 presents results for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for Antidepressant Medication Management. As illustrated, there was a decline in the effective acute phase treatment rate (-4.4%) and a decline in the effective continuation phase treatment rate (-8.1%) from DY1 to DY2. Both declines were statistically significant at the 95% confidence level.

Upon review of the individual MCO performance during the same time period, there were declines across all MCOs for the effective acute phase treatment rate: BCBS (-8.6%), MHC (-7.4%), PHP (-1.1%), and UHC (-9.4%). Of these, only the PHP decline was not statistically significant at the 95% confidence level. There were also declines across all MCOs for the effective continuation phase treatment rate: BCBS (-17.5%), MHC (-10.2%), PHP (-7.0%), and UHC (-11.3%). Of these, only the PHP decline was not statistically significant at the 95% confidence level.

The effective acute phase treatment rate increased substantially from the baseline to DY2 (22.9%), which was statistically significant at the 95% confidence level. Similarly, the effective continuation phase treatment rate increased substantially from the baseline to DY2 (32.2%), which was statistically significant at the 95% confidence level.

Upon review of the individual MCO performance from the baseline to DY2, BCBS had the largest increase for the effective acute phase treatment rate (28.1%), followed by MHC (21.5%), and UHC (11.0%). Both the BCBS and MHC rates were statistically significant at the 95% confidence level. Likewise, BCBS had the largest increase for the effective continuation phase treatment rate (31.8%), followed by MHC (38.4%) and UHC (15.7%). Both the BCBS and MHC rates were statistically significant at the 95% confidence level.

Exhibit 50 – Antidepressant Medication Management[70]



	Effective Acute Phase Treatment	Effective Continuation Phase Treatment
2013 Baseline	43.2%	28.6%
DY1 Centennial Care	55.6%	41.1%
DY2 Centennial Care	53.1%	37.8%
2015 National Avg	54.5%	39.5%

[70] Source: MCO annual HEDIS reports for 2013 – 2015. The 2013 baseline rate was adjusted in this report compared to the DY1 report due to corrected data.

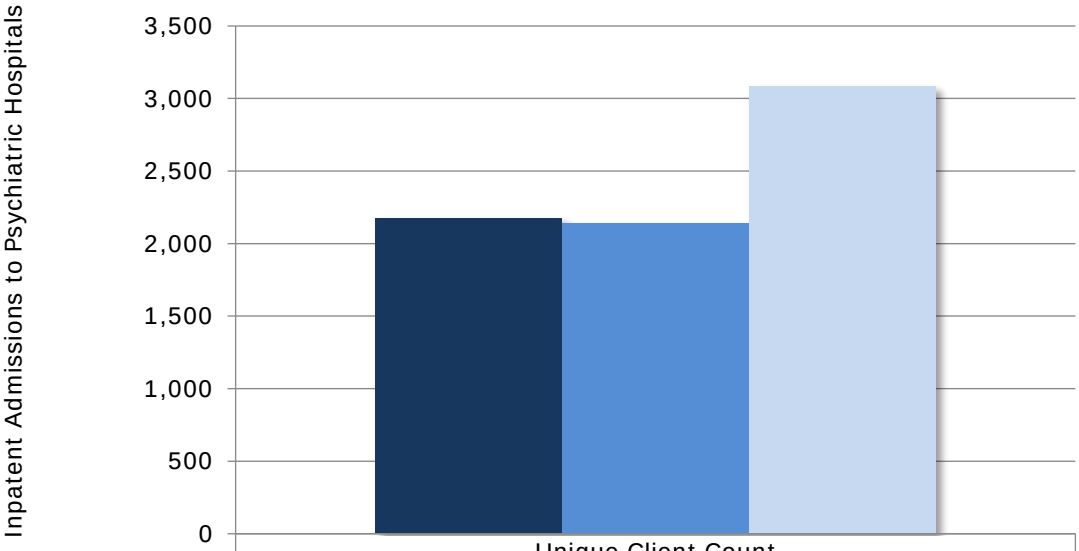
Measure 51 – Inpatient admissions to psychiatric hospitals and residential treatment centers.

Exhibit 51.a presents results for the 2013 baseline, DY1, and DY2 for the Inpatient Admissions to Psychiatric Hospitals measure in aggregate. As illustrated, the count increased 44.1% from DY1 to DY2. Similarly, the count increased by 41.8% from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 51.a – Inpatient Admissions to Psychiatric Hospitals[71]



	Unique Client Count
Baseline	2,177
DY1 Centennial Care	2,141
DY2 Centennial Care	3,086

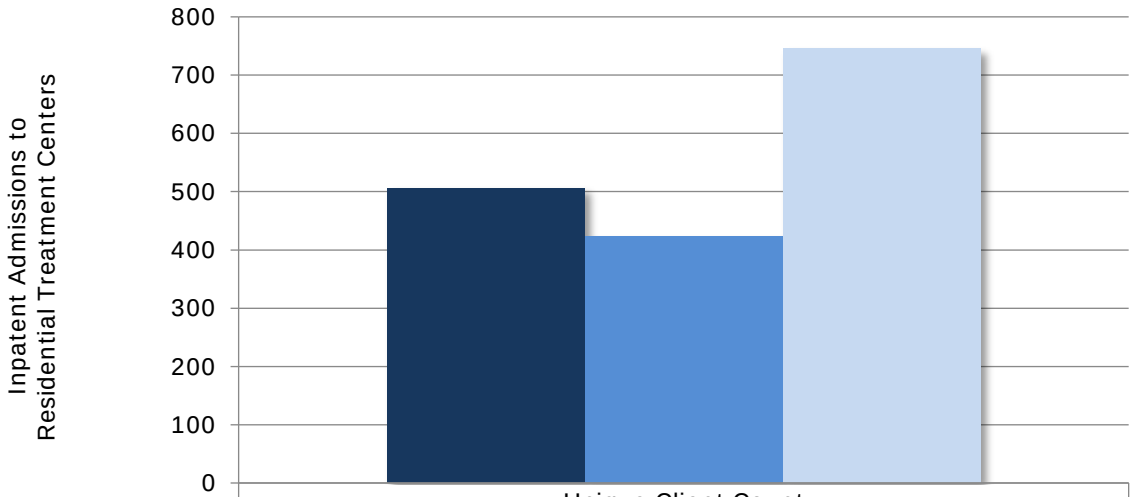
Exhibit 51.b presents counts for Admissions to Residential Treatment Centers (RTCs) in the 2013 baseline, DY1, and DY2. Note that RTCs treat Centennial Care's youth population through age 21. As illustrated, the number of inpatient admissions to RTCs increased 76.1% from DY1 to DY2. Similarly, the count increased by 47.2% from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

[71] Source: Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports.

Exhibit 51.b – Inpatient Admissions to Residential Treatment Centers[72]



	Unique Client Count
2013 Baseline	506
DY1 Centennial Care	423
DY2 Centennial Care	745

[72] Source: Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports.

Measure 52 – Percentage of nursing facility members who transitioned from a low nursing facility (NF) to a high nursing facility (NF).

Exhibit 52 presents results for DY1, DY2, and DY3 for the Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility. As illustrated, there was an increase in the percentage of members who met low nursing facility LOC (6.9%) and a decline in the percentage of members who met high nursing facility LOC (-55.1%) from DY2 to DY3. These changes were not statistically significant.

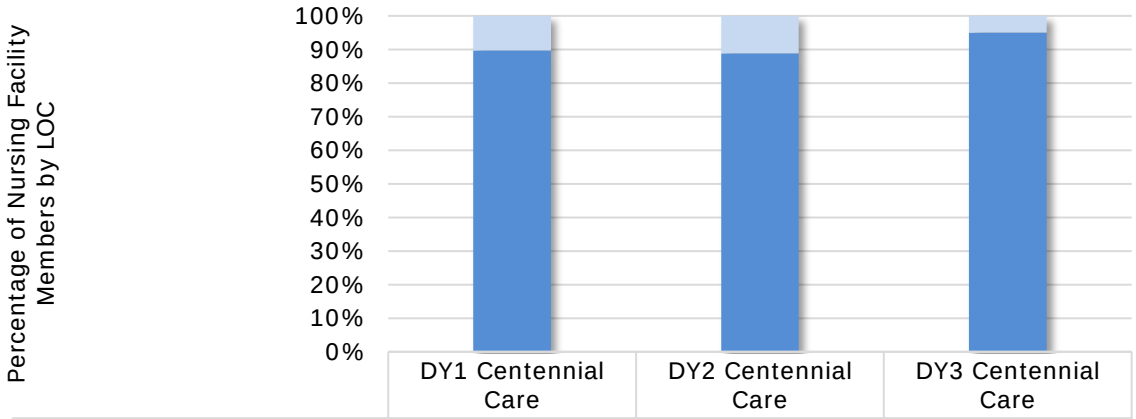
Upon review of the individual MCO performance during the same time period, the percentage of members who met low nursing facility LOC increased for BCBS (2.1%), MHC (28.2%), PHP (13.6%), and UHC (1.2%). Conversely, the percentage of members who met high nursing facility LOC declined across all MCOs: BCBS (-19.4%), MHC (-70.7%), PHP (-66.9%), and UHC (-36.7%). None of these changes were statistically significant.

The percentage of members who met low nursing facility LOC increased 5.9% while the percentage of members who met high nursing facility LOC decreased 51.4% from DY1 to DY3. These changes were not statistically significant.

Upon review of the individual MCO performance during the same time period, the percentage of members in low nursing facilities increased for BCBS (4.7%), MHC (16.3%), PHP (14.5%), and UHC (1.5%) and the percentage of members who met high nursing facility declined for all MCOs: BCBS (-34.7%), MHC (-60.6%), PHP (-68.2%), and UHC (-42.1%). None of these changes were statistically significant.

A national comparison rate could not be identified for this measure.

Exhibit 52 – Percent of NF Residents by LOC[73]



	DY1 Centennial Care	DY2 Centennial Care	DY3 Centennial Care
Percentage of Members who Meet High Nursing Facility Acuity	10.3%	11.2%	5.0%
Percentage of Members who Meet Low Nursing Facility Acuity	89.7%	88.8%	95.0%

[73] Source: MCO reports for 2014 – 2016 (HSD 8).

Measure 53 – Fall risk intervention.

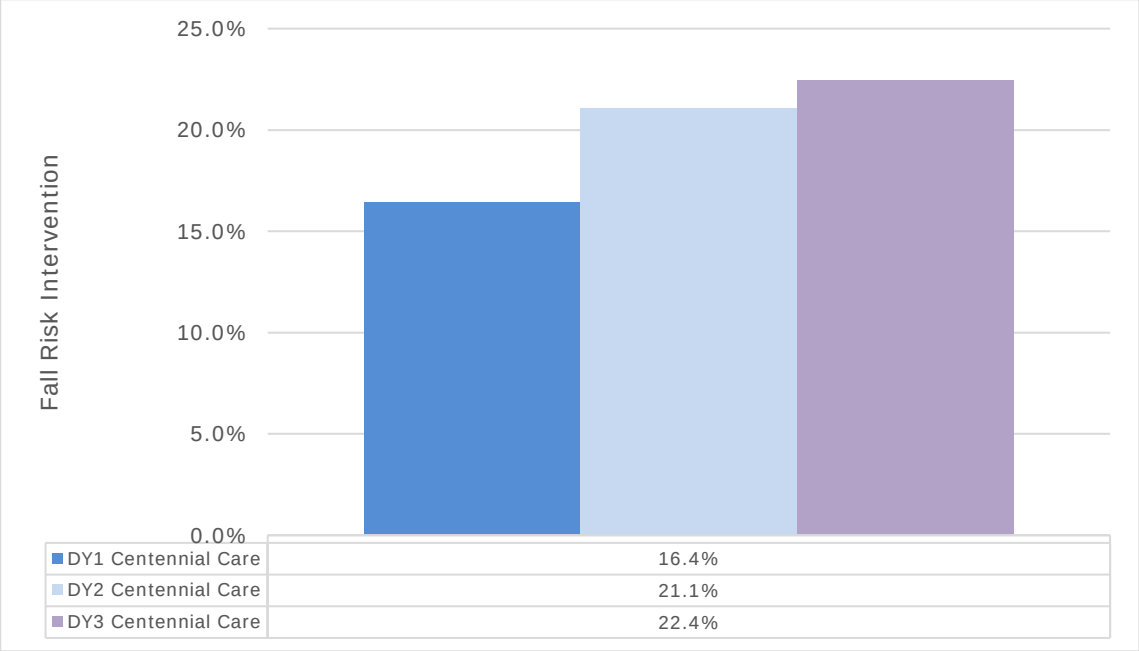
Exhibit 53 presents rates for DY1, DY2, and DY3 for Fall Risk Intervention, which measures members 65 years of age and older who have had a fall or problem with balance in the 12 months and who were seen by a provider and who received a fall risk intervention. It should be noted that the data source for this measure was revised and therefore the DY1 baseline has been modified to reflect the new data source.

As illustrated, the percentage of members that received a fall risk intervention increased from 21.1% in DY2 to 22.4% in DY3 (a 6.6% change).

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data.

Exhibit 53 – Fall Risk Intervention[74]



[74] Source: NM HEDIS rates calculated by Mercer for 2014 – 2015.

Research Question 2.B

Is care integration effective under Centennial Care?

The Centennial Care waiver consolidates services within a single program and seeks to improve care delivery through an integrated model of care that includes PH, BH, and LTSS and provides a care coordination benefit to all members.

The Evaluation is reviewing Centennial Care's impact on care integration through analysis of 11 measures that address utilization of PCP, BH, LTSS, ER and ambulatory health services, nursing facility transition and HCBS, movement between care coordination levels, and HEDIS measures for co-occurring PH and BH conditions. For each measure, performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs' care integration efforts show mixed results with respect to managing member acuity and improving the utilization of outpatient services.

Rates improved in 4 out of 11 measures from the baseline to DY2. New Mexico saw increases in the percentage of members who had a BH service and also received an LTSS service, and increases in the percentage of members who had a BH service and also received an outpatient ambulatory visit in the same year. There were also improvements across subcomponents for the care coordination level transitions and favorable declines in the percentage of members with BH needs who had an ER visit.

The percentage of members accessing a LTSS service and a PCP visit and the percentage of members who had a BH service and also accessed HCBS in the same year remained relatively consistent from the baseline to DY2.

Potential opportunities for improvement were identified for 4 out of 11 measures. The percentage of members accessing both a BH service and a PCP visit in the same year declined, as did diabetes screening and monitoring rates (diabetes screening for members with schizophrenia or bipolar disorder; diabetes monitoring for members with diabetes and schizophrenia). There was also an unfavorable increase in the percentage of members with LTSS needs who had an ER visit.

There was also a decrease in the percentage of member at risk for NF placement who remained in the community, but this measure is expected to be retired as members are no longer required to enter a NF as the only means to being allocated NF LOC services, and thus the measure is no longer valid.

Emerging trends for measures that have DY3 data available indicate a continuation of baseline to DY2 trend, including continuing improvements for the percentage of members who had a BH service and also received an LTSS service, the percentage of members who had a BH service and also accessed HCBS, and improvements across subcomponents for the care coordination level transitions.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 54 – Percentage of population accessing a behavioral health service that received a PCP visit in the same year.

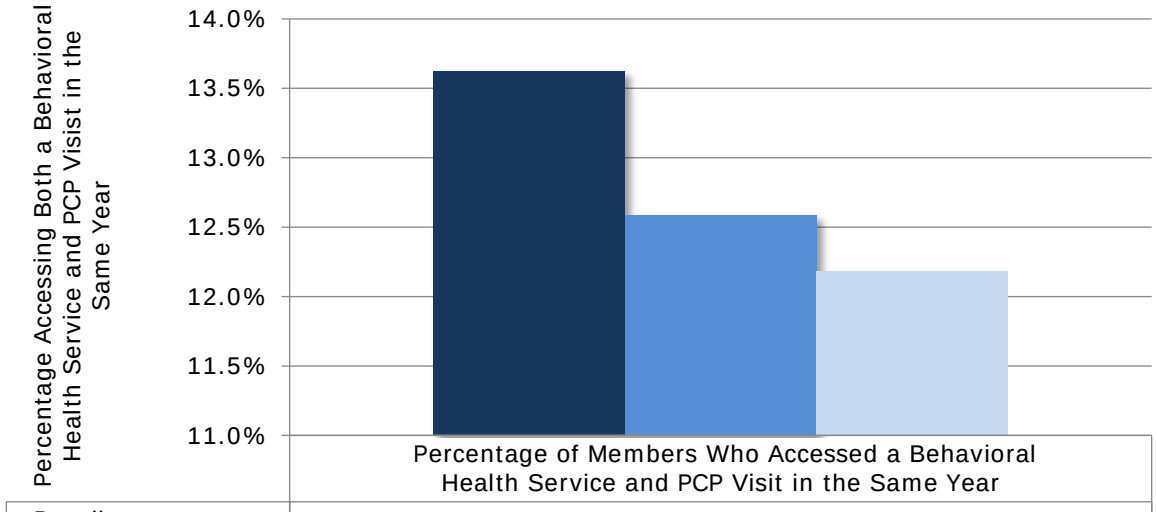
Exhibit 54 presents results for the 2013 baseline, DY1, and DY2 for the Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year. As illustrated, there was a 3.2% decline in the percentage of members that accessed both a BH service and PCP visit in the same year from DY1 to DY2. This change was statistically significant at the 95% confidence level. As mentioned in discussion of measure 15, there were significant changes in the number of BH providers participating in DY2 which had an impact on members' ability to access BH services during certain periods of DY2.

Upon review of the individual MCO performance over the same time period, PHP experienced a larger decline (-10.5%) than MHC (-4.8%), and UHC (-2.2%). BCBS experienced an 8.8% increase from DY1 to DY2.

There was a 10.6% decline in the percentage of members utilizing both a BH service and PCP visit in the same year from baseline to DY2. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 54 – Percentage of the Population Accessing a Behavioral Health Service and a PCP Visit in the Same Year[75]



Baseline	13.6%
DY1 Centennial Care	12.6%
DY2 Centennial Care	12.2%

[75] Source: BH and PCP Visits MMIS reports.

Measure 55 – Percentage of the LTSS population that received a PCP visit in the year (Percentage of population accessing an LTSS service that received a PCP visit in the same year).

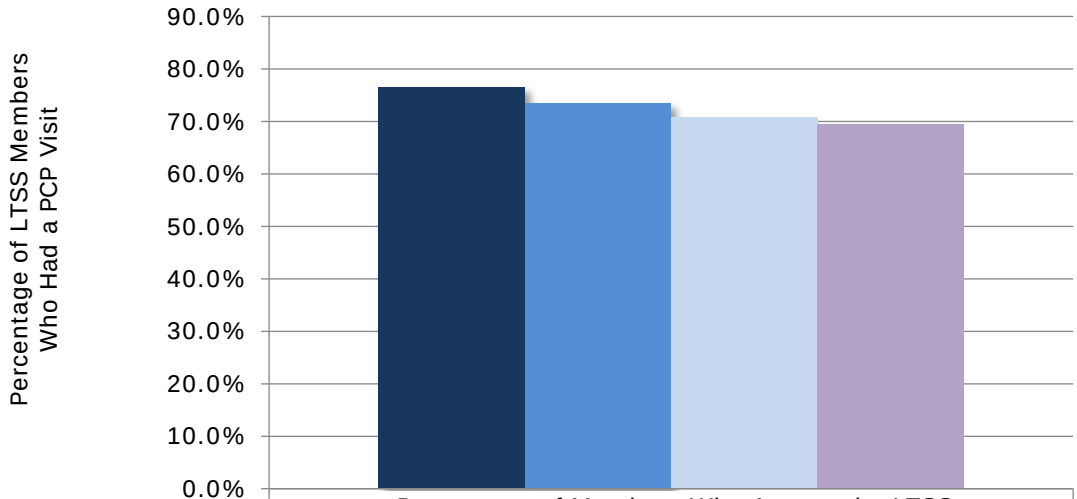
Exhibit 55 presents results for the 2013 baseline, DY1, DY2, and DY3 for the Percentage of the LTSS Population that Received a PCP Visit in the Same Year. This measure has been modified to isolate the LTSS population as the eligible population, or denominator. Previously this measure used the entire Centennial Care population as the denominator and then isolated those that received both LTSS services and a PCP visit within the reporting year. We believe this change more accurately captures the purpose of the measure, namely to measure what percent of the LTSS population, which is a higher needs, higher cost population, received a PCP visit.

As illustrated, the percentage changed from 70.7% in DY2 to 69.4% in DY3 (a -1.9% change) for the members utilizing both an LTSS service and PCP visit in the same year. This change was not statistically significant.

When analyzing changes from the baseline to DY3, there was a 9.3% decrease in percentage of members accessing an LTSS service that received a PCP visit in the same year. This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 55 – Percentage of Members Who Accessed an LTSS Service and PCP Visit in the Same Year[76]



	Percentage of Members Who Accessed a LTSS Service and PCP Visit in the Same Year
Baseline	76.5%
DY1 Centennial Care	73.5%
DY2 Centennial Care	70.7%
DY3 Centennial Care	69.4%

[76] Source: LTSS and PCP Visits MMIS reports.

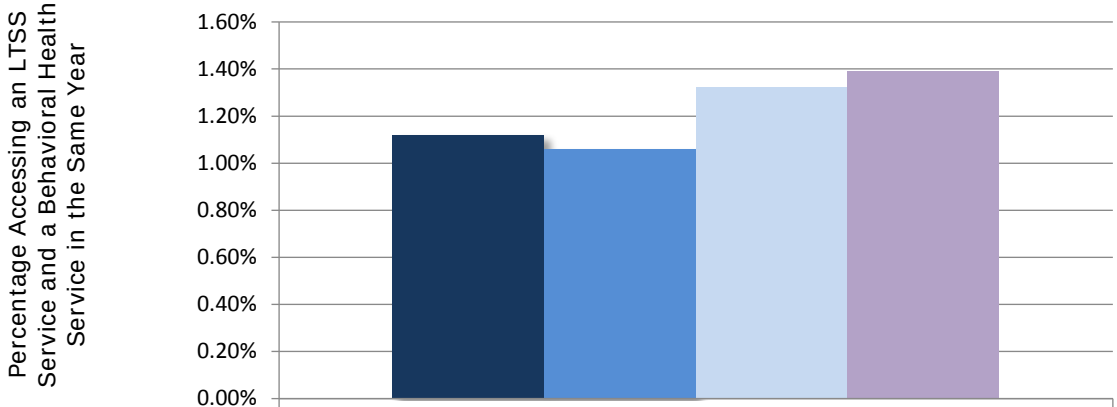
Measure 56 – Percentage of the population accessing an LTSS service and a behavioral health visit in the same year.

Exhibit 56 below presents results for the 2013 baseline, DY1, DY2 and DY3 for the measure Percentage of Participants Who Accessed an LTSS Service and a Behavioral Health Visit in the Same Year. As illustrated, there was an increase in the percentage of members accessing both LTSS and a BH service from 1.32% in DY2 to 1.39% in DY3 (a 4.89% change), and the percentage has been increasing each year since the implementation of Centennial Care. This change was not statistically significant.

Similarly, the percentage of participants accessing both an LTSS service and BH service in the same year has increased from 1.12% for the baseline to 1.39% in DY3 (a 24.20% change). This change was statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 56 – Percentage of the Population Accessing an LTSS Service and a Behavioral Health Visit in the Same Year [77]



	Percentage of Participants Who Accessed an LTSS Service and a Behavioral Health Service in the Same Year
2013 Baseline	1.12%
DY1 Centennial Care	1.06%
DY2 Centennial Care	1.32%
DY3 Centennial Care	1.39%

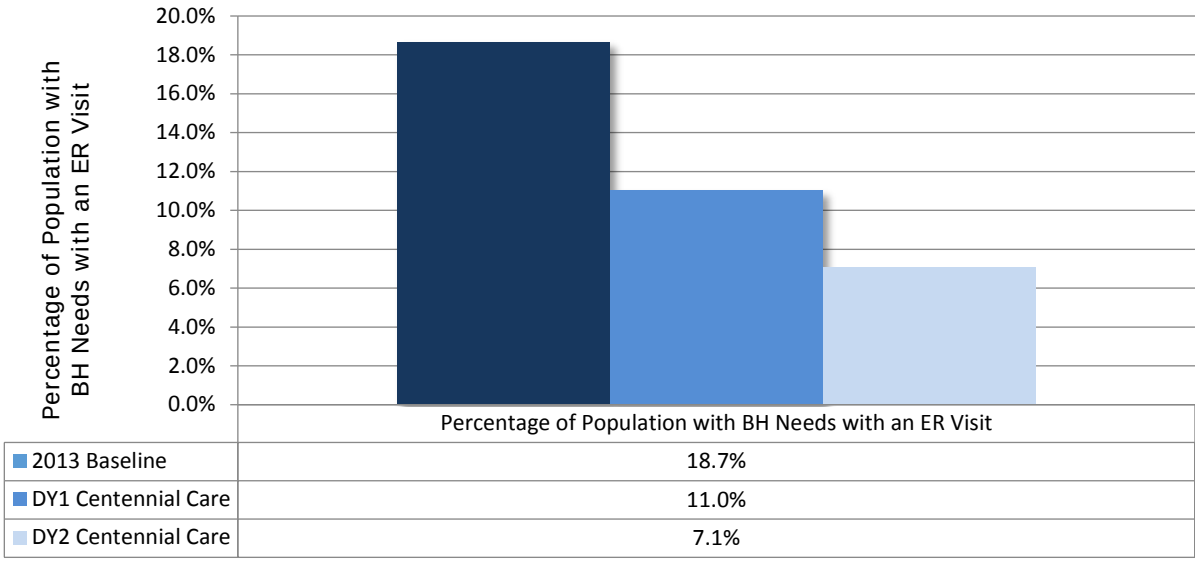
[77] Source: LTSS and BH MMIS reports.

Measure 57 – Percentage of population with behavioral health needs with an ER visit by type of ER visit.

Exhibit 57.a presents results for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with Behavioral Health Needs with an ER Visit. As illustrated, there was a favorable decline in the total percentage of members from 11.0% in DY1 to 7.1% in DY2 (a 36.5% change), and a favorable decline in the percentage from 18.7% in the baseline to 7.1% in DY2 (a 62.5% change). These changes were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 57.a – Percentage of the Population with Behavioral Health Needs with an ER Visit[78]



	Percentage of Population with BH Needs with an ER Visit
2013 Baseline	18.7%
DY1 Centennial Care	11.0%
DY2 Centennial Care	7.1%

[78] Source: BH population with ED visits MMIS reports.

Exhibit 57.b presents results for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with BH Needs with an ER Visit by Type of ER Visit. As illustrated, there were favorable declines in four (EMTALA, Moderate, Life threatening, and Admitted through the ER) of the eight ER visit types from DY1 to DY2 with a range from 7.48% to 82.76%.

There were unfavorable increases in three (Limited or Minor, Low to Moderate, and High Severity) of the eight ER visit types from DY1 to DY2 with a range from 12.59% and 23.54%.

All changes from DY1 to DY2 were statistically significant at the 95% confidence level except for EMTALA and Urgent Care ER visit changes.

There were favorable declines in all rates from the baseline to DY2. The largest decline was in urgent care visits (-95.53% change). The smallest decline was in limited to minor type ER visits (-36.91% change). All changes from the baseline to DY2 were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 57.b – Percentage of the Population with Behavioral Health Needs with an ER Visit by Type of ER Visit[79]

ER Visit Type	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care
EMTALA	0.23%	0.09%	0.08%
Urgent Care	0.02%	0.00%	0.00%
Limited or Minor	0.59%	0.32%	0.37%
Low to Moderate	1.77%	0.59%	0.73%
Moderate	6.41%	2.49%	2.21%
High Severity	7.00%	2.24%	2.52%
Life Threatening	5.39%	2.47%	2.29%
Admitted through the ER	3.57%	5.14%	0.89%

[79] Source: BH population with ED visits MMIS reports.

Measure 58 – Percentage of population with LTSS needs with an ER visit by type of ER visit.

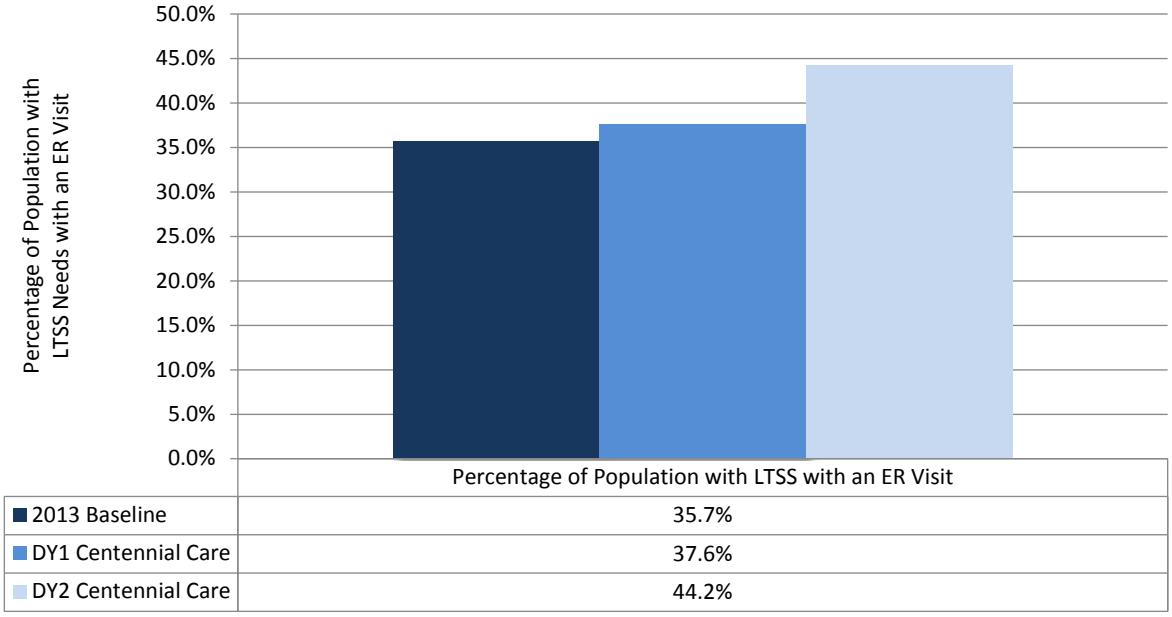
Exhibit 58.a below presents rates for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with LTSS Needs with an ER Visit. As illustrated, there was an unfavorable increase in the total rate from 37.6% in DY1 to 44.2% in DY2 (a 17.7% change).

Similarly, there was an unfavorable increase in the total rate from 35.7% in the baseline to 44.2% in DY2 (a 23.8% change).

These changes were statistically significant at the 95% confidence level.

A national comparison rate could not be identified for this measure.

Exhibit 58.a – Percentage of the Population with LTSS Needs with an ER Visit[80]



	Percentage of Population with LTSS with an ER Visit
2013 Baseline	35.7%
DY1 Centennial Care	37.6%
DY2 Centennial Care	44.2%

[80] Source: LTSS Population with ED visits MMIS reports.

Exhibit 58.b presents rates for the 2013 baseline, DY1, and DY2 for the measure Percentage of the Population with LTSS Needs with an ER Visit by Type of ER Visit. As illustrated, there was a favorable decrease in the reported rate for once (Urgent Care) of the eight ER visit types from DY1 to DY2 with a decrease from 0.02% to 0.01%.

There was an unfavorable increase in the reported rate for seven (EMTALA, Admitted through ER, Limited or Minor, Life Threatening, Low to Moderate, Moderate, and High Severity) of the eight ER visit types from DY1 to DY2 with a range of changes from 13.16% to 52.12%. There were favorable declines in two rates from the baseline to DY2: EMTALA (1.82% change) and Urgent Care (43.27% change).

All changes were statistically significant at the 95% confidence level except the changes for EMTALA and Urgent Care type ER visits.

A national comparison rate could not be identified for this measure.

Exhibit 58.b – Percentage of the Population with LTSS Needs with an ER Visit by Type of ER Visit[81]

ER Visit Type	2013 Baseline	DY1 Centennial Care	DY2 Centennial Care
EMTALA	0.30%	0.25%	0.29%
Urgent Care	0.02%	0.02%	0.01%
Limited or Minor	1.50%	1.76%	2.68%
Low to Moderate	3.91%	3.73%	4.88%
Moderate	13.33%	13.78%	16.06%
High Severity	15.18%	15.46%	19.67%
Life Threatening	13.19%	14.07%	17.22%
Admitted through the ER	8.66%	12.78%	14.47%

[81] Source: LTSS Population with ED visits MMIS reports.

Measure 59 – Number at risk for nursing facility placement who remain in the community (Percentage of the population at risk for nursing facility placement who remain in the community).

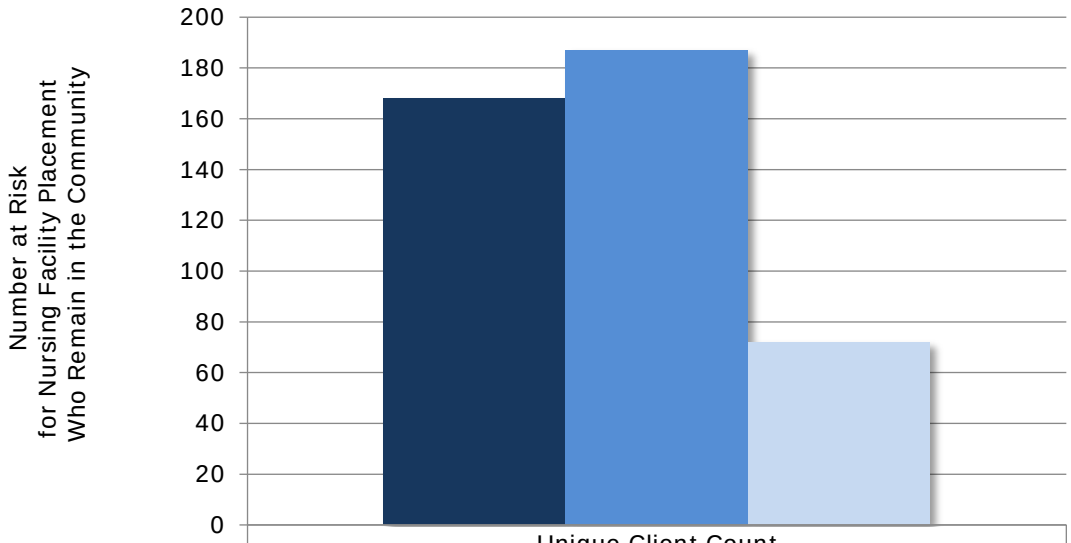
Exhibit 59 presents results for the 2013 baseline, DY1, and DY2 for the Number at Risk for Nursing Facility Placement Who Remain in the Community. As illustrated, the number of members that transitioned from NFs into the community declined 61.5% from DY1 to DY2. Similarly, the rate also declined (57.1%) from the baseline to DY2.

Although there has been a decrease in the number of members transitioning from NFs into the community, more people are accessing community benefits under Centennial Care. With the implementation of Centennial Care, members are no longer required to enter a NF as the only means to being allocated NF LOC services. As a result, this measure is no longer valid and HSD has requested that CMS retire this measure.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data.

Exhibit 59 – Number at Risk for Nursing Facility Placement Who Remain in the Community[82]



	Unique Client Count
SFY 2013 Baseline	168
SFY 2014 Centennial Care	187
SFY 2015 Centennial Care	72

[82] Source: NM Medical Assistance Division (MAD) reports.

Measure 60 – Number and percentage of members who accessed a behavioral health service that also accessed HCBS in the same year.

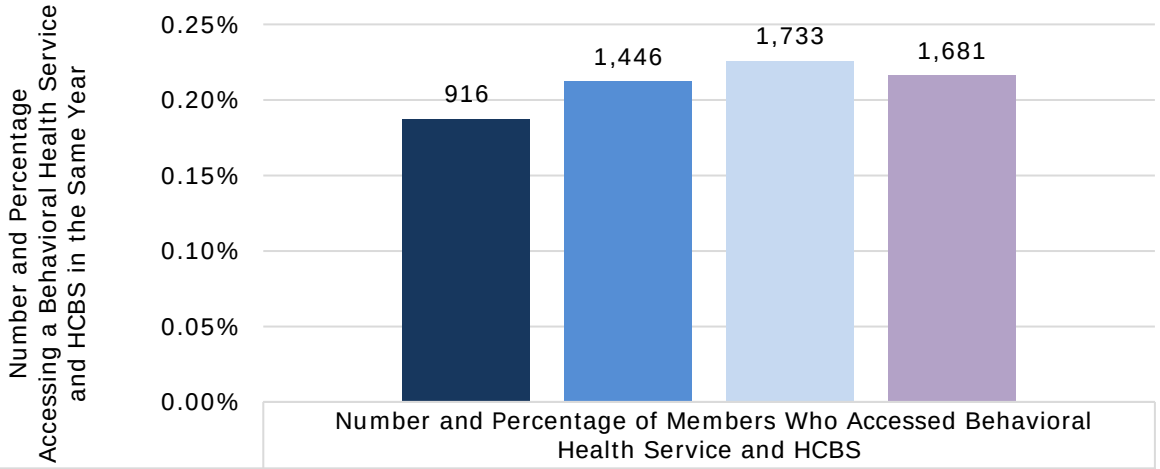
Exhibit 60 below presents results for the 2013 baseline, DY1, DY2, and DY3 for the Number and Percentage of Members who Accessed a Behavioral Health Service that also Accessed HCBS in the Same Year. As illustrated, there was a slight decrease in the percentage of members accessing both BH and HCBS services from 0.23% in DY2 to 0.22% in DY3 (a 7.53% change) which was not a statistically significant change.

Overall, results for DY3 were relatively consistent with the results from DY1 and DY2, and all three years have shown a slight increase over the baseline. As illustrated, there was an increase from 0.19% in the baseline to 0.22% in DY3 (a change of 15.37%). This change was statistically significant at the 95% confidence level.

A plan by plan analysis was performed but the results did not yield any significant outliers across any of the MCOs.

A national comparison rate could not be identified for this measure.

Exhibit 60 – Number and Percentage of Members Who Accessed a Behavioral Health Service and That Also Accessed HCBS in the Same Year[83]



2013 Baseline	0.19%
DY1 Centennial Care	0.21%
DY2 Centennial Care	0.23%
DY3 Centennial Care	0.22%

[83] Source: BH Population with HCBS MMIS reports.

Measure 61 – Number and percentage of members that maintained their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level.

Exhibit 61 presents results for DY1, DY2, and DY3 for the Number and Percentage of Members That Maintained Their Care Coordination Level, Moved to a Lower Care Coordination Level, or Moved to a Higher Care Coordination Level. As illustrated, there was a 6.9% increase in the average number of members that maintained their care coordination from DY2 to DY3. The percentage of members that maintained their care coordination level with respect to the average total number of members receiving care coordination increased by 0.4% over the same period.

There was a 7.5% increase in the average number of members that moved to a lower care coordination level from DY2 to DY3. The percentage of members that moved to a lower care coordination level with respect to the average total number of members receiving care coordination increased by 0.9% over the same period.

There was a 9.1% decrease in the average number of members that moved to a higher care coordination level from DY2 to DY3. The percentage of members that moved to a higher care coordination level with respect to the average total number of members receiving care coordination decreased by 14.6%.

Upon review of the individual MCO performance over the same period, there were slight increases in the percentage of members that maintained their care coordination level for PHP (0.8%), MHC (0.8%), BCBS (0.6%), and UHC (0.3%), and all MCOs had a DY3 rate of over 93.0% for this subcomponent. Similarly, three MCOs experienced slight increases for the percentage of members that moved to a lower level of care coordination: PHP (5.6%), MHC (3.5%), BCBS (17.6%), while UHC experienced a decline (-35.9%). The percentage of members that moved to a higher care coordination level declined across all four MCOs: PHP (-18.6%), MHC (-22.0%), BCBS (-19.2%), and UHC (-14.5%). It should be noted that the membership in this subcomponent relative to total members receiving care coordination tends to be low and for DY3 all rates were below 5.0%, therefore even a small difference in the rate year-over-year results in a relatively larger calculated percent change.

When analyzing DY1 to DY3, there was a 69.8% increase in the average number of members that maintained their care coordination, and the percentage of members that maintained their care coordination level with respect to the average total number of members receiving care coordination increased by 4.2%.

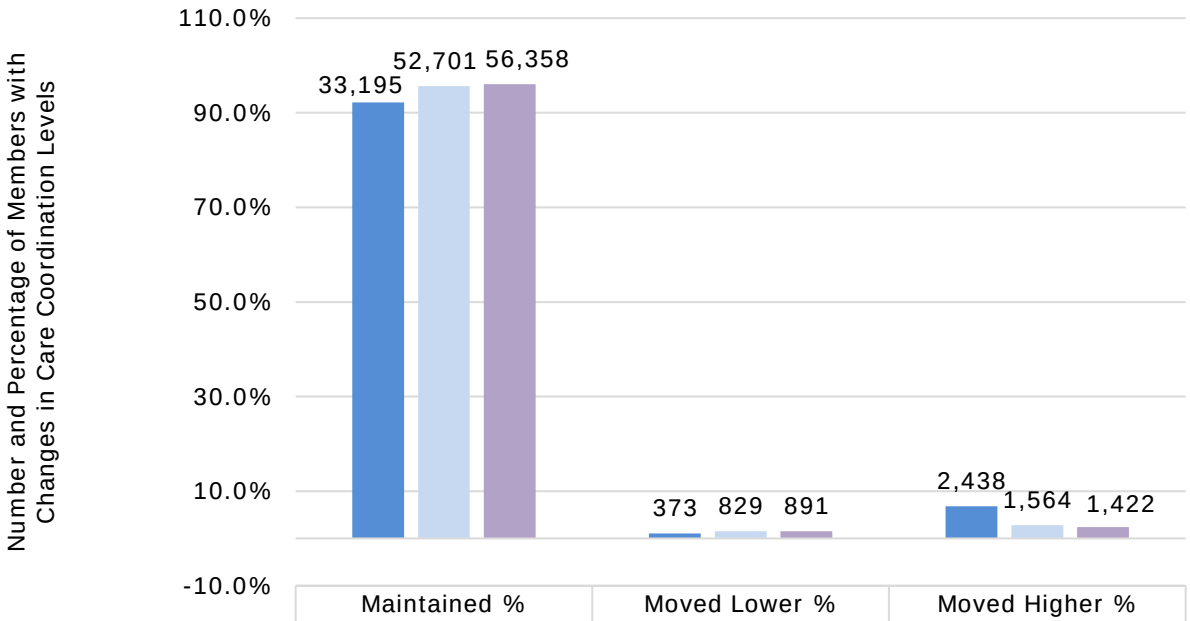
The average number of members that moved to a lower care coordination level increased 138.9% and the percentage of members that moved to a lower care coordination level with respect to the average total number of members receiving care coordination increased by 46.6% over the same period.

There was a 41.7% decrease in the average number of members that moved to a higher care coordination level from DY1 to DY3, and the percentage of members that moved to a higher care coordination level with respect to the average total number of members receiving care coordination declined by 64.2%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 61 – Number and Percentage of Members Who Maintained or Changed Care Coordination Levels[84]



	Maintained %	Moved Lower %	Moved Higher %
DY1 Centennial Care	92.2%	1.0%	6.8%
DY2 Centennial Care	95.7%	1.5%	2.8%
DY3 Centennial Care	96.1%	1.5%	2.4%

[84] Source: MCO ad hoc care coordination reports for 2014 – 2016.

Measure 62 – Percentage of population accessing a behavioral health service that received an outpatient ambulatory visit in the same year.

Exhibit 62 presents results for the 2013 baseline, DY1, and DY2 for the Percentage of the Population Accessing a Behavioral Health Service that Received an Outpatient Ambulatory Visit in the Same Year. As illustrated, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year increased from 13.9% in DY1 to 15.6% in DY2 (a 12.7% change). This change was statistically significant at the 95% confidence level.

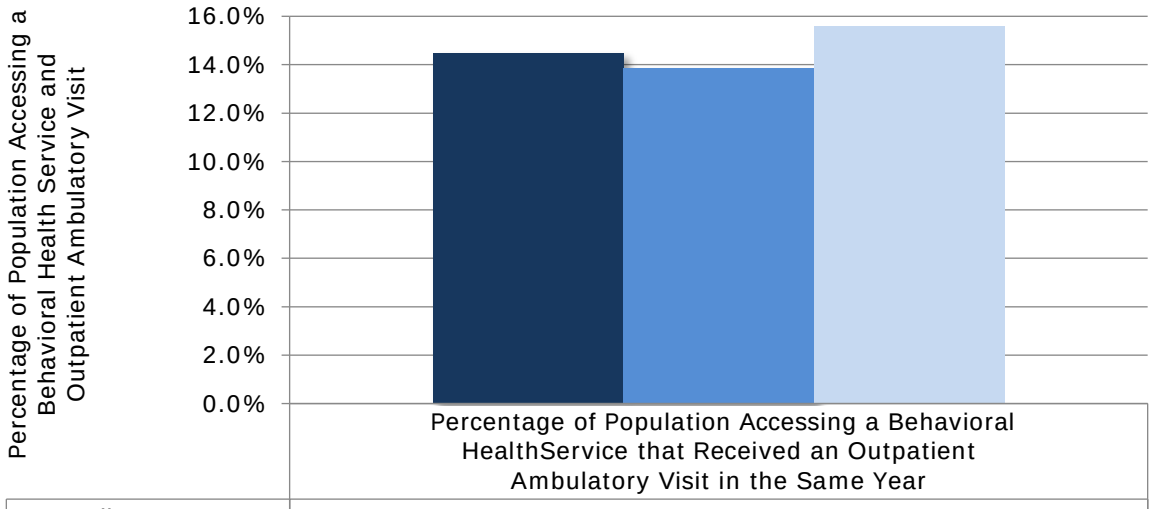
Upon review of the individual MCO performance over the same time period, there were increases in the percentage of members accessing a BH service that received an outpatient ambulatory visit in the same year for BCBS (25.9%), MHC (9.8%), PHP (3.6%), and UHC (19.2%).

When analyzing the baseline to DY2 performance trend, the percentage of members utilizing both a BH service and outpatient ambulatory visit in the same year increased from 14.5% to 15.6% (a 7.7% change). This change was statistically significant at the 95% confidence level.

A plan by plan analysis was not performed for baseline to DY2 because there was not a direct comparison based on the plans that participated during the baseline measurement period.

A national comparison rate could not be identified for this measure.

Exhibit 62 – Percentage of Population Who Accessed a Behavioral Health Service and Outpatient Ambulatory Visit in the Same Year[85]



	Percentage of Population Accessing a Behavioral HealthService that Received an Outpatient Ambulatory Visit in the Same Year
Baseline	14.5%
DY1 Centennial Care	13.9%
DY2 Centennial Care	15.6%

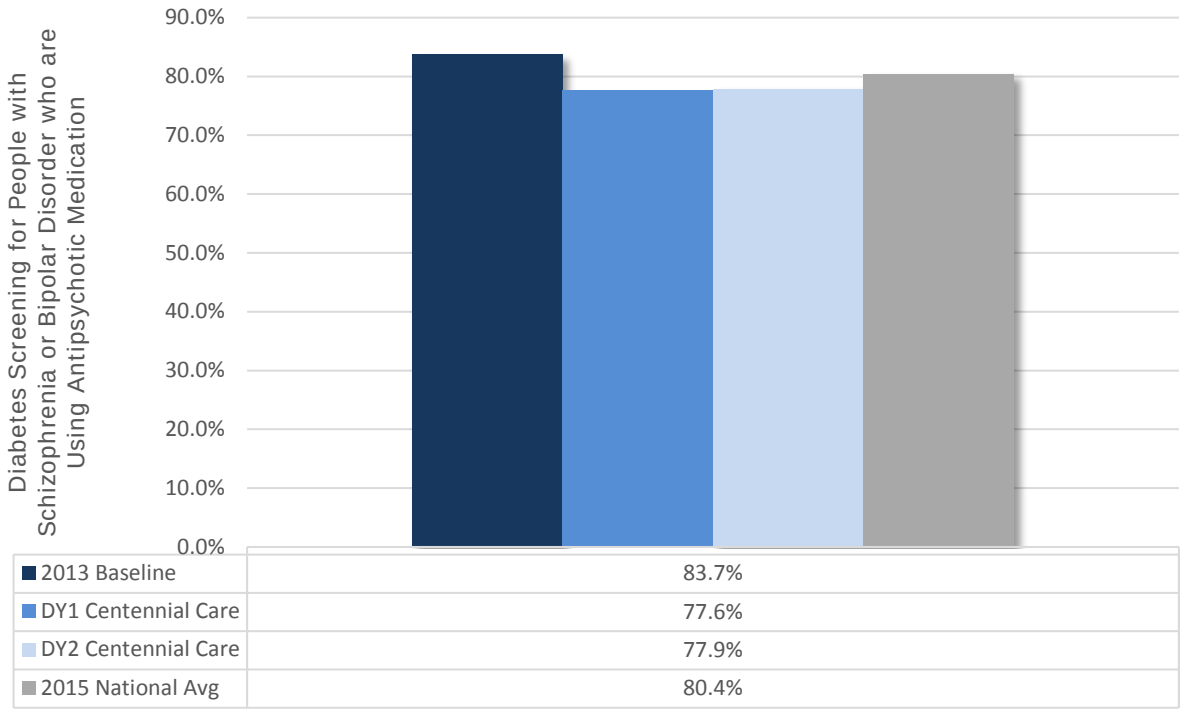
[85] Source: BH Clients with Outpatient Ambulatory Visits MMIS reports.

Measure 63 – Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications.

Exhibit 63 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. As illustrated, there was a modest increase (0.3%) in the rate from DY1 to DY2, but the change was not statistically significant at the 95% confidence level.

The rate declined from the baseline to DY2 (-7.0%), which was statistically significant at the 95% confidence level. Upon review of the individual MCO performance during the same time period, there were no changes that were statistically significant at the 95% confidence level.

Exhibit 63 – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication[86]



2013 Baseline	83.7%
DY1 Centennial Care	77.6%
DY2 Centennial Care	77.9%
2015 National Avg	80.4%

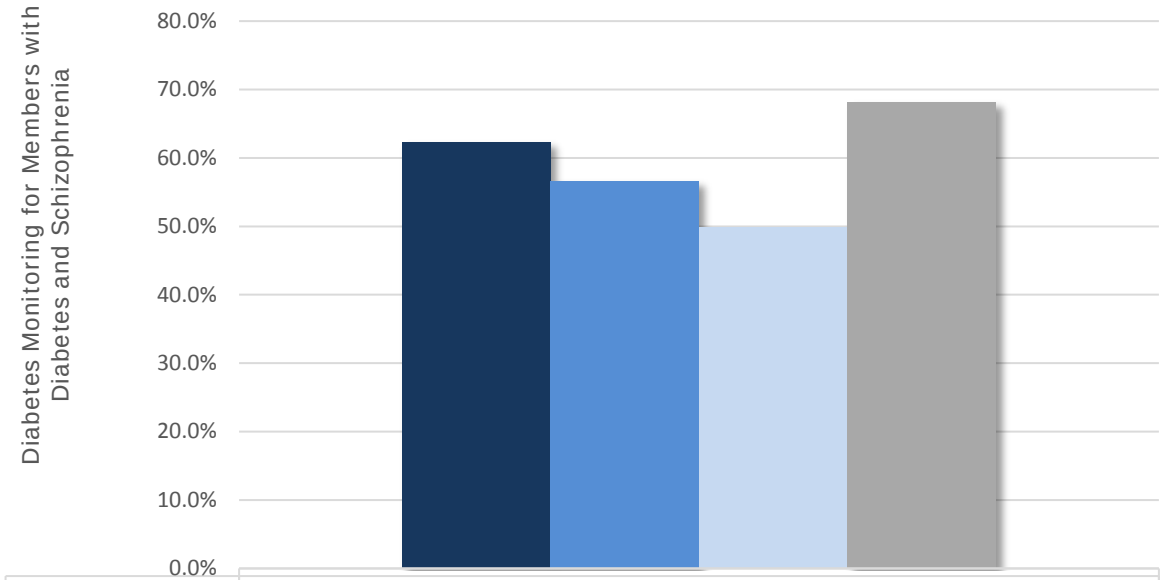
[86] Source: MCO annual HEDIS reports for 2013 – 2015.

Measure 64 – Diabetes monitoring for people with diabetes and schizophrenia.

Exhibit 64 presents rates for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average for the measure Diabetes Monitoring for People with Diabetes and Schizophrenia. As illustrated, there was a decline in the rate from DY1 to DY2 (-11.8%), which was statistically significant at the 95% confidence level. Upon review of the individual MCO performance during the same time period, PHP was the only MCO that experienced a statistically significant decline, with a decline of 26.8%.

The rate declined more drastically from the baseline to DY2 (-20.0%). This decline was also statistically significant at a 95% confidence level. Of the two plans for which there was sufficient data to calculate rates for both time periods, PHP's decline (-28.4%) was statistically significant at the 95% confidence level, while UHC's decline (-15.0%) was not.

Exhibit 64 – Diabetes Monitoring for Member with Diabetes and Schizophrenia[87]



2013 Baseline	62.4%
DY1 Centennial Care	56.6%
DY2 Centennial Care	49.9%
2015 National Avg	68.2%

[87] Source: MCO annual HEDIS reports for 2013 – 2015.

Hypothesis 3

The rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services.

Hypothesis 3 asks whether the rate of growth in program expenditures under Centennial Care will trend lower over the course of the waiver through lower utilization and/or substitution of less costly services. The Evaluation found that the State's managed care program is achieving cost savings based on budget neutrality expectations and is generally seeing a shift from what are typically more costly services to less costly services.

The information illustrated in some of the tables was compiled from Centennial Care MCO reported utilization data. The information presented is aggregated for all Medicaid populations for the Physical Health and Behavioral Health groupings. The data presented has not been adjusted to account for changes in the enrollment between populations (physical health and Other Adult Group) or the changes in the proportion enrollment (age / gender) that occurred between periods.

The Other Adult Group population experienced significant growth between DY1 and DY3, and based on discussions with the State, more acute and higher cost individuals enrolled in DY1 and less acute enrolled later (DY2 and DY3). These enrollment changes likely influenced the per 1,000 statistics reported for each year and may cause significant variation in the percentage change reported.

In addition, the State has indicated that some Centennial Care MCOs changed their provider networks which resulted in either expanding or eliminating certain sub-capitated arrangements between the years presented. Since the data presented is non-capitated utilization, these changes may have affected the results in the utilization for services like non-emergency transportation which is often covered through a sub-capitated arrangement.

It should also be noted that the data has not been adjusted for impacts associated with fee schedule and benefit changes implemented by HSD during DY2 and DY3. The changes include:

- Increases to private nursing facilities low bed day reimbursement (July 1, 2015)
- Reductions to dental services provided in outpatient facilities (December 1, 2015)
- Reductions to professional dental reimbursement (July 1, 2016)
- Reductions to community benefit reimbursement (July 1, 2016)
- Reductions to outpatient hospital reimbursement, excluding outpatient dental (July 1, 2016)
- Reductions to inpatient hospital reimbursement (July 1, 2016)
- Reductions to professional fee schedule (August 1, 2016)
- Patient loss on Ability (April 2015 - impacts behavioral health pharmacy cost)
- Added autism spectrum disorder service coverage (May 2015)

Research Question 3.A

To what extent did service utilization and costs increase or decrease due to the implementation of the Centennial Care program for Medicaid/CHIP beneficiaries in New Mexico?

As previously mentioned under Research Questions 1.A – 1.C, the Centennial Care waiver seeks to manage medical service utilization through care coordination for the Medicaid managed care population and to control cost by consolidating covered services within an integrated health care delivery system.

The Evaluation is reviewing Centennial Care's Budget Neutrality as stipulated in the STCs and utilization management through analysis of 15 performance measures that track total costs and cost per member for specific eligibility groups as well as utilization trends for various categories of service. Service categories tracked include ER use, HCBS, hospital costs, mental health and substance abuse services, and use of pharmaceuticals, among others. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY3 of the program, costs continue to be budget neutral and utilization is shifting away from more costly services. There were clear improvements in 9 of 15 performance measures and their subcomponents, with five other measures showing both positive and negative results depending on the subcomponent and two showing a decline.

New Mexico saw improvement from the baseline to DY3 for total program expenditures, costs per member, and costs per user for five out of six MEGs for each of the three measures. There were also increases in most subcomponents for the use of mental health services, increases in the use of substance abuse services and use of HCBS, and positive shifts for pharmacy utilization where usage of generic drugs is more prevalent than brand drugs. Inpatient services exceeding $50,000 and all cause readmission rates have also seen favorable declines.

There were mixed results for 3 out of 15 measures, particularly measures with multiple subcomponents. These include utilization by category of service, where there were favorable decreases in average length of stay for acute and specialty hospitals and favorable decreases in higher LOC NF use while lower LOC NF use increased, a positive utilization shift to less costly services. Other categories such as non-emergency transportation had unfavorable increases in utilization from the baseline to DY3. The use of institutional care experienced increases in days per thousand but decreases in admits per thousand. Use of inpatient and mental health/substance abuse services also saw increases in services in the RTC setting though the psychiatric hospital setting remained fairly consistent.

There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and for ED use, all of which experienced unfavorable increases. However it is important to note that diagnostic imaging costs remain very immaterial and ED utilization has trended down year-over-year from DY1 to DY3.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 65 – Total program expenditures.

Exhibit 65.a and Exhibit 65.b presents total costs by MEG for DY1, DY2, and DY3 compared to the baseline projected program expenditures. In Exhibit 65.a and Exhibit 65.b, "DYX STC" indicates the projected dollar cost for a particular MEG by multiplying the PMPM for a particular demonstration year by the actual member months for the same demonstration year. The goal of the Centennial Care Waiver is to meet budget neutrality requirements, which is to say that the total "with waiver" costs do not exceed the total "without" waiver costs. As illustrated, total costs by MEG for DY1, DY2, and DY3 were below cost projections for all MEGs apart from the NF LOC Dual group[88]. Total DY3 costs as of March 6, 2017 were 21.8% below the STC cost projections for DY3.

The Group VIII (Medicaid-expansion eligible adults) and TANF groups experienced the greatest dollar difference between projected costs and actual costs in DY3. The SSI-Dual group also experienced material differences between projected and actual costs in DY3, where actual costs were 30.7% below projected costs and made up the third largest dollar difference.

The significant difference in comparing baseline projected costs to actual expenditures for the NF LOC group is partially attributable to the large PMPM cost cap that was estimated for this group. Under STC 107 that cost cap is $4,936.92 PMPM for DY1, and will increase by 3.1% per year through the end of DY5. The reportable data from CMS-64 Schedule C and the HSD Budget Neutrality tables submitted to CMS indicate relatively lower costs for the NF LOC population. In addition, with less than 3,000 member months attributed to this MEG, the variance between actual costs from costs estimated from STC 107 is greater than the variance between actual and estimated costs under MEGs with a larger population base.

In regards to the NF LOC Dual group, HSD determined that the estimated PMPM for budget neutrality included a population of healthy duals. Healthy duals have a very low cost PMPM which, when weighted across the whole NF LOC Dual population, pushed the estimated PMPM down. The final CMS approved population attributed to NF LOC Dual for the waiver demonstration did not include the aforementioned healthy duals, yet their costs were included in the estimated PMPM under STC 107. With the waiver demonstration population for NF LOC Dual not including healthy duals, the PMPM cost increased relative to the original estimates and NF LOC Dual exceeds the budget neutrality "test one" limit.

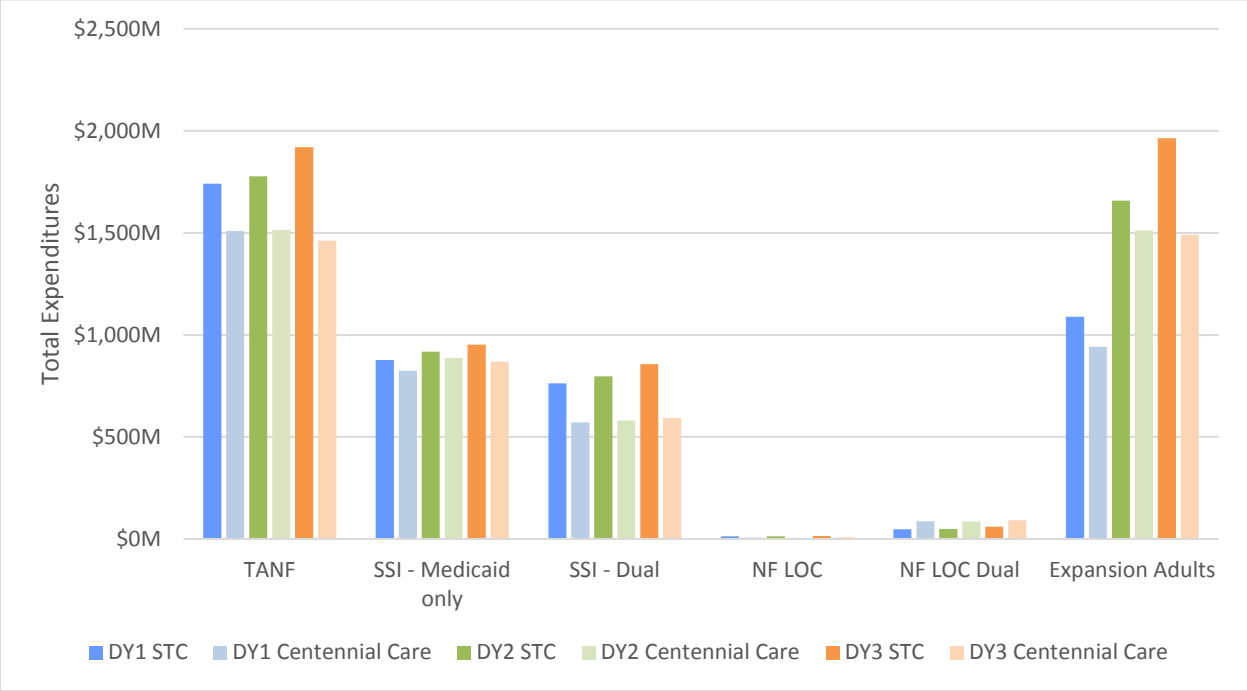
The footnote of Exhibit 65.b below specifies that the cost comparison for TANF members does not include the costs and member months for children living in families with incomes between 133% and 185% of the federal poverty level as those costs and member months were reported under CHIP. Expenses reported in CHIP are not subject to budget neutrality, except when the State has exhausted its CHIP allotment (STCs 99 to 101). The impact of excluding the costs and member months of these children in TANF is that the reportable costs and member months for TANF were understated relative to the baseline.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[88] The MEGs "NF LOC" and "NF LOC Dual" are equivalent to the MEGs "217-like Medicaid" and "217-like Group Dual" respectively as defined by STC 18.

Exhibit 65.a – DY1 to DY3 Total Program Expenditures by MEG[89]



[89] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 65.b – DY1 to DY3 Total Program Expenditures by MEG[90]

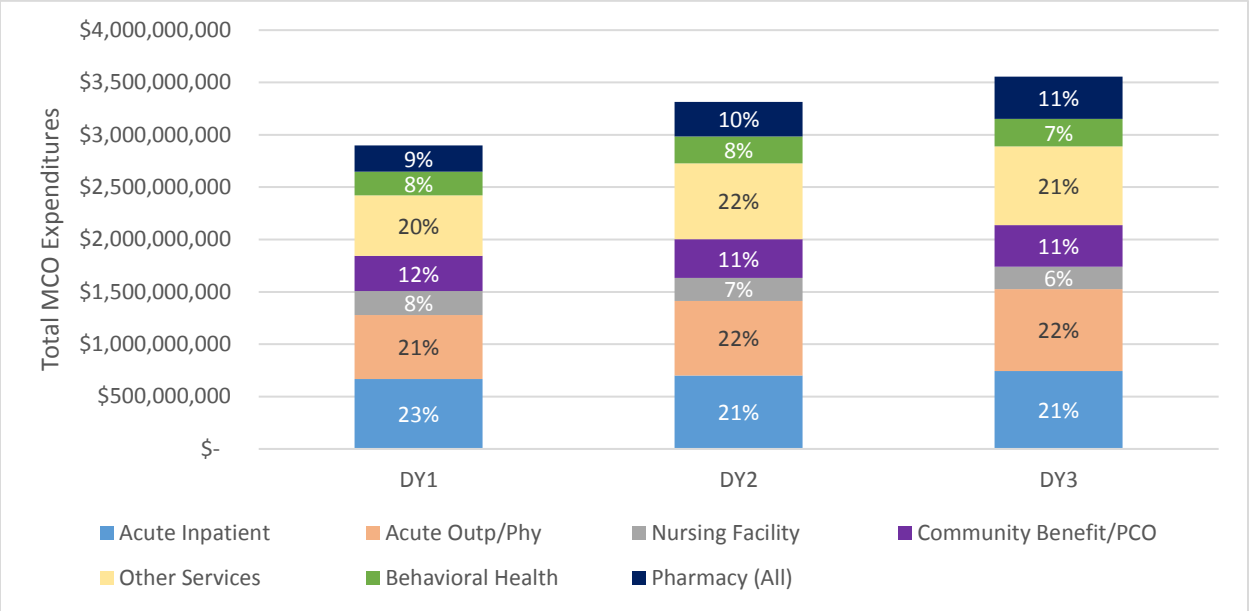
Year and Measure		TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults	Uncompensated Care	HQII	Total
2014	STC	$1,741,829,516	$877,545,542	$762,650,368	$13,403,738	$47,908,778	$1,088,709,391	$68,889,322	$0	**$4,600,936,654**
	Centennial Care	$1,508,687,841	$824,511,459	$570,589,894	$6,662,907	$86,784,521	$941,763,087	$68,889,323	$0	**$4,007,889,032**
	Measured Over/ (Under) Baseline	($233,141,675)	($53,034,083)	($192,060,474)	($6,740,831)	$38,875,743	($146,946,304)	$1	$0	**($593,047,622)**
	% Measured Over / (Under) Baseline	-13.4%	-6.0%	-25.2%	-50.3%	81.1%	-13.5%	0.0%	0.0%	**-12.9%**
2015	STC	$1,777,899,080	$917,996,550	$796,997,595	$12,369,818	$49,614,962	$1,657,978,073	$68,889,322	$2,824,462	**$5,284,569,863**
	Centennial Care	$1,515,008,918	$886,963,101	$581,487,225	$5,631,972	$84,975,937	$1,511,725,079	$68,889,323	$2,824,462	**$4,657,506,017**
	Measured Over/ (Under) Baseline	($262,890,162)	($31,033,449)	($215,510,370)	($6,737,846)	$35,360,975	($146,252,994)	$1	$0	**($627,063,846)**
	% Measured Over / (Under) Baseline	-14.8%	-3.4%	-27.0%	-54.5%	71.3%	-8.8%	0.0%	0.0%	**-11.9%**
2016	STC	$1,920,328,873	$952,799,905	$856,853,167	$14,827,775	$60,473,905	$1,963,790,716	$68,889,322	$5,764,727	**$5,843,728,390**
	Centennial Care	$1,462,319,710	$868,969,133	$593,582,822	$7,962,326	$90,826,284	$1,490,021,951	$51,667,000	$5,764,727	**$4,571,113,953**
	Measured Over/ (Under) Baseline	($458,009,163)	($83,830,772)	($263,270,345)	($6,865,449)	$30,352,379	($473,768,765)	($17,222,322)	$0	**($1,272,614,437)**
	% Measured Over / (Under) Baseline	-23.9%	-8.8%	-30.7%	-46.3%	50.2%	-24.1%	-25.0%	0.0%	**-21.8%**

[1]The expenses and member months of the optional children who qualified for Medicaid under Sections 1902(a)(10)(A)(u)(IX) and 1902(l)(2) were included in MEG1 – TANF and Related for the calculation of the PMPM cost "without waiver", but the actual expenses and member months of this group of children were reported under the CHIP program, which is not subject to budget neutrality testing.

The Evaluation also examined data summarized by Mercer which demonstrates the distribution of total program expenditures by service category in DY1, DY2, and DY3. As Exhibit 65.b illustrates, the distribution of program expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steady increase in expenditures for pharmacy. There has also been a steady decrease in expenditures for NF, which aligns to program goals for moving members to the community care setting when able. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total program expenditures in each year. Meanwhile NF has been the least expensive service category, costing less than 10% of program expenditures in each year.

[90] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016. The 2016 uncompensated care payment consists of three quarters of payments; one quarter of payments have not been made and reported as of December 31, 2016

Exhibit 65.b – DY1 to DY3 Total Program Expenditure Distribution by Service Category[91]



Measure 66 – Costs per member.

Exhibit 66.a presents the annual cost per member for DY1, DY2, and DY3 compared to the baseline PMPM costs. In the exhibit, "DYX STC" is the PMPM caps by MEG for that particular demonstration year. The budget neutrality goal of the Centennial Care Waiver is to ensure that the "with waiver" PMPM costs for each MEG do not exceed the "without waiver" PMPM costs for each MEG. Furthermore, the State is not at risk for total expenditures as a result of increases in membership. As illustrated, and consistent with measure 65, the costs for all MEGs stayed below the MEG PMPM cap throughout DY1 to DY3 apart from the NF LOC Dual group.

In addition, the PMPM costs for all MEGs experienced decreases in the range of 1.0% to 12.5% from DY2 to DY3, apart from the NF LOC group. The PMPM reduction is particularly noteworthy for the Expansion Adults population, which is population that had not previously had access to these benefits and has continued to experience tremendous enrollment growth since DY1. The PMPM costs for this group in particular decreased 12.5% from DY2 to DY3 and decreased 3.1% from DY1 to DY3.

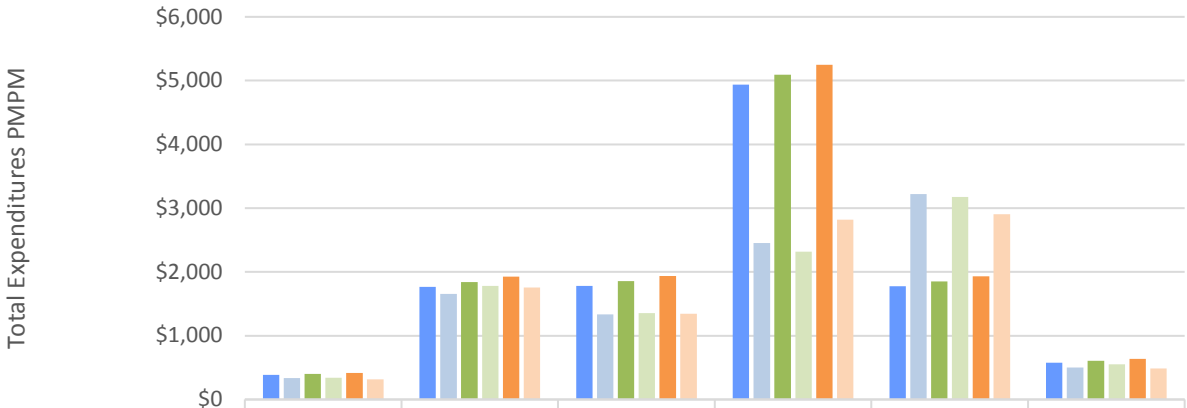
The aggregate program PMPM decreased 7.6% from DY2 to DY3 and decreased 2.6% from DY1 to DY3. These decreases in PMPM by MEG demonstrates that the Centennial Care program is experiencing success with respect to cost containment, a principal goal of the program.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

[91] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Exhibit 66.a – DY1 to DY3 PMPM Expenditures by MEG[92]

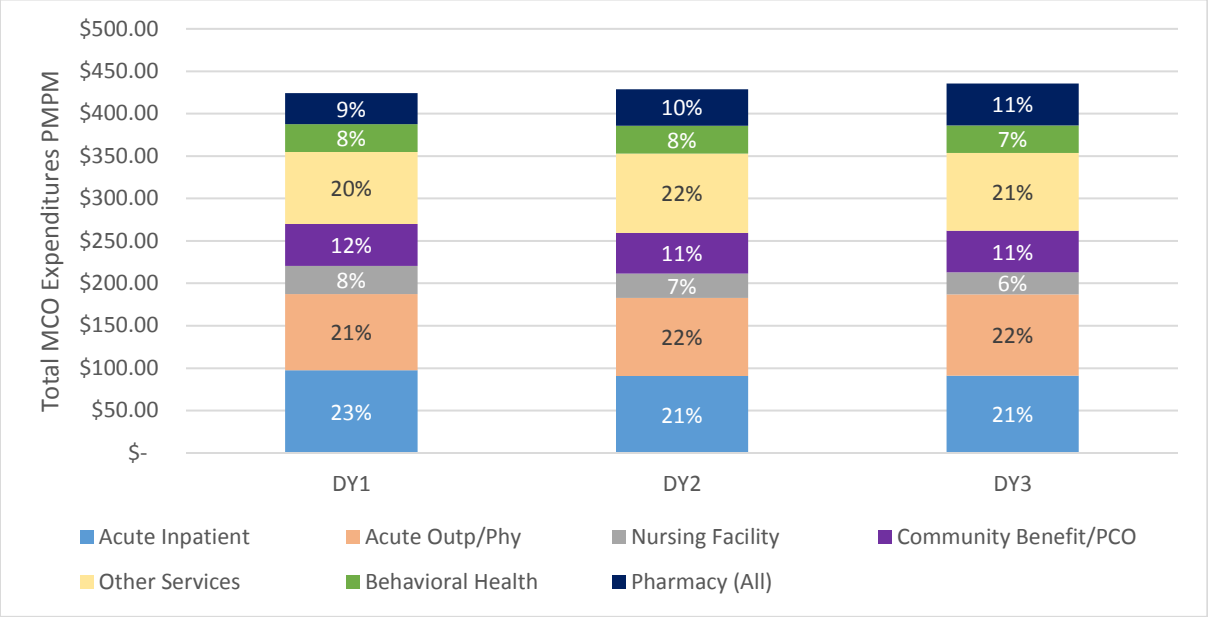


	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$385.80	$1,763.90	$1,780.77	$4,936.92	$1,776.90	$577.87
DY1 Centennial Care	$334.16	$1,657.30	$1,332.31	$2,454.11	$3,218.77	$499.87
DY2 STC	$400.77	$1,842.83	$1,857.34	$5,090.46	$1,853.31	$607.34
DY2 Centennial Care	$341.51	$1,780.53	$1,355.11	$2,317.68	$3,174.18	$553.77
DY3 STC	$416.32	$1,925.21	$1,937.21	$5,248.77	$1,933.00	$638.31
DY3 Centennial Care	$317.03	$1,755.82	$1,342.00	$2,818.52	$2,903.19	$484.32

The Evaluation also examined data summarized by Mercer which shows the distribution of PMPM program expenditures by service category in DY1, DY2, and DY3. As Exhibit 66.b illustrates, and consistent with measure 65 above, the distribution of PMPM expenditure has been relatively stable throughout DY1 to DY3. Notable trends from DY1 to DY3 include the steadily increasing PMPM expenditures for pharmacy and steadily decreasing PMPM expenditures for NF. Overall, acute inpatient, acute outpatient/physician, and other services remain as the largest spending categories PMPM. In particular, acute inpatient and acute outpatient/physician services together make up over 40% of total PMPM expenditure in each year. Meanwhile nursing facility has been the least expensive service category, making up less than 10% of total PMPM expenditures in each year.

[92] Source: Budget Neutrality tables, sourced from CMS-64 Schedule C, Quarter End December 2016.

Exhibit 66.b – DY1 to DY3 PMPM Expenditure Distribution by Service Category[93]



[93] Source: Data summarized by Mercer based on financial statements submitted by MCOs. MCO expenditures are not the same as Centennial Care total program expenditures, though cost distribution across categories of service would generally align.

Measure 67 – Costs per user of services.

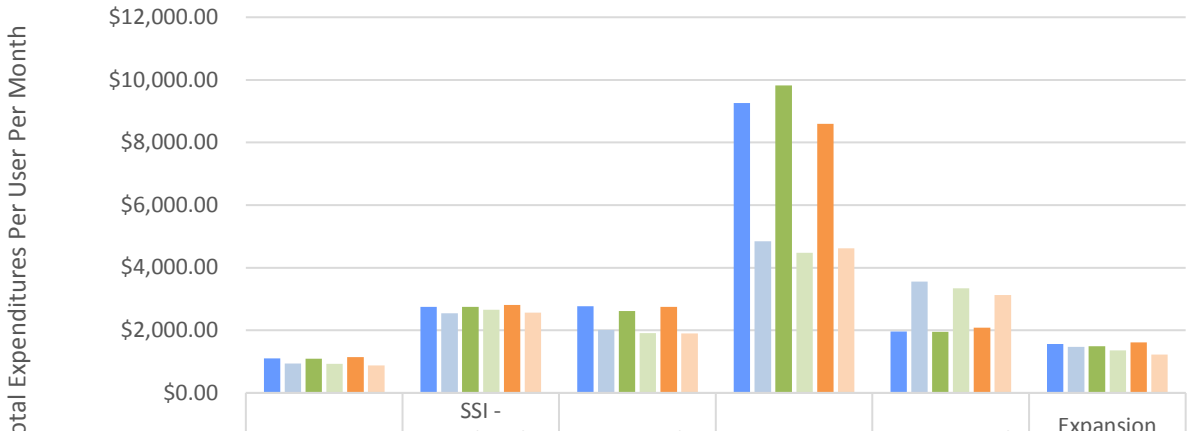
Exhibit 67 presents the calculated costs per user by MEG for DY1, DY2, and DY3 compared to the baseline costs. In the exhibit, "DYX STC" is the cost-per-user caps by MEG. As the exhibit illustrates, and consistent with the measure 65, the costs for all MEGs, apart from NF LOC Dual, remained below the MEG cost-per-user cap throughout DY1 to DY3.

Consistent with results from the PMPM costs measure, the Per User Per Month (PUPM) costs for all MEGs experienced decreases from DY2 to DY3, apart from the NF LOC group. These decreases in costs, which ranged from 0.3% to 10.0%, demonstrate that the Centennial Care program is experiencing success with respect to cost containment.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 67 – Cost per User of Services[94]



	TANF	SSI - Medicaid only	SSI - Dual	NF LOC	NF LOC Dual	Expansion Adults
DY1 STC	$1,099.95	$2,747.08	$2,770.82	$9,263.12	$1,963.64	$1,560.03
DY1 Centennial Care	$939.42	$2,540.92	$2,017.46	$4,848.78	$3,555.20	$1,474.95
DY2 STC	$1,090.73	$2,747.84	$2,617.08	$9,825.11	$1,952.04	$1,487.91
DY2 Centennial Care	$929.44	$2,654.95	$1,909.41	$4,473.37	$3,343.27	$1,356.66
DY3 STC	$1,148.13	$2,809.02	$2,746.76	$8,595.81	$2,082.65	$1,609.30
DY3 Centennial Care	$874.29	$2,561.87	$1,902.81	$4,615.84	$3,127.95	$1,221.05

[94] CMS-64 Schedule C , Quarter End December 2016; Cost Per User of Service MMIS reports.

Measure 68 – Utilization by category of service.

Exhibit 68 presents the utilization of various service categories across PH and LTSS for the Q1 2014 baseline, DY1, DY2, and DY3.

For inpatient PH services for specialty hospitals, the trend of decreasing average length of stay has continued throughout the baseline to DY3. There were smaller increases in days per 1,000 and larger increases in admits per 1,000 from DY2 to DY3 as well as from the baseline to DY3, resulting in decreases in the average length of stay in both periods. For acute hospitals, the average length of stay increased slightly in DY3 compared to DY2, but overall both the days per 1,000 and admits per 1,000 have decreased substantially from the baseline.

For other PH services, there were minor decreases in visits per 1,000 for outpatient surgeries and outpatient hospital visits to urgent care from DY2 to DY3. However, both subcomponents experienced increases in utilization from the baseline to DY3 (17.5% for outpatient surgeries and 59.7% for urgent care). There was also a significant increase (282.1%) in non-emergent transportation trips from DY2 to DY3.

Inpatient LTSS services (including acute hospitals, specialty hospitals, and hospital swing bed) showed mixed performance results across time periods. From DY2 to DY3, utilization of both acute and specialty hospital services generally experienced increases in days per 1,000, admits per 1,000, and average length of stay, although the average length of stay in specialty hospitals experienced a slight decrease. However, overall from the baseline to DY3, utilization of both acute and specialty hospital services experienced substantial decreases in the same measures; only average length of stay in specialty hospitals experienced a significant increase. Utilization of hospital swing bed appears to experience decreases in performance from the baseline to DY3, but there is limited data to draw sound conclusions.

Overall from the baseline to DY3, NF care for high levels of care experienced decreases in utilization, while low levels of care experienced increases in utilization. This trend is desirable as shifting utilization from higher levels of care to lower levels of care should result in a net decrease in healthcare costs.

Other LTSS services that experienced increases in utilization from the baseline to DY3 include the use of personal care services (73.6% for T1019, 207.5% for 99509), outpatient urgent care (128.1%), and non-emergent transportation (15,563.2%). Outpatient surgery visits experienced a slight decrease (-9.5%) from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 68 – Utilization by Category of Service[95]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
UTILIZATION BY CATEGORY OF SERVICE										
PHYSICAL HEALTH										
Inpatient Hospital - Acute	Days per 1,000	2,152.6	2,086.0	-3.1%	1,634.6	-21.6%	-24.1%	1,392.6	-14.8%	-35.3%
Inpatient Hospital - Acute	Admits per 1,000	281.0	281.5	0.2%	275.6	-2.1%	-1.9%	220.5	-20.0%	-21.5%
Inpatient Hospital - Acute	Average Length of Stay	7.7	7.4	-3.2%	5.9	-20.0%	-22.6%	6.3	6.5%	-17.6%
Inpatient - Specialty Hospital	Days per 1,000	19.0	16.2	-14.5%	21.2	30.4%	11.6%	25.5	20.3%	34.2%
Inpatient - Specialty Hospital	Admits per 1,000	1.1	0.9	-13.9%	1.3	46.1%	25.8%	2.1	58.8%	99.7%
Inpatient - Specialty Hospital	Average Length of Stay	17.8	17.7	-0.7%	15.8	-10.7%	-11.3%	12.0	-24.2%	-32.8%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	14.3	17.4	21.2%	18.0	3.5%	25.5%	16.8	-6.4%	17.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	31.3	44.6	42.5%	50.2	12.6%	60.4%	50.0	-0.5%	59.7%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	0.0	0.0	N/A	73.6	N/A	N/A	281.1	282.1%	N/A
LTSS										
Nursing Facility State Owned - High Level of Care	Days per 1,000	328.4	171.9	-47.7%	164.5	-4.3%	-49.9%	159.7	-2.9%	-51.4%
Nursing Facility State Owned - Low Level of Care	Days per 1,000	1,849.5	1,881.6	1.7%	1,923.9	2.2%	4.0%	2,054.5	6.8%	11.1%
Nursing Facility Private - High Level of Care	Days per 1,000	6,436.2	3,564.5	-44.6%	1,631.5	-54.2%	-74.7%	2,408.3	47.6%	-62.6%
Nursing Facility Private - Low Level of Care	Days per 1,000	19,719.3	21,622.5	9.7%	22,997.1	6.4%	16.6%	21,081.8	-8.3%	6.9%
Hospital Swing Bed - High Level of Care	Days per 1,000	2.3	2.7	15.7%	0.0	-100.0%	-100.0%	0.2	N/A	-93.0%
Hospital Swing Bed - Low Level of Care	Days per 1,000	0.9	3.1	247.5%	2.1	-33.2%	132.2%	0.0	-100.0%	-100.0%
Personal Care Option - T1019	15 Minute Intervals per 1,000	447,638.9	495,883.9	10.8%	705,853.0	42.3%	57.7%	777,046.9	10.1%	73.6%
Personal Care Option - 99509	1 Hour Intervals per 1,000	39,516.6	54,837.6	38.8%	161,393.9	194.3%	308.4%	121,531.8	-24.7%	207.5%
Inpatient Hospital - Acute	Days per 1,000	2,429.4	2,748.6	13.1%	1,308.4	-52.4%	-46.1%	1,552.0	18.6%	-36.1%
Inpatient Hospital - Acute	Admits per 1,000	292.4	309.9	6.0%	209.2	-32.5%	-28.5%	211.7	1.2%	-27.6%
Inpatient Hospital - Acute	Average Length of Stay	8.3	8.9	6.8%	6.3	-29.5%	-24.7%	7.3	17.2%	-11.7%
Inpatient - Specialty Hospital	Days per 1,000	377.1	361.4	-4.1%	106.0	-70.7%	-71.9%	132.2	24.7%	-64.9%
Inpatient - Specialty Hospital	Admits per 1,000	54.1	52.8	-2.5%	5.5	-89.6%	-89.9%	7.3	33.2%	-86.5%
Inpatient - Specialty Hospital	Average Length of Stay	7.0	6.9	-1.7%	19.4	183.0%	178.2%	18.1	-6.4%	160.4%
Ambulatory Surgery Centers - Outpatient Surgeries	Vists per 1,000	65.5	69.4	5.9%	61.7	-11.1%	-5.9%	59.3	-3.8%	-9.5%
Outpatient Hospital - Urgent Care	Vists per 1,000	10.4	15.8	52.2%	18.3	16.2%	76.9%	23.6	29.0%	128.1%
Non-Emergent Transportation - Non-Capitated	Trips per 1,000	31.7	30.0	-5.3%	1,658.7	5,425.9%	5,135.3%	4,962.6	199.2%	15,563.2%

[95] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

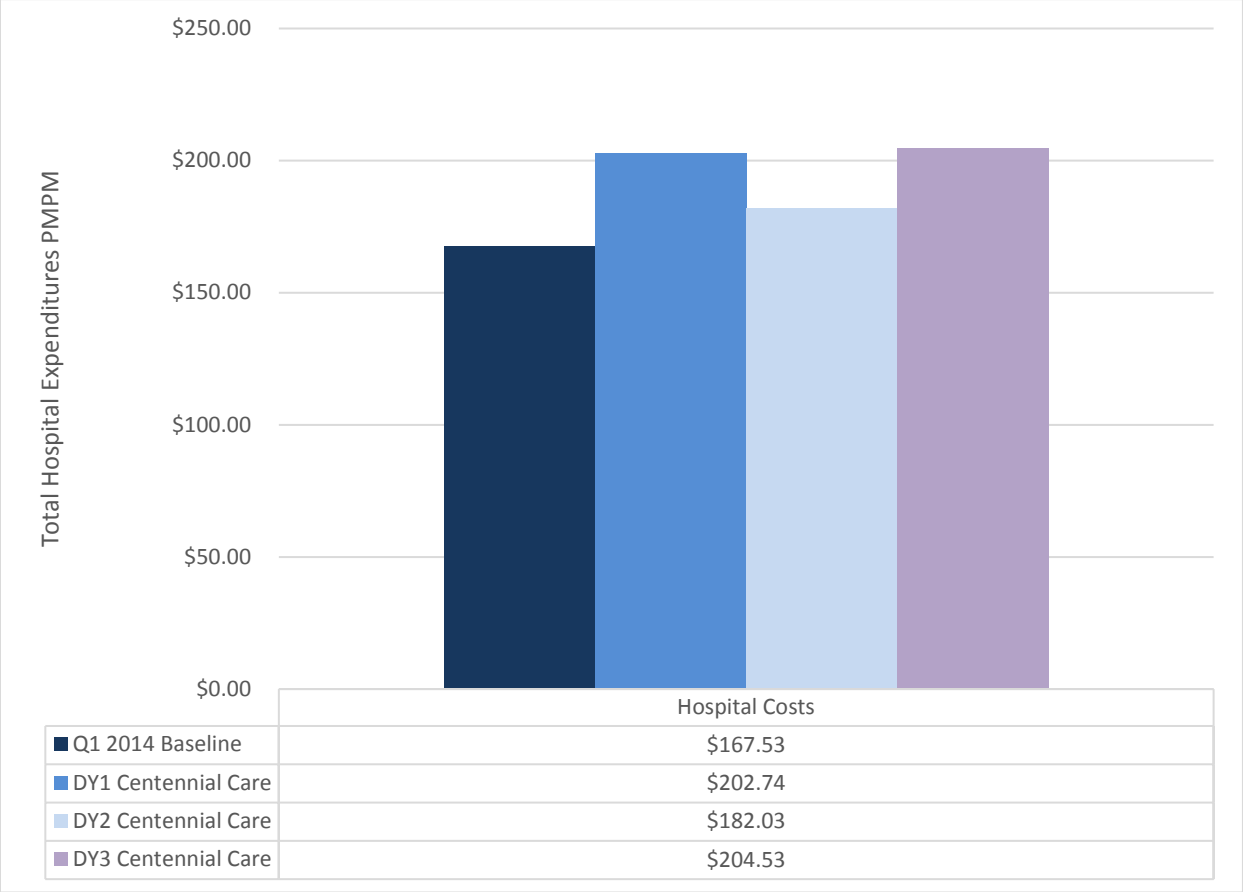
Measure 69 – Hospital costs.

Exhibit 69 presents the PMPM cost for services that are associated with hospital, clinic, and facility visits for DY1, DY2, and DY3 compared to the baseline PMPM. Refer to Appendix A for a complete listing of all services included in this measure. As illustrated, the average PMPM across all hospital services experienced a 10.2% year-over-year decrease in DY2 followed by a 12.4% year-over year increase in DY3, and actual PMPM cost exceed the baseline PMPM in each year.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 69 – Hospital Cost PMPM[96]



	Hospital Costs
Q1 2014 Baseline	$167.53
DY1 Centennial Care	$202.74
DY2 Centennial Care	$182.03
DY3 Centennial Care	$204.53

[96] Source: Revenue and expense reports (Report 1) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 70 – Use of HCBS.

Essential to the Centennial Care program is the Community Benefit (CB) home and community-based services (HCBS) program for members who require LTSS to remain in the family residence, in their own home, or in community residences. The CB is a less costly alternative to placement in a Nursing Facility (NF) and is available to members who meet Nursing Facility Level of Care (NF LOC). CB services supplement a member's natural supports but do not provide 24-hour care.

Exhibit 70 presents the annualized utilization for various HCBS services for the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the use of adult day health and assisted living benefits have increased 43.2% and 36.6% respectively, while the use of respite, environmental modifications, and private duty nursing benefits all decreased between 15.7% to 61.5% percent.

Overall from the baseline to DY3, the use of HCBS benefits has increased significantly, with increases in subcategories ranging from 109.4% to 7,929.1%. These HCBS increases are in line with Centennial Care's goal with respect to enhancing services with more effective coordination of care. In addition, the influx of members through the expansion of eligibility may also have had an impact on the calculated increase in utilization. Despite the general trend of increasing utilization, the private duty nursing subcomponent has been consistently experiencing decreases year-over-year, and has decreased 87.4% from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 70 – Use of HCBS[97]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
USE OF HOME AND COMMUNITY BASED SERVICES (HCBS)									
Community Benefit - Respite	15 Minute Intervals per 1,000	3,355.9	6,172.0	83.9%	10,955.2	77.5%	7,027.1	-35.9%	109.4%
Community Benefit - Adult Day Health	Days per 1,000	366.3	1,225.1	234.4%	3,233.4	163.9%	4,630.1	43.2%	1,163.9%
Community Benefit - Assisted Living	Days per 1,000	500.9	573.4	14.5%	779.4	35.9%	1,064.7	36.6%	112.6%
Community Benefit - Environmental Modifications	Modifications per 1,000	6.9	20.7	198.7%	660.2	3,089.3%	556.5	-15.7%	7,929.1%
Community Benefit - Private Duty Nursing	15 Minute Intervals per 1,000	853.0	372.9	-56.3%	279.3	-25.1%	107.4	-61.5%	-87.4%

[97] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 71 – Use of institutional care (skilled nursing facilities).

Exhibit 71 presents the annualized utilization for services related to institutional care for the Q1 2014 baseline, DY1, DY2, and DY3. The days per 1,000 subcomponent increased (105.4%) while the admits per 1,000 subcomponent decreased (-69.7%), resulting in a 578.1% increase in the average length of stay from the baseline to DY3. These increases were consistent with DY2 to DY3 trends for this measure.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 71 – Use of Institutional Care (Skilled Nursing Facilities)[98]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF INSTITUTIONAL CARE (SKILLED NURSING FACILITY)										
Non-Acute LTC/SNF/Respite	Days per 1,000	76.0	117.4	54.3%	121.9	3.8%	60.3%	156.2	28.1%	105.4%
Non-Acute LTC/SNF/Respite	Admits per 1,000	20.7	29.9	44.3%	6.6	-77.8%	-67.9%	6.3	-5.7%	-69.7%
Non-Acute LTC/SNF/Respite	Average Length of Stay	3.7	3.9	6.9%	18.3	366.8%	399.2%	24.9	35.8%	578.1%

[98] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 72 – Use of mental health services.

Exhibit 72 presents the annualized utilization for services related to mental health services in the Q1 2014 baseline, DY1, DY2, and DY3. From DY2 to DY3, the utilization of RTCs (-7.9%) and average length of stay for psychiatric hospitalization service (-0.6%) decreased while utilization for foster care therapeutic (47.0%) and Federally Qualified Health Centers (FQHCs) (21.1%) increased. Similar to DY2 to DY3 trends in performance change, the utilization of RTCs (-9.3%) and average length of stay for psychiatric hospitalization service (-12.2%) decreased while utilization for foster care therapeutic (24.4%) and FQHCs (65.8%) increased from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 72 – Use of Mental Health Services[99]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF MENTAL HEALTH SERVICES										
Residential Treatment Center, ARTC and Group Homes < 21	Days per 1,000	217.1	209.5	-3.5%	213.8	2.1%	-1.5%	197.0	-7.9%	-9.3%
Foster Care Therapeutic (TFC I & II) < 21	Days per 1,000	127.9	129.3	1.1%	108.2	-16.3%	-15.4%	159.1	47.0%	24.4%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Days per 1,000	56.6	61.9	9.3%	68.8	11.1%	21.4%	103.1	50.0%	82.1%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Admits per 1,000	6.7	7.5	10.9%	9.3	24.0%	37.5%	14.0	50.9%	107.5%
Hospital Inpatient Facility (Psychiatric Hospitalization Services)	Average Length of Stay	8.4	8.3	-1.4%	7.4	-10.4%	-11.7%	7.4	-0.6%	-12.2%
Federally Qualified Health Centers (FQHC's)	Vists per 1,000	147.8	150.1	1.5%	202.3	34.8%	36.8%	245.0	21.1%	65.8%

[99] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 73 – Use of substance abuse services.

Exhibit 73 presents the annualized utilization for services related to substance abuse in the Q1 2014 baseline, DY1, DY2, and DY3. In the MCO financial reports, methadone treatment was the only category of service determined to be specifically characterized as a substance abuse service, which saw an increase in visits per 1,000 of 35.9% from DY2 to DY3, and a total increase from the baseline to DY3 of 316.8%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 73 – Use of Substance Abuse Services[100]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
USE OF SUBSTANCE ABUSE SERVICES									
Methadone Treatment	Vists per 1,000	44.9	65.9	46.8%	137.7	108.9%	187.1	35.9%	316.8%

[100] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 74 – Use of pharmacy services.

Exhibit 74 presents the annualized utilization for services related to pharmacy in the Q1 2014 baseline, DY1, DY2, and DY3. Generally there were decreases in the number of scripts per 1,000 for brand, generic, and other drugs in the PH, BH, and LTSS care settings from DY2 to DY3, with decreases in the range of 2.8% to 97.6%. The only increases in drug utilization was seen in generic drugs for the PH setting (4.1%) and BH setting (0.9%).

Similar to the DY2 to DY3 timeframe, most drug utilization decreased across BH and LTSS care settings from the baseline to DY3, with decreases in the range of 9.8% to 98.3%. The only increases in scripts per 1,000 were for brand (8.5%) and generic drugs (16.9%) in the PH setting, generic (2.1%) in the BH setting, and other drugs (20.8%) in the LTSS setting.

One item of particular interest was the sharp decrease in the use of "other" type drugs in DY3. We are working with the State to investigate this decrease and determine the reason or identify any potential reporting issue.

When comparing the baseline results to other years, it is important to note that seasonality (the regular and predictable changes which recur every calendar year) may account for some of the difference since the baseline is only the first quarter of 2014. Additionally, although lowering utilization is generally considered a positive outcome, under this measure, higher utilization of generic drugs is desirable as shifting utilization from brand name drugs to generic drugs generally results in a decrease in overall drug costs.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

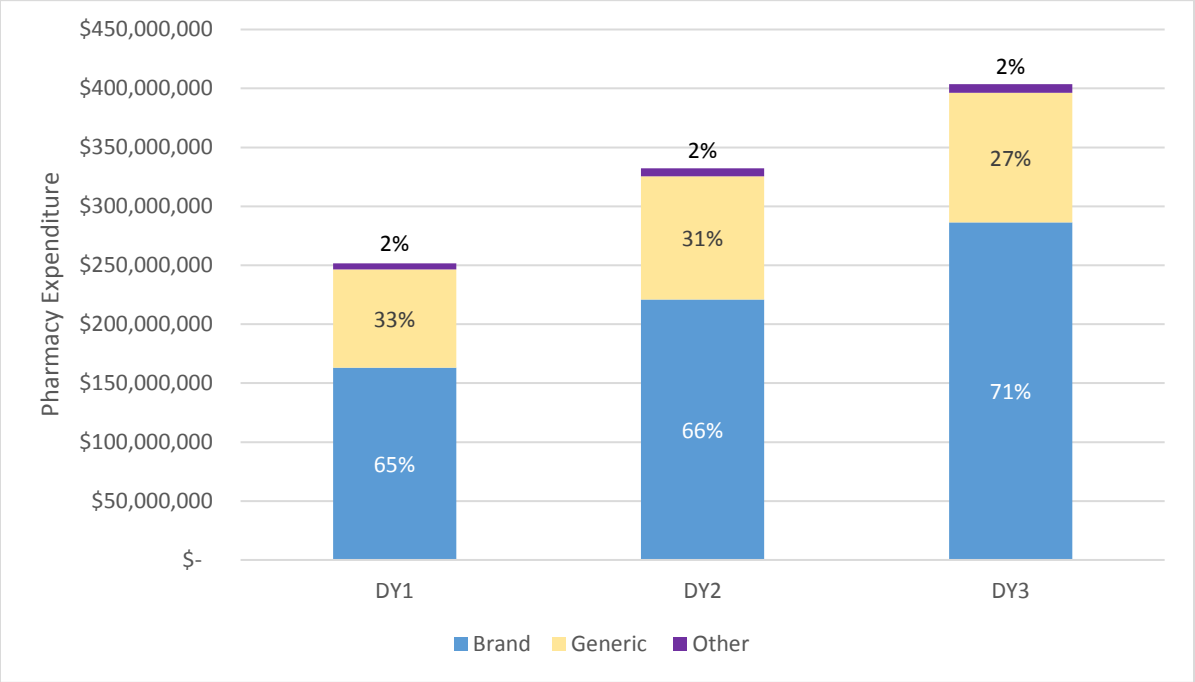
Exhibit 74 – Use of Pharmacy Services[101]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
USE OF PHARMACY										
PHYSICAL HEALTH										
Prescribed Drugs - Brand Name	Scripts per 1,000	842.1	890.8	5.8%	939.4	5.5%	11.6%	913.5	-2.8%	8.5%
Prescribed Drugs - Generic	Scripts per 1,000	5,489.7	5,875.4	7.0%	6,270.9	6.7%	14.2%	6,418.4	2.4%	16.9%
Prescribed Drugs - Other	Scripts per 1,000	180.0	174.2	-3.2%	162.1	-7.0%	-9.9%	24.3	-85.0%	-86.5%
BEHAVIORAL HEALTH										
BH Pharmaceuticals - Brand Name	Scripts per 1,000	183.3	166.9	-9.0%	149.3	-10.5%	-18.6%	141.6	-5.2%	-22.8%
BH Pharmaceuticals - Generic	Scripts per 1,000	1,713.8	1,742.1	1.7%	1,733.5	-0.5%	1.2%	1,749.8	0.9%	2.1%
BH Pharmaceuticals - Other	Scripts per 1,000	71.9	57.0	-20.7%	50.8	-10.9%	-29.4%	1.2	-97.6%	-98.3%
LTSS										
Prescribed Drugs - Brand Name	Scripts per 1,000	1,676.7	1,677.9	0.1%	1,505.5	-10.3%	-10.2%	1,398.3	-7.1%	-16.6%
Prescribed Drugs - Generic	Scripts per 1,000	9,609.5	9,625.5	0.2%	9,237.2	-4.0%	-3.9%	8,666.3	-6.2%	-9.8%
Prescribed Drugs - Other	Scripts per 1,000	358.3	378.0	5.5%	385.2	1.9%	7.5%	432.9	12.4%	20.8%

[101] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports.

The Evaluation also examined data summarized by Mercer which shows the distribution of pharmacy expenditure in DY1, DY2, and DY3. As illustrated in Exhibit 74, total drug expenditure has been increasing throughout DY1 to DY2, with a 21.4% increase from DY2 to DY3. In addition, pharmacy expenditure has been shifting from generic drugs to brand name drugs from DY1 to DY3. Possible explanations for this shift may include effective but expensive brand name drugs entering the market (such as newly-developed, brand name drugs for Hepatitis C treatment that were utilized mainly by the Medicaid adult expansion group), increases in prices of existing brand name drugs, etc. In DY3, brand name drug expenditure made up 71% of total drug cost, while generic drugs accounted for 27%.

Exhibit 74 – Distribution of Pharmacy Expenditures by Brand, Generic, and Other Drugs[102]



[102] Source: Data summarized by Mercer based on financial statements submitted by MCOs.

Measure 75 – Inpatient services exceeding $50,000.

Exhibit 75 presents the inpatient services exceeding $50,000 as a percentage of total healthcare related expenditures as reported by the MCOs for DY1, DY2, and DY3. The percentage of high cost inpatient service expenditure continues to drop each year from DY1 to DY3, with high cost inpatient claims representing only 1.3% of total healthcare related expenditures in DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 75 – Inpatient Services Exceeding $50,000 as % of Total Healthcare Expenditures[103]

	DY1	DY2	DY3
Baseline	4.1%	4.1%	4.1%
Measured Total	4.1%	2.5%	1.3%
Difference Measured Over/(Under) Baseline	0.0%	-1.7%	-2.8%

[103] Source: Revenue and expense reports and high cost claims reports (Report 1 and Report 7) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 76 – Diagnostic imaging costs.

Exhibit 76 presents the PMPM cost for services related to diagnostic imaging for the Q1 2014 baseline, DY1, DY2, and DY3. Although the PMPM cost of diagnostic imaging service dropped below the baseline in DY2, it increased substantially in DY3 and exceeded the baseline by 21.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as the aggregate nature of the information was not appropriate for statistical significance testing.

Exhibit 76 – Diagnostic Imaging Cost PMPM[104]

	Q1 2014	DY1	DY2	DY3
Baseline	$0.67	$0.67	$0.67	$0.67
Measured Total	$0.67	$0.71	$0.49	$0.82
Measured Over/(Under) Baseline	$0.00	$0.04	-$0.19	$0.15
% Measured Over/(Under) Baseline	0.0%	5.5%	-28.0%	21.7%

[104] Source: Expense reports (Report 2) contained within the 2014 – 2016 annual supplemental FIN reports.

Measure 77 – Emergency department use.

Exhibit 77 presents ER utilization for the Q1 2014 baseline, DY1, DY2, and DY3. As the exhibit illustrates, utilization for ER services increased in both PH and LTSS care settings from the baseline to DY3, which is an undesirable trend given that ER services are high cost in nature. However, it is important to note that ER utilization has been experiencing annual decreases from DY1 to DY3 in the PH care setting, which serves a population base that is more than twelve times larger than the population served in the LTSS care setting.

It is likely that the membership change in the adult expansion group had an impact on the results for this measure since this measure is inclusive of all populations and not limited to a specific population subset or MEG.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 77 – Emergency Department Use[105]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline	DY3	Diff. from DY2	Diff. from Baseline
EMERGENCY DEPARTMENT USE										
PHYSICAL HEALTH										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.5	579.0	4.8%	557.8	-3.7%	1.0%	556.2	-0.3%	0.7%
LTSS										
Outpatient Hospital - Emergency Room	Vists per 1,000	552.6	599.8	8.5%	690.8	15.2%	25.0%	734.9	6.4%	33.0%

[105] Source: Utilization reports (Report 3) contained within the 2014 – 2016 annual supplemental FIN reports. In 2016, the "Ambulance – Ground" category of service was removed from PH and Other Adult Group – Physical Health (OAGPH) reports, therefore analysis for this measure no longer includes ambulance services.

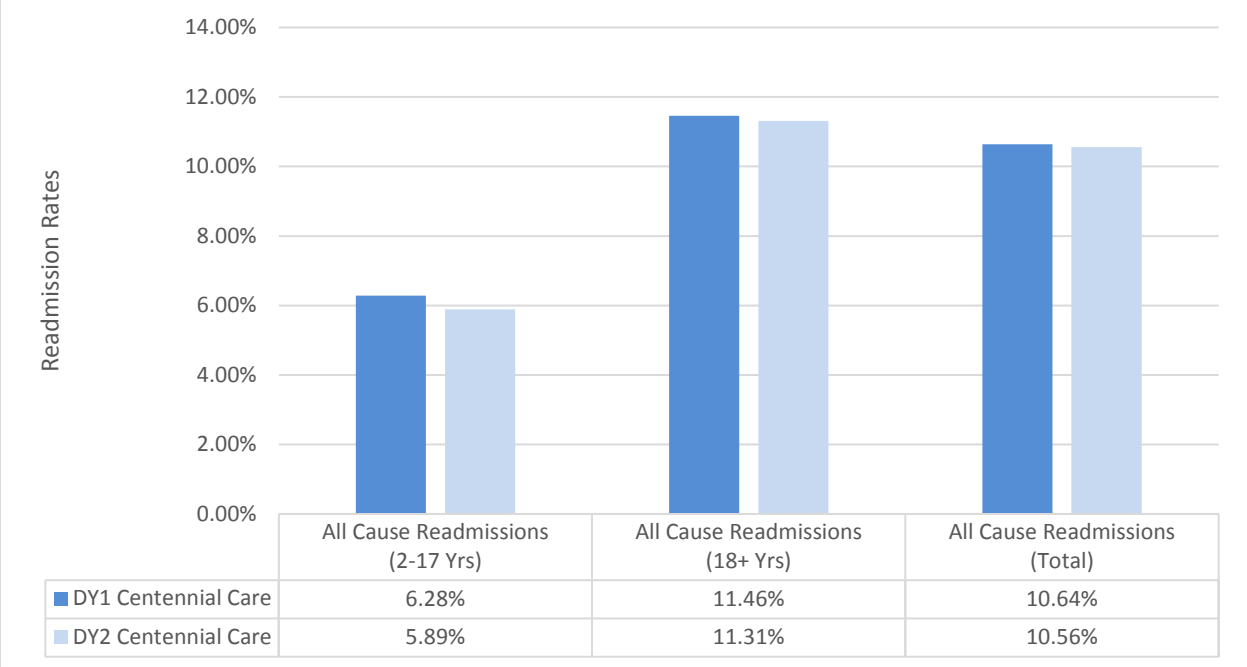
Measure 78 – All cause readmissions.

Exhibit 78 presents readmission rates for the 2-17 years of age cohort, 18+ years of age cohort, and the weighted average of both cohorts in DY1 and DY2. As illustrated, all cause readmission rates decreased for both the 2-17 years of age cohort (-6.2%) and the 18+ years of age cohort (-1.3%), which resulted in a 0.8% decrease in the weighted average readmission rate from DY1 to DY2. It should be noted that since the 18+ years of age cohort is roughly ten times larger than the 2-17 years of age cohort, the aggregate readmission rate is weighted more heavily toward the rate of the 18+ years of age cohort.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 78 – All Cause Readmission Rate[106]



	All Cause Readmissions (2-17 Yrs)	All Cause Readmissions (18+ Yrs)	All Cause Readmissions (Total)
DY1 Centennial Care	6.28%	11.46%	10.64%
DY2 Centennial Care	5.89%	11.31%	10.56%

[106] Source: Data provided by Mercer. HSD indicated a data source change for this measure in DY2 to replace MMIS data with Mercer summary data. Due to the change in available fields in the new reports, there is a change in the subcomponents analyzed for this measure compared to the DY1 Annual Report.

Measure 79 – Inpatient mental health/substance use services.

Exhibit 79 presents the utilization for services related to inpatient mental health and substance abuse for the Q1 2014 baseline, DY1, and DY2. The utilization of psychiatric hospitals stayed relatively consistent throughout the baseline to DY2, at around 1.3 encounters per client. There was a slight decrease (-28.0%) in utilization of RTCs from DY1 to DY2, but an overall significant increase (683.6%) from the baseline to DY2.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 79 – Inpatient Mental Health/Substance Use[107]

Category of Service	Units	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	Diff. from Baseline
INPATIENT MENTAL HEALTH/SUBSTANCE ABUSE SERVICES							
Psychiatric Hospital	Encounters per Client	1.28	1.27	-1.4%	1.30	2.5%	1.1%
Residential Treatment Center	Encounters per Client	1.04	11.33	987.9%	8.16	-28.0%	683.6%

[107] Source: Inpatient mental health and substance use MMIS reports.

Research Question 3.B

Has the member rewards program encouraged members to better manage their care?

The Centennial Rewards program is an incentive program that went live on April 1, 2014 as part of Centennial Care and is designed to motivate members to better manage their own health. For example, members can earn rewards for adhering to medication regiments and routine exams for various chronic illnesses or behavioral conditions such as refilling prescriptions for asthma, schizophrenia, bipolar and taking medical exams for diabetes. To increase program awareness and engagement, MCOs have been actively involved in outreach, communication, and marketing, including distributing program materials and reaching out to members through the call center. There is also a public portal that allows individuals not registered for the program to learn more about Centennial Rewards.

The Evaluation is reviewing the impact of the Centennial Rewards program on member behavior through analysis of nine measures designed to monitor members' compliance with various treatment protocols or use of annual preventive services. Currently, performance measures are not reported for Centennial Rewards enrollees by specific cohorts. For the purposes of this report, the reward-earning and redemption rates associated with the health compliance activities were examined in detail for the population as a whole.

Overall through DY2 of the Centennial Care program, all measures experienced significant increases in members earning rewards and redemption rates. This includes increases in members earning and redeeming rewards for managing chronic conditions such as asthma, schizophrenia, bipolar disorder, and diabetes. There were also increases in members earning and redeeming rewards for engaging in preventive services such as receiving an annual bone density test for those at risk for osteoporosis, pregnant women enrolling in prenatal programs, and child and adult members receiving an annual dental visit.

These results indicate that the Centennial Rewards program has encouraged members to engage in the program and better manage their own health and wellness.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

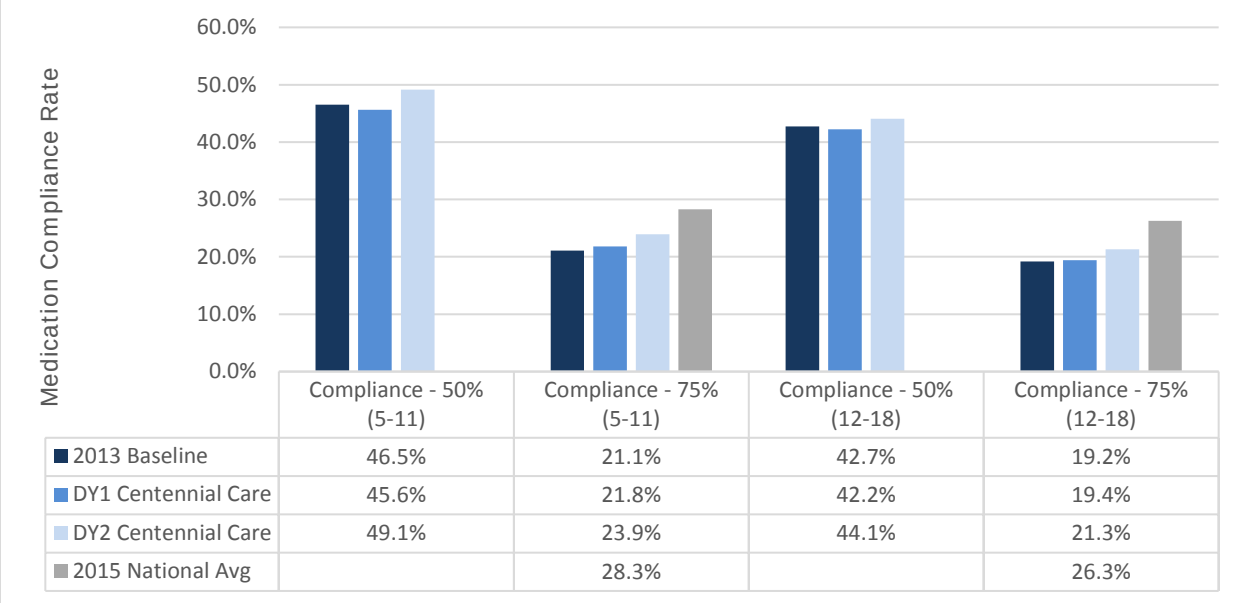
Measure 80 – Asthma controller medication compliance (children).

Exhibit 80.a demonstrates asthma medication compliance for children at various compliance levels and age cohorts. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Aggregate compliance rates increased from DY1 to DY2 for all compliance thresholds and age cohorts, but the only statistically significant change was the 7.7% increase of the 50% compliance rate for the 5-11 years of age cohort. Upon review of individual MCO performance, PHP was the only MCO that experienced statistically significant changes from DY1 to DY2, with 17.4% to 34.8% increases across all age cohorts.

Aggregate compliance rates increased from the baseline to DY2 for all thresholds and cohorts, but the only statistically significant rate of change was a 13.6% increase of the 75% compliance rate for the 5-11 years of age cohort. The compliance rates at the 75% threshold show slight positive trends year-over-year but remained below the 2015 national average. PHP was the only MCO that experienced statistically significant changes from the baseline to DY2, with increases ranging between 11.5% and 30.2% across all subcomponents.

Exhibit 80.a – Asthma Medication Compliance for Children[108]



	Compliance - 50% (5-11)	Compliance - 75% (5-11)	Compliance - 50% (12-18)	Compliance - 75% (12-18)
2013 Baseline	46.5%	21.1%	42.7%	19.2%
DY1 Centennial Care	45.6%	21.8%	42.2%	19.4%
DY2 Centennial Care	49.1%	23.9%	44.1%	21.3%
2015 National Avg		28.3%		26.3%

[108] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 80.b summarizes activity of members earning and redeeming Centennial Rewards points for activities to manage their children's asthma condition. As indicated in the exhibit, the number of members earning rewards and the percentage of members that are redeeming their rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 80.b Centennial Rewards for Activities Related to Asthma in Children, DY1 – DY2[109]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Asthma	1st Asthma	6,274	9.1%	11,152	29.1%	77.7%	218.9%
Asthma	3rd Asthma	4,771	8.6%	8,198	30.4%	71.8%	252.6%
Asthma	6th Asthma	2,510	7.5%	4,139	33.1%	64.9%	340.2%
Asthma	9th Asthma	1,246	5.9%	2,260	33.8%	81.4%	476.3%
Asthma	12th Asthma	663	5.7%	1,252	35.3%	88.8%	516.0%

[109] Source: Finity 2015 member rewards data.

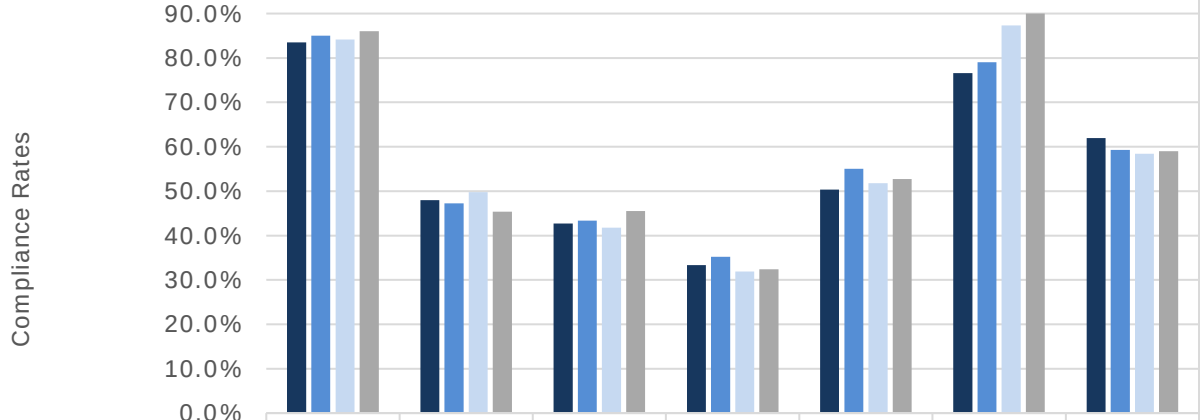
Measure 81 – Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam.

Exhibit 81.a demonstrates compliance rates for various preventive services associated with diabetes care and monitoring. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Nephropathy was the only subcomponent that showed increased compliance (10.4% increase) from DY1 to DY2, which was statistically significant at the 95% confidence level. Of the subcomponents that showed decreases, eye exam was the only statistically significant change with a decrease of 5.9%. Note that while the rate for HbA1c poor control subcomponent increased from DY1 to DY2, it is an inverse measure, meaning a decrease in the rate indicates improved compliance and vice versa.

The baseline to DY2 rate of change for nephropathy was 14.0% and the baseline to DY2 rate of change for blood pressure control was -5.7%, which were the only statistically significant rates of change between the baseline and DY2. Of the non-statistically significant rates of change, HbA1C testing and eye exams rates increased, while HbA1c control (<8.0% and <7.0%) rates decreased, and HbA1c poor control experienced an unfavorable increase from the baseline to DY2.

Exhibit 81.a – Comprehensive Diabetes Care[110]



	HbA1c Testing	HbA1c Poor Control	HbA1c Control (<8.0%)	HbA1c Control (<7.0%)	Eye Exam	Nephropathy	Blood Pressure
2013 Baseline	83.5%	47.9%	42.7%	33.3%	50.4%	76.6%	62.0%
DY1 Centennial Care	85.0%	47.2%	43.4%	35.2%	55.0%	79.1%	59.3%
DY2 Centennial Care	84.1%	49.8%	41.8%	31.9%	51.8%	87.3%	58.4%
2015 National Avg	86.0%	45.4%	45.5%	32.4%	52.7%	90.0%	59.0%

[110] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 81.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage their diabetes. As seen in the table, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 81.b Centennial Rewards for Activities Related to Diabetes, DY1 – DY2[111]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Diabetes	Eye Exam	9,874	8.0%	21,951	24.1%	122.3%	203.5%
Diabetes	HbA1c Test	18,135	9.2%	28,723	25.9%	58.4%	180.9%
Diabetes	LDL Test	13,569	9.2%	23,617	26.7%	74.1%	190.8%
Diabetes	Nephropathy Exam	14,944	9.0%	28,072	24.2%	87.8%	168.2%

[111] Source: Finity 2015 member rewards data.

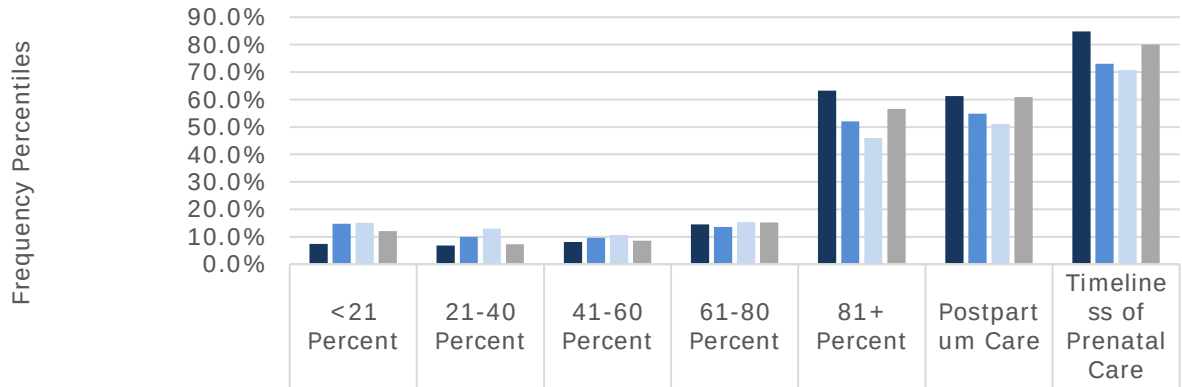
Measure 82 – Prenatal program.

Exhibit 82.a demonstrates compliance rates of frequency for ongoing prenatal care, postpartum care, and timeliness of prenatal care. The compliance rates are shown for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average.

Three subcomponents had statistically significant rates of change from DY1 to DY2. The percentage of deliveries that received 21-40% of expected visits increased 30.5%, and the percentage of deliveries that received over 81% of expected prenatal visits decreased 11.8%. The percentage of deliveries that received postpartum care decreased 6.7%. Three subcomponents experienced increase in rates but are not statistically significant: deliveries that received under 21%, between 41-60%, and between 61-80% expected visits. Timeliness of prenatal care rates decreased from DY1 to DY2 although not statistically significant.

From the baseline to DY2, lower frequencies of prenatal visits increased across compliance categories (deliveries receiving under 21% expected visits increased 104.9%, deliveries receiving 21-40% expected visits increased 89.5%, deliveries receiving 41-60% expected visits increased 32.2%, deliveries receiving 61-80% expected visits increased 5.7%), while the percentage of deliveries that received over 81% of expected prenatal visits decreased 27.3%. The percentage of deliveries that received postpartum care decreased 16.5%, and the timeliness of prenatal care decreased 16.6% from the baseline to DY2. All changes from the baseline to DY2 were statistically significant at the 95% confidence level except for rates of deliveries receiving 61-80% expected prenatal visits. Most subcomponents of the prenatal program measure underperformed compared to the 2015 national average rates in DY2.

Exhibit 82.a – Prenatal Program[112]



	<21 Percent	21-40 Percent	41-60 Percent	61-80 Percent	81+ Percent	Postpartum Care	Timeliness of Prenatal Care
2013 Baseline	7.4%	6.8%	8.1%	14.5%	63.2%	61.3%	84.8%
DY1 Centennial Care	14.8%	9.9%	9.6%	13.6%	52.1%	54.8%	73.0%
DY2 Centennial Care	15.1%	13.0%	10.6%	15.3%	45.9%	51.2%	70.7%
2015 National Avg	12.0%	7.3%	8.6%	15.2%	56.6%	60.9%	80.0%

[112] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 82.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to enroll in the prenatal program. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 82.b – Centennial Rewards for Activities Related to Prenatal Program, DY1 – DY2[113]

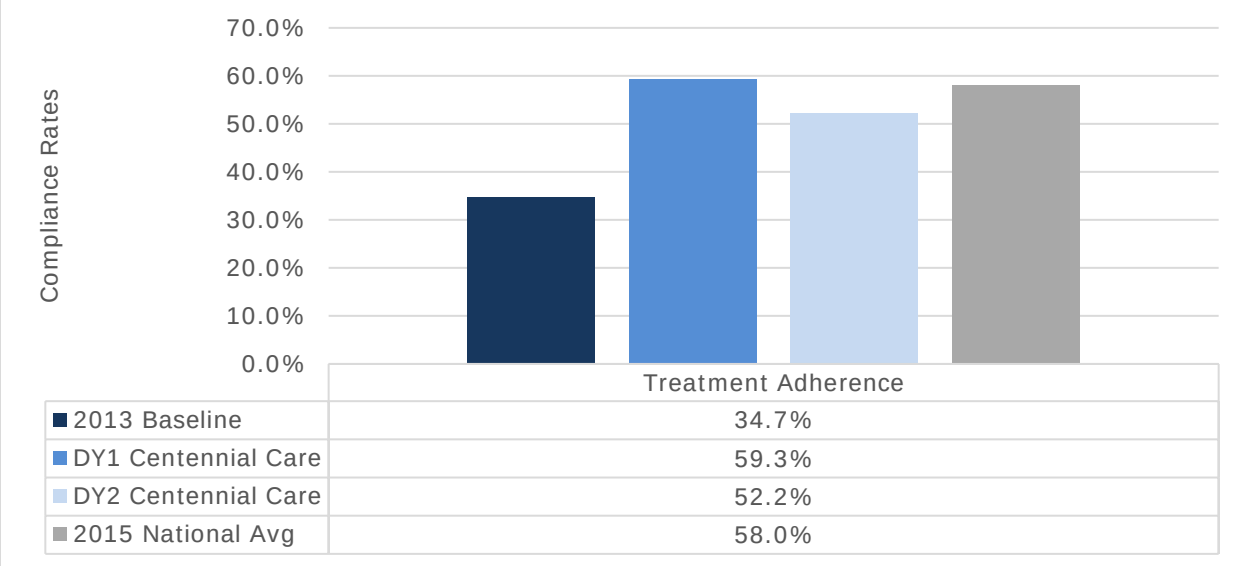
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Pregnancy	Prenatal Enrollment	3,441	10.8%	7,386	24.0%	114.6%	122.4%

[113] Source: Finity 2015 member rewards data.

Measure 83 – Treatment adherence – schizophrenia.

Exhibit 83.a presents the schizophrenia treatment adherence rate for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. Although the treatment adherence rate experienced a statistically significant decline of 12.0% from DY1 to DY2, the aggregate change from the baseline to DY2 was a statistically significant increase of 50.3%. This increase from the baseline to DY2 was mainly driven by PHP's increase of 135.4%, which was the only statistically significant change among all MCOs. The DY2 performance was below the national average rate for 2015.

Exhibit 83.a – Treatment Adherence – Schizophrenia[114]



	Treatment Adherence
2013 Baseline	34.7%
DY1 Centennial Care	59.3%
DY2 Centennial Care	52.2%
2015 National Avg	58.0%

[114] Source: MCO annual HEDIS reports for 2013 – 2015.

Exhibit 83.b summarizes activity on members earning and redeeming Centennial Rewards points for activities to manage schizophrenia. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program encourages greater treatment adherence for the subset of Centennial Care members that are registered for the Centennial Rewards program compared to the broader Centennial Care population.

Exhibit 83.b – Centennial Rewards for Activities Related to Schizophrenia, DY1 – DY2[115]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Schizophrenia	1st Schizophrenia	3,083	6.8%	4,718	19.9%	53.0%	190.8%
Schizophrenia	3rd Schizophrenia	2,515	6.7%	3,888	21.0%	54.6%	213.8%
Schizophrenia	6th Schizophrenia	1,944	6.0%	3,038	22.0%	56.3%	268.5%
Schizophrenia	9th Schizophrenia	1,570	5.2%	2,460	22.4%	56.7%	328.8%
Schizophrenia	12th Schizophrenia	1,100	5.2%	1,885	22.2%	71.4%	327.9%

[115] Source: Finity 2015 member rewards data.

Measure 85 – Osteoporosis management in elderly women - females aged 65+ years.

Exhibit 85.a presents data on osteoporosis management in elderly women for the 2013 baseline, DY1, DY2, and DY3. The number of unique clients and unique encounters both increased significantly from the baseline to DY3. However, the more relevant subcomponent is the number of unique encounters per client, which decreased by 2.0% from the baseline to DY3.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure as an appropriate test could not be identified based on the aggregate nature of the data.

Exhibit 85.a – Osteoporosis Management in Elderly Women – Females Age 65+ Years[116]

Program Measure	Baseline	DY1	Diff. from Baseline	DY2	Diff. from DY1	DY3	Diff. from DY2	Diff. from Baseline
Unique Count of Clients	106	159	50.0%	227	42.8%	253	11.5%	138.7%
Unique Count of Encounter Claims	127	195	53.5%	271	39.0%	297	9.6%	133.9%
Unique Count of Encounter Per Client	1.20	1.23	2.4%	1.19	-2.7%	1.17	-1.7%	-2.0%

Exhibit 85.b summarizes activity on members earning and redeeming Centennial Rewards points for bone density testing. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 85.b – Centennial Rewards for Bone Density Testing, DY1 – DY2[117]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Bone Density	Bone Density Test	374	5.1%	749	20.3%	100.3%	299.5%

[116] Source: Osteoporosis MMIS Report.
[117] Source: Finity 2015 member rewards data.

Measure 86 – Annual dental visit – adult.

Exhibit 86.a illustrates frequency of dental visits among members 19-21 years of age for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of young adults receiving at least one dental visit annually had an increase of 15.9% from DY1 to DY2, although there has been a decrease of 9.0% from the baseline to DY2. Both rates of change are statistically significant. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average.

Exhibit 86.a – Annual Dental Visit – Adult[118]

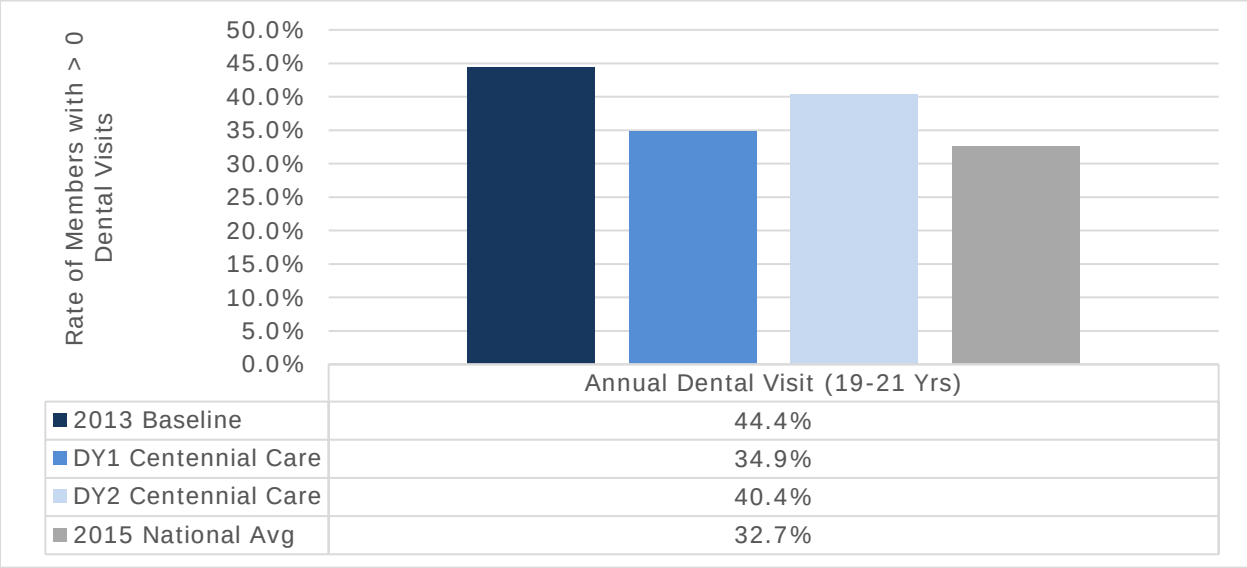


Exhibit 86.b summarizes activity on members earning and redeeming Centennial Rewards points for having their annual dental visit. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards have increased substantially from DY1 to DY2, which may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 86.b – Centennial Rewards for Adult Annual Dental Visits, DY1 – DY2[119]

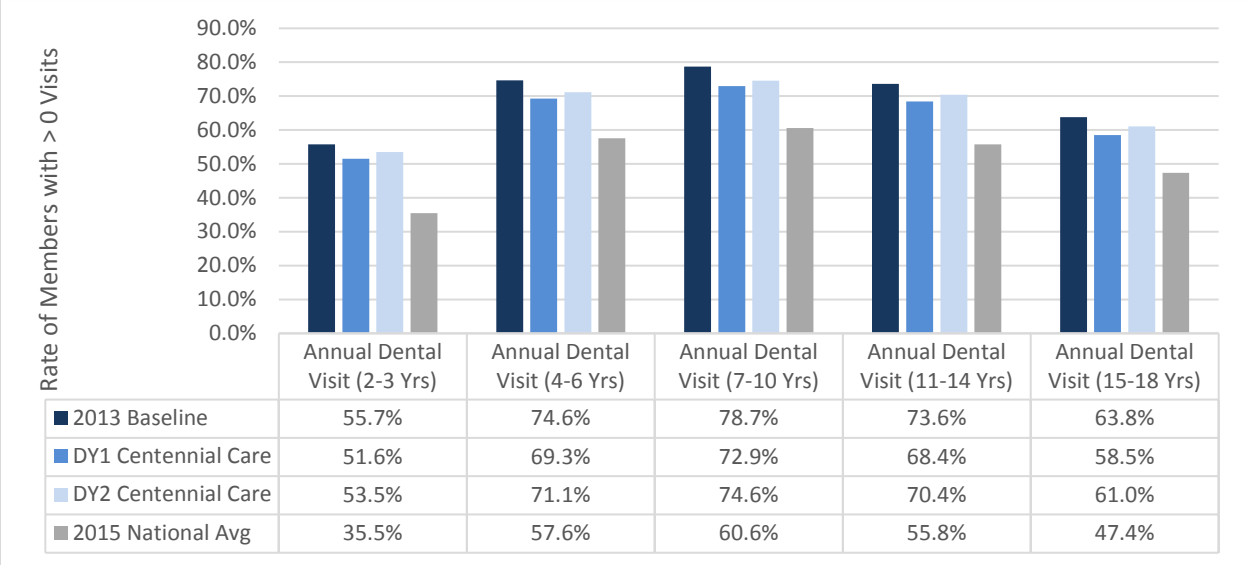
		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Adult Dental Visit	82,646	7.4%	152,833	19.7%	84.9%	164.4%

[118] Source: MCO annual HEDIS reports for 2013 – 2015.
[119] Source: Finity 2015 member rewards data.

Measure 87 – Annual dental visit – child.

Exhibit 87.a illustrates frequency of dental visits among children up to age 18 for the 2013 baseline, DY1, DY2, and the 2015 HEDIS Medicaid national average. The percentage of children receiving at least one dental visit annually increased in the range of 2.3% to 4.4% across all age cohorts from DY1 to DY2, although the rates decreased in the range of 4.0% to 5.2% across all age cohorts from the baseline to DY2. All rates of change are statistically significant at the 95% confidence level. It is important to note that DY2 performance exceeded the HEDIS Medicaid national average across all age cohorts.

Exhibit 87.a – Annual Dental Visit – Child[120]



	Annual Dental Visit (2-3 Yrs)	Annual Dental Visit (4-6 Yrs)	Annual Dental Visit (7-10 Yrs)	Annual Dental Visit (11-14 Yrs)	Annual Dental Visit (15-18 Yrs)
2013 Baseline	55.7%	74.6%	78.7%	73.6%	63.8%
DY1 Centennial Care	51.6%	69.3%	72.9%	68.4%	58.5%
DY2 Centennial Care	53.5%	71.1%	74.6%	70.4%	61.0%
2015 National Avg	35.5%	57.6%	60.6%	55.8%	47.4%

Exhibit 87.b summarizes members earning and redeeming Centennial Rewards points for activities performed to manage their children's dental health. As seen in the exhibit, the number of members earning rewards and the percentage of members redeeming rewards has increased substantially from DY1 to DY2. This may suggest the Centennial Rewards program incentivizes greater compliance for those registered and active in the program compared to the broader Centennial Care population.

Exhibit 87.b – Centennial Rewards for Child Annual Dental Visits, DY1 – DY2[121]

		Cumulative DY1		Cumulative DY1-DY2		% Change	
Activity Group	Activity	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	Number of Members Earning Rewards	Percentage of Members Redeeming Rewards	% Change in Members Earning Rewards	% Change in Redemption Rates
Dental	Child Dental Visit	157,152	8.9%	214,036	25.7%	36.2%	188.5%

[120] Source: MCO annual HEDIS reports for 2013 – 2015.
[121] Source: Finity 2015 member rewards data.

Measure 88 – Number of members spending credits.

Exhibit 88 summarizes the number of members spending credits in DY1 and DY2. As illustrated in the exhibit, the number of members registered, earning, and redeeming rewards all increased significantly from DY1 to DY2. More importantly, a larger percentage of members that are earning rewards are redeeming rewards in DY2 (20.0%) compared to DY1 (8.4%).

Exhibit 88 – Number of Members Spending Credits[122]

Measure	DY1	DY2
Number of Members Registered in the Rewards Program	46,537	155,764
Number of Members Earning Rewards	263,336	502,448
Number of Members Redeeming Rewards	22,150	100,579
Percentage of Members Redeeming Rewards	8.4%	20.0%

[122] Source: Finity 2015 member rewards data.

Hypothesis 4

Streamlining through Centennial Care will result in improved health care experiences for beneficiaries, improved claims processing for providers, and efficiencies in program administration for the state.

Centennial Care supports improved healthcare delivery and emphasizes greater access to primary care services. Access to primary care is important for preventive care and management of existing conditions because primary care may allow for members to increase use of preventive services and care management for existing conditions. Centennial Care seeks to enhance the access and availability of primary care to address existing care needs and prevent more serious conditions.

The Evaluation found that results of the Centennial Care program have been mixed, producing some improved outcomes and some that have declined since the implementation of the program. These outcomes vary among populations surveyed for individuals measured.

Research Question 4.A

Are enrollees satisfied with their providers and the services they receive?

The Centennial Care waiver consolidates services within a single program and defines performance standards for contracted MCOs related to timely adjudication of member grievances and appeals, access to providers, and responsive customer service. These performance standards are intended, in part, to improve the member experience and increase satisfaction with the program.

The Evaluation is reviewing Centennial Care's impact on member satisfaction through the analysis of 12 measures that address grievance and appeal resolution timeliness and components of member satisfaction. For each measure, performance is tracked over time against a baseline value as well as on an annual basis.

Overall through DY2 of the Centennial Care program, programmatic performance was generally positive from the member's perspective. Member satisfaction rates and grievances/appeals performance metrics reported showed improvement in 7 out of 12 measures. Improved performance was experienced in the percentage of expedited appeals resolved on time; and the percentage of appeals upheld, partially overturned, and overturned. There were also improvements across all three cohorts for the number and percentage of members satisfied with their care coordination, slight improvements for two of three subcomponents for the rating of personal doctors, and improvements across all three cohorts for customer service.

Measure performance remained relatively consistent through DY2 for the percentage of grievances resolved within 30 days and the number and percentage of calls answered within 30 seconds, both of which maintained high rates each year.

Opportunities for continued improvement were identified for the remaining three measures: rating of health care, which experienced slight decreases in two of three cohorts; rating for how well doctors communicate, which also experienced decreases in two of three cohorts; and the rating for the specialist seen most often, which decreased for two of three cohorts.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

In Appendix D, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative and conclusions of the report due to the timing that the data was received, but it is provided for the reader's consideration for more recent data.

Measure 88 – Percentage of expedited appeals resolved within three business days.

Exhibit 88 presents the rate at which expedited appeals were resolved within their allowed timeframes for DY1 and DY2. The overall resolution rate increased by 0.6% from DY1 to DY2.

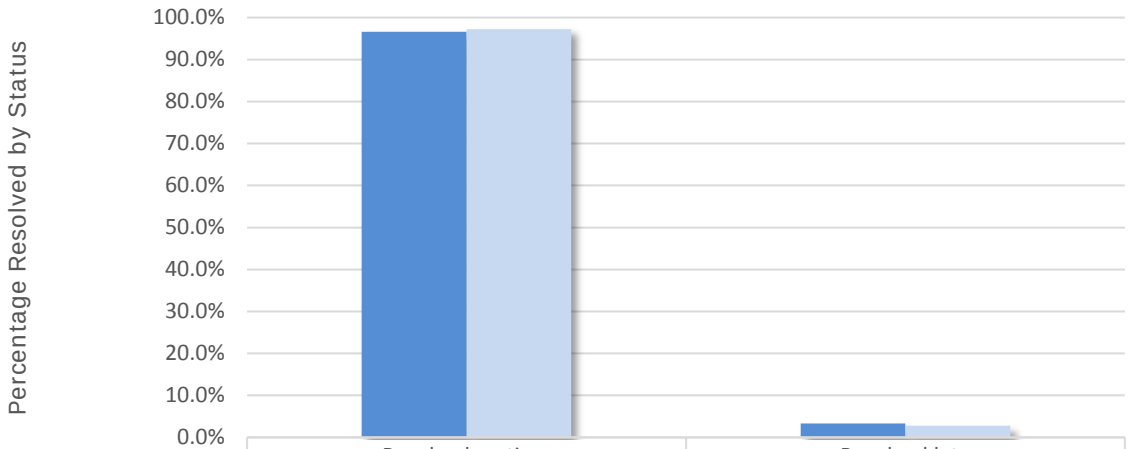
When analyzing changes from DY1 to DY2 among individual MCOs, PHP experienced the greatest increase (4.3%) followed by UHC (2.1%), while BCBS (-4.4%) and MHC (-0.9%) both experienced declines.

Emerging data through November of DY3 suggests that the rate at which expedited appeals were resolved within their allowed timeframe may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 88 – Percent of Expedited Appeals Resolved on Time[123]



	Resolved on time	Resolved late
DY1 Centennial Care	96.7%	3.3%
DY2 Centennial Care	97.2%	2.8%

[123] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 89 – Percentage of grievances resolved within 30 days.

Exhibit 89 presents the rate at which grievances were resolved within 30 days for DY1 and DY2. The overall resolution rate increased slightly by 0.1% from DY1 to DY2.

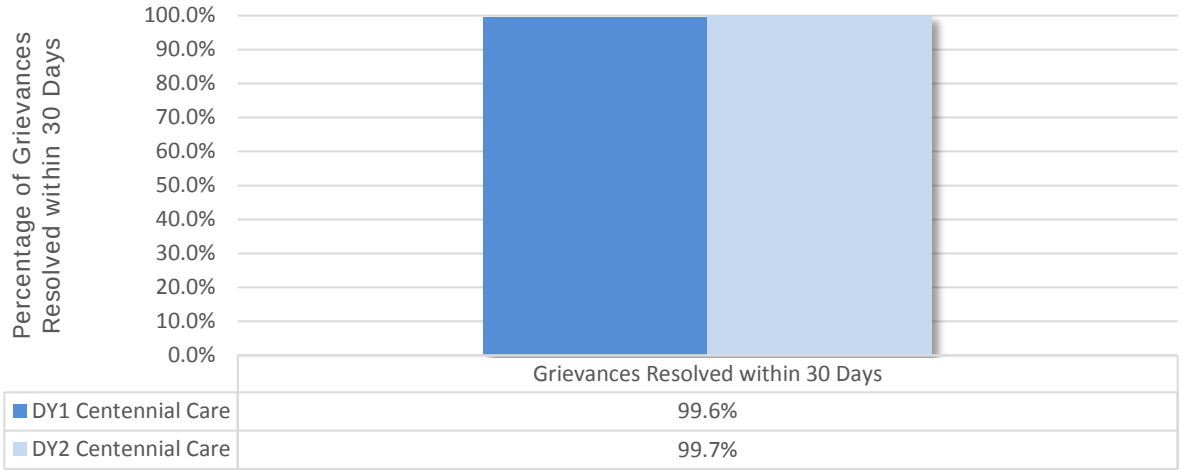
Among individual MCOs, BCBS experienced a 1.2% increase, and PHP's rate did not change from DY1 to DY2; MHC and UHC experienced declines in their rates over the same period of 0.1% and 0.4% respectively.

Emerging data through November of DY3 suggests that the rate at which grievances were resolved within 30 days may decline slightly from DY2 to DY3, however it should be noted that the overall resolution rates across all three demonstration years are very high.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 89 – Percentage of Grievances Resolved on Time[124]



[124] Source: MCO reports for 2014 – 2015 (HSD 37).

Measures 90, 91, and 92 – Percentage of appeals by adjudication (upheld, partially overturned, and overturned).

Exhibit 90 presents the rate at which appeals were upheld, partially overturned, or overturned. The rate at which appeals were upheld declined 6.4% from DY1 to DY2, while the rate at which appeals were partially overturned and fully overturned decreased over the same period by 45.4% and 11.0%, respectively.

Three of four MCOs experienced an increase in upheld appeals, a development that reflects positively on the adjudication of appeals under Centennial Care. The largest relative increase among MCOs was a 25.7% increase experienced by UHC. The other changes among BCBS, MHC, and PHP were -3.8%, 2.6%, and 3.4%, respectively.

BCBS, PHP, and UHC experienced decreases in the percentage of appeals that were partially overturned, which is also considered a positive development. MHC's rate did not change from DY1 to DY2.

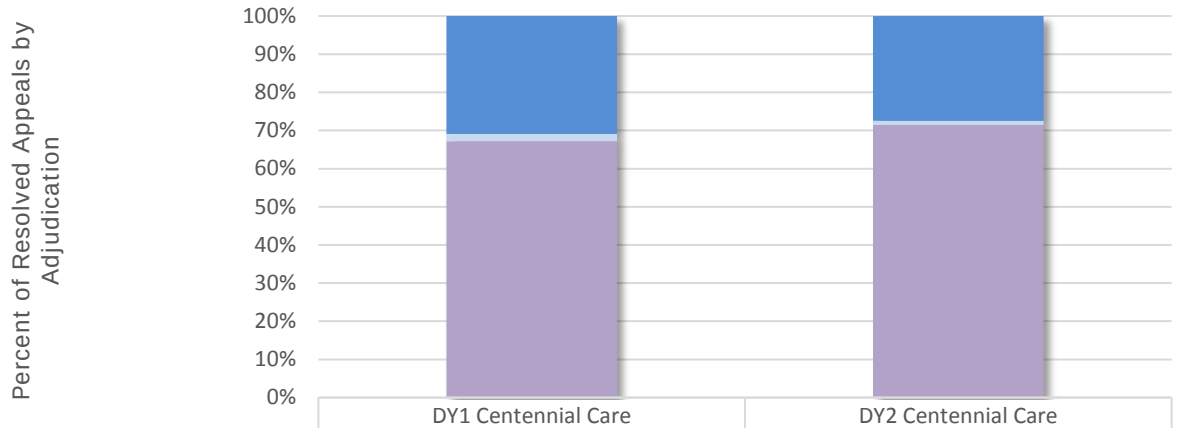
For the percentage of appeals fully overturned, MHC, PHP, and UHC each experienced a decline in the rate from DY1 to DY2, which is a positive development. BCBS experienced a slight increase over the same period.

Emerging data through November of DY3 suggests that Centennial Care may see a slight decline from DY2 to DY3 in appeals upheld and appeals partially overturned, and an increase in the percentage of appeals fully overturned.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 90 – Appeals by Adjudication[125]



	DY1 Centennial Care	DY2 Centennial Care
Appeals overturned	30.9%	27.5%
Appeals partially overturned	1.9%	1.0%
Appeals upheld	67.2%	71.5%

[125] Source: MCO reports for 2014 – 2015 (HSD 37).

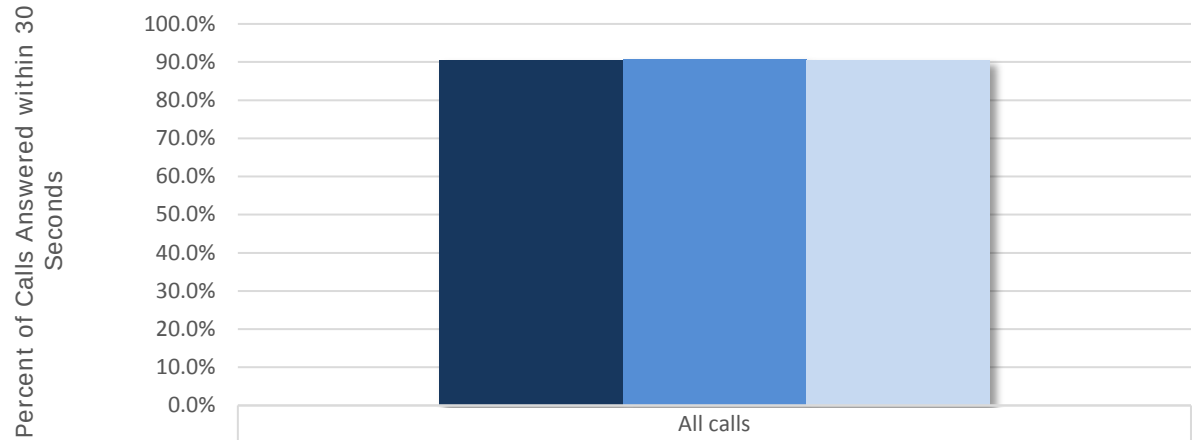
Measure 93 – Number and percentage of calls answered within 30 seconds.

Exhibit 93 presents rates for the 2013 baseline, DY1, and DY2 for the percentage of calls answered within 30 seconds. The percentage of calls answered within 30 seconds declined slightly from DY1 to DY2 by 0.3%, a change that was not statistically significant at a 95% confidence level. Overall, the rate declined slightly from the baseline to DY2 by 0.2%, which was not statistically significant at the 95% confidence level.

Only two MCOs, PHP and UHC, had a reportable rate in DY2, compared to all four having a reportable rate in DY1. Both rates improved from DY1 to DY2. UHC's increase (2.4%) was relatively larger than PHP's increase (0.3%), and both increases were statistically significant at the 95% confidence level. Both plans' increases from the baseline to DY2 were also statistically significant, and UHC's increase (1.9%) was greater than that of PHP (1.4%).

A national comparison rate could not be identified for this measure.

Exhibit 93 –Percentage of Calls Answered within 30 Seconds[126]



[126] Source: MCO Annual HEDIS Reports for 2013 – 2015.

Measure 94 – Number and percentage of participants satisfied with care coordination.

Exhibit 94 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average comparison rate for the percentage of participants satisfied with their care coordination. This information is based on CAHPS surveys that are sent out to random samples of eligible members covered under each MCO. Results of the survey are segmented into three population subgroups, the adult group, the child group ("child general population"), and children with chronic conditions (CCC).

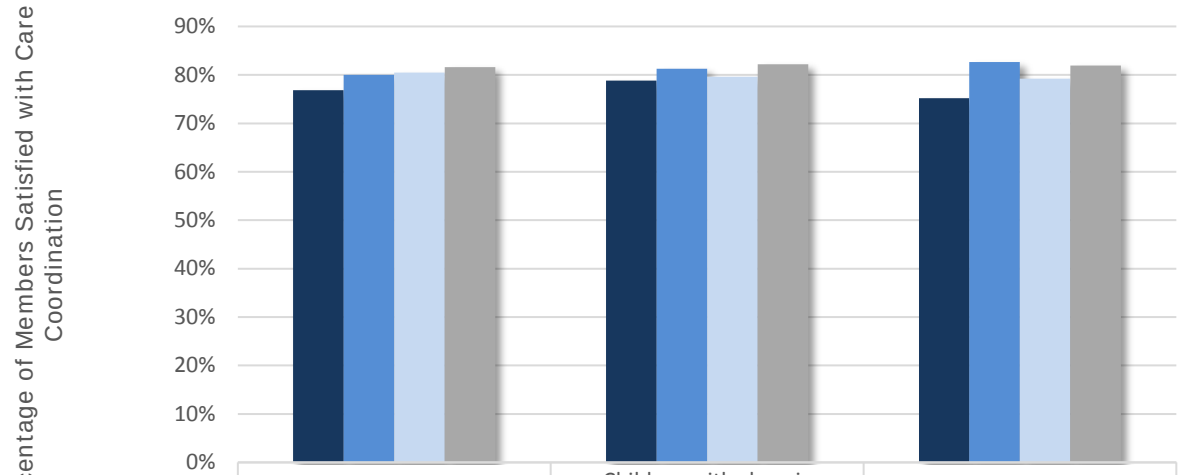
As illustrated, the percentage for the adult population in increased between DY1 and DY2 (1%), though declines were experienced among children with chronic conditions (-2%) and the child general population (-4%) during the same period.

All three population subgroups have experienced increases from the baseline to DY2 in the percentage of members that expressed satisfaction with their care coordination. The adult population has increased 5%, children with chronic conditions has increased 1%, and the child general population has increased 5% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 94 –Percentage of Participants Satisfied with Care Coordination[127]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	77%	79%	75%
DY1 Centennial Care	80%	81%	83%
DY2 Centennial Care	81%	80%	79%
2015 National Avg	82%	82%	82%

[127] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 95 – Rating of personal doctor.

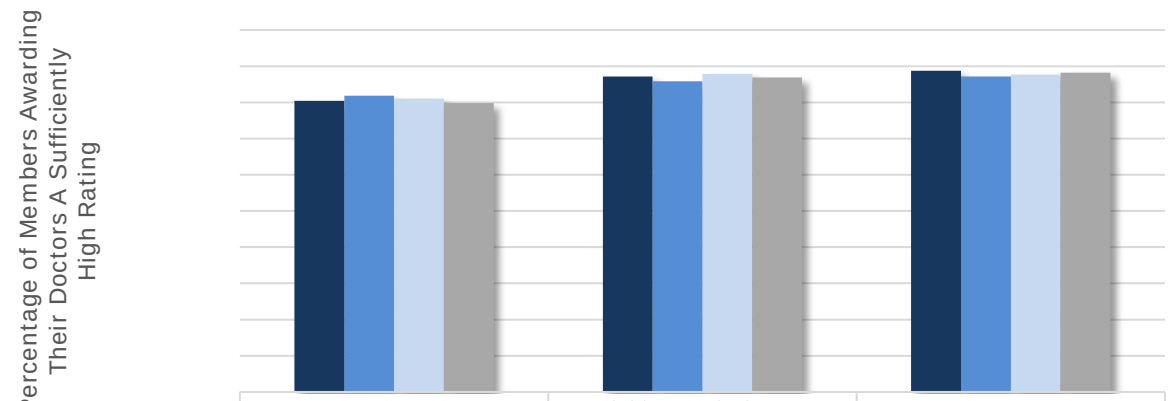
Exhibit 95 presents percentages for the 2013 baseline, DY1, DY2 and an appropriate national average for the percentage of participants satisfied with their personal doctor. As illustrated, the satisfaction percentage increased for two of three populations between DY1 and DY2, namely the child general population (1%) and children with chronic conditions (2%). The adult population's satisfaction with their personal doctor declined (-1%) over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with their personal doctor increased (1%) as did the percentage of children with chronic conditions (1%). The satisfaction of the child general population declined 1% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 95 –Percentage of Participants Satisfied with Personal Doctor[128]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	80%	87%	89%
DY1 Centennial Care	82%	86%	87%
DY2 Centennial Care	81%	88%	88%
2015 National Avg	80%	87%	88%

[128] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 96 – Rating of health care.

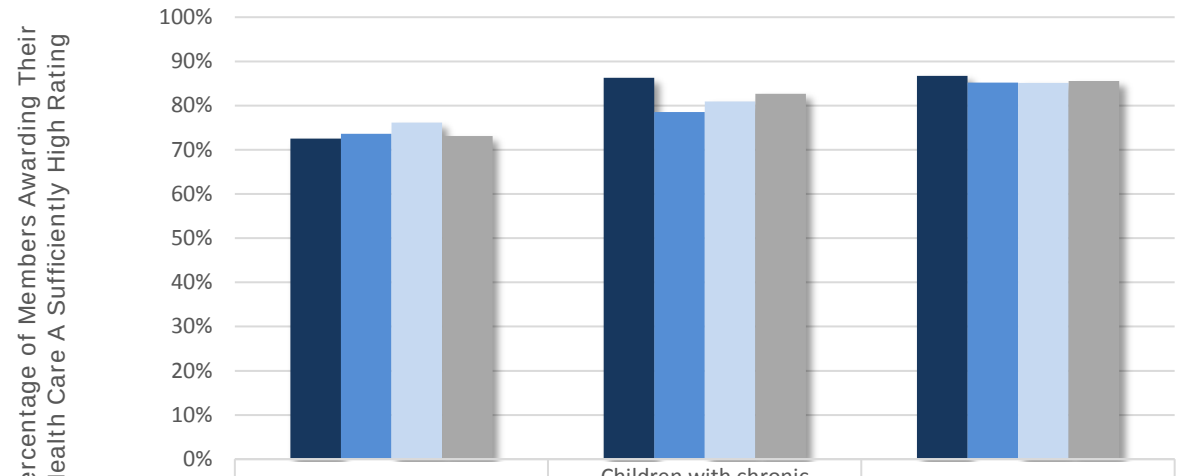
Exhibit 96 presents percentage for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members satisfied with their health care. As illustrated, the satisfaction percentage increased for two of three subcomponents between DY1 and DY2, namely the children with chronic conditions population (3%) and the adult population (3%). The child general population's high percentage of satisfaction with their personal doctor remained stable over the same period.

When analyzing the baseline to DY2 performance trends, the percentage of children with chronic condition satisfied with their health care declined (-6%) as did the percentage of the child general population (-2%). The satisfaction of the adult population increased by 5% from the baseline to DY2.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 96 – Percentage of Participants Satisfied with Health Care[129]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	73%	86%	87%
DY1 Centennial Care	74%	79%	85%
DY2 Centennial Care	76%	81%	85%
2015 National Avg	73%	83%	86%

[129] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 97 – Percentage of participants satisfied with how well their doctors communicate.

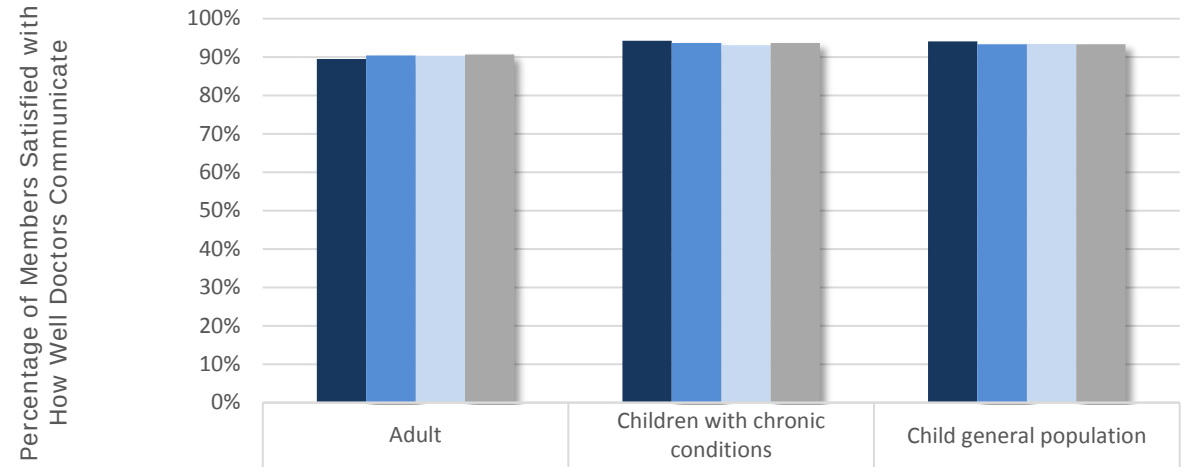
Exhibit 97 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of participants satisfied with how well their doctors communicate. As illustrated, the satisfaction percentage remained level for the child general population and the adult population from DY1 and DY2. There was a slight decline for the children with chronic conditions population (-1%) over this period.

When analyzing the baseline to DY2 performance trends, the percentage of adults satisfied with how well their doctors communicate increased (1%) while the satisfaction for the child general population and the children with chronic condition population both declined (-1%). The satisfaction percentage for DY2 were all within 1% of national averages.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 97 – Percentage of Participants Satisfied with How Well Their Doctors Communicate[130]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	90%	94%	94%
DY1 Centennial Care	90%	94%	93%
DY2 Centennial Care	90%	93%	93%
2015 National Average	91%	94%	93%

[130] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 98 – Customer service satisfaction.

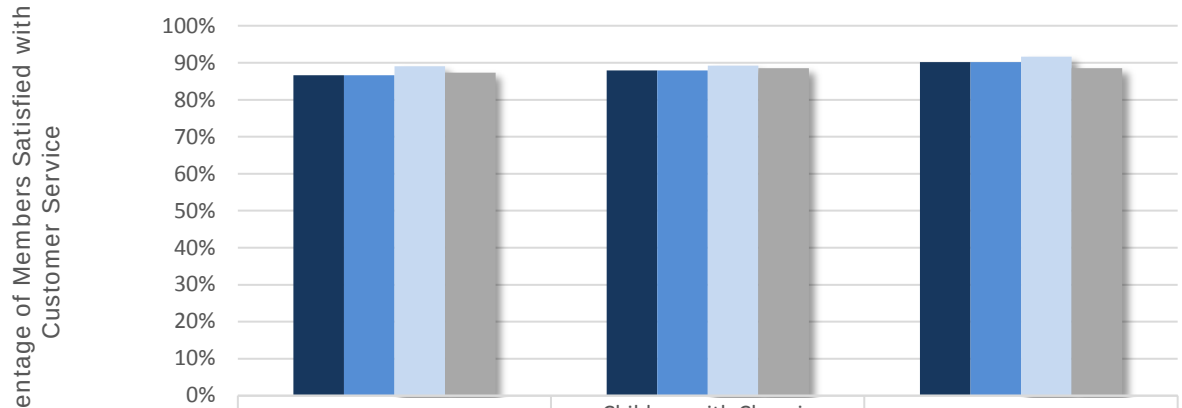
Exhibit 98 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with customer service. As illustrated, customer service satisfaction percentages increased across all three populations: adult satisfaction increased by 3%, satisfaction for children with chronic conditions increased by 1%, and the child general population satisfaction increased by 2% between DY1 and DY2.

When comparing the baseline to DY2 performance trends, all three populations experienced increases in the satisfaction rates by the same percentages as the DY1 to DY2 increases.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark rate for the adult and general child populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark rate as the SPH Analytics benchmark was not available.

Exhibit 98 – Customer Service Satisfaction[131]



	Adult	Children with Chronic Conditions	Child general population
2013 Baseline	87%	88%	90%
DY1 Centennial Care	87%	88%	90%
DY2 Centennial Care	89%	89%	92%
2015 National Avg	87%	89%	89%

[131] Source: MCO annual CAHPS reports for 2013 – 2015.

Measure 99 – Rating of specialist seen most often.

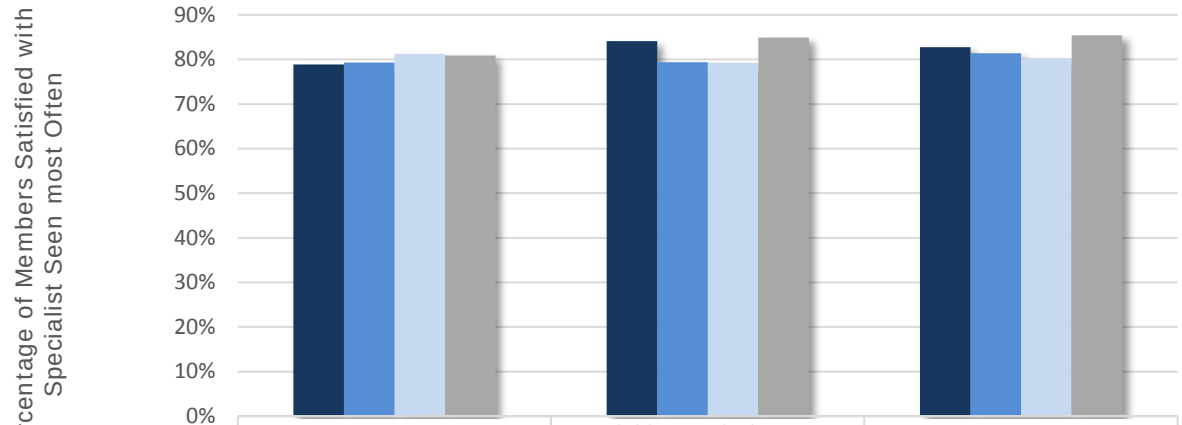
Exhibit 99 presents percentages for the 2013 baseline, DY1, DY2, and an appropriate national average for the percentage of members who were satisfied with the specialist seen most often. As illustrated, satisfaction increased among the adult population (2%) and decreased among the child general population (-1%) from DY1 to DY2. The percentage for the children with chronic conditions population did not change over this period.

When comparing the baseline to DY2 performance trends, the adult satisfaction with specialists increased (3%) while satisfaction declined for both children with chronic conditions (-6%) and child general population (-3%).

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

For a national average Deloitte used the SPH Analytics benchmark percentage for the adult and child general populations. For the children with chronic conditions population, Deloitte used the QC All Plans benchmark percentage as the SPH Analytics benchmark percentage was not available.

Exhibit 99 – Rating of Specialist Seen Most Often[132]



	Adult	Children with chronic conditions	Child general population
2013 Baseline	79%	84%	83%
DY1 Centennial Care	79%	79%	81%
DY2 Centennial Care	81%	79%	80%
2015 National Avg	81%	85%	85%

[132] Source: MCO annual CAHPS reports for 2013 – 2015.

Research Question 4.B

Are provider claims paid accurately and on time?

The Centennial Care program requires contracted MCOs to adjudicate and pay claims accurately and in accordance with prescribed timeliness standards. The program also includes a provider grievance and appeals process with uniform resolution timeliness standards. Centennial Care's streamlined processes are intended to improve the provider experience and increase provider satisfaction with the program. This, in turn, should encourage provider participation and facilitate member access to care.

The Evaluation is reviewing Centennial Care's impact on these processes through the analysis of five measures that address components of claim adjudication, processing, and payment from the health pan to the providers. For each measure, performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, the MCOs continue to demonstrate high compliance rates across the measures. There was a favorable decrease in the percentage of claims denied, and the percentage of provider grievances and provider appeals both remained relatively consistent with rates over 99% for both.

Results were mixed across subcomponents for the percentage of clean claims adjudicated; the 30 and 90 day adjudication rates declined slightly, though the 30 day rate was greater than HSD standards of 90%; for claims subject to the 15/30 day standard, the 15-day subcomponent increased slightly while the 30 day component decreased slightly. For each of the four subcomponents, the adjudication rates exceeded 96% in DY2.

The dollar accuracy rate also showed mixed results, as 5 of 10 subcomponents experienced slight decreases in accuracy rates while the others showed slight increases. The crossover claim type subcomponent demonstrated the greatest increase since program inception and is worth noting, as crossover claims are often complex to adjudicate due to the presence of Medicare as an additional payer. All accuracy rate subcomponents exceeded 93% in DY2.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 100 – Percentage of clean claims adjudicated within 30/90 days.

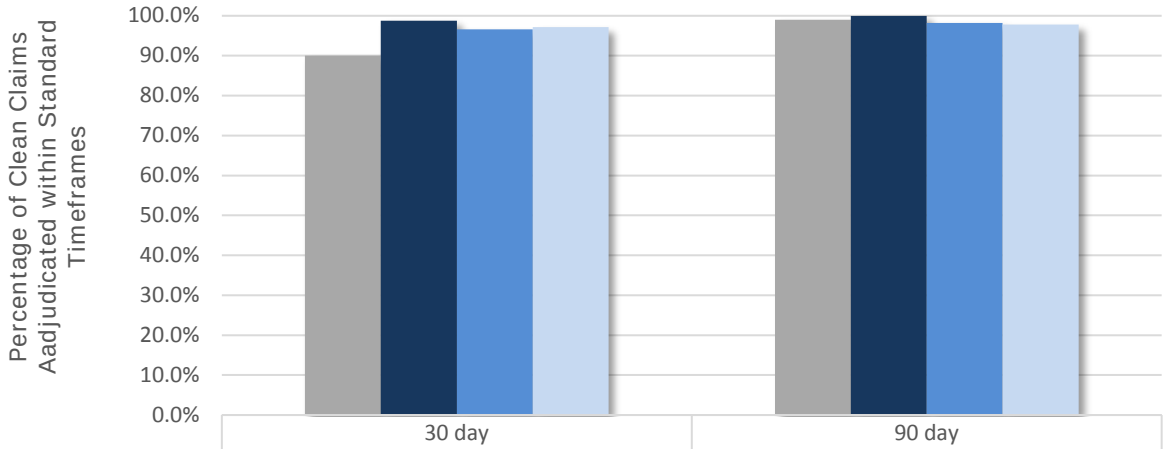
Exhibit 100.a presents the results for SFY 2013, DY1, and DY2 of the rate at which claims with a 30/90 day adjudication standard were resolved within 30 days. As illustrated, the rate increased from DY1 to DY2 by 0.6%. The rate at which these same claims were resolved within the 90 day interval declined slightly by 0.4%.

The rate at which claims with a 30/90 day adjudication standard were resolved within 30 days fell by 1.6% from SFY 2013 to DY2. The rate at which these same claims were resolved within the 90 day standard fell by 2.1% over the same period.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 100.a – Clean Claims Adjudicated within 30/90 Day Standard[133]



	30 day	90 day
HSD Standard	90.0%	99.0%
SFY 2013	98.8%	99.9%
DY1 Centennial Care	96.6%	98.2%
DY2 Centennial Care	97.2%	97.8%

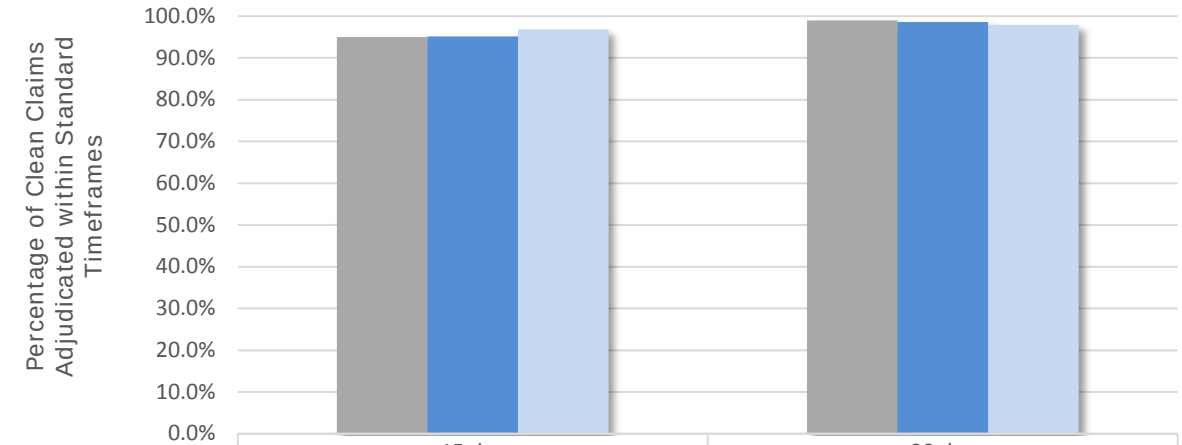
[133] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

Exhibit 100.b presents the results for DY1 and DY2 of the rate at which claims with a 15/30 day adjudication standard were adjudicated within 15 days. As illustrated, the rate increased by 1.7% from DY1 to DY2. The rate at which these same claims were adjudicated within the 30 day standard during this same interval declined by 0.7%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 100.b – Clean Claims Adjudicated within 15/30 Day Standard[134]



	15 day	30 day
HSD Standard	95.0%	99.0%
DY1 Centennial Care	95.2%	98.6%
DY2 Centennial Care	96.8%	97.9%

[134] Source: MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

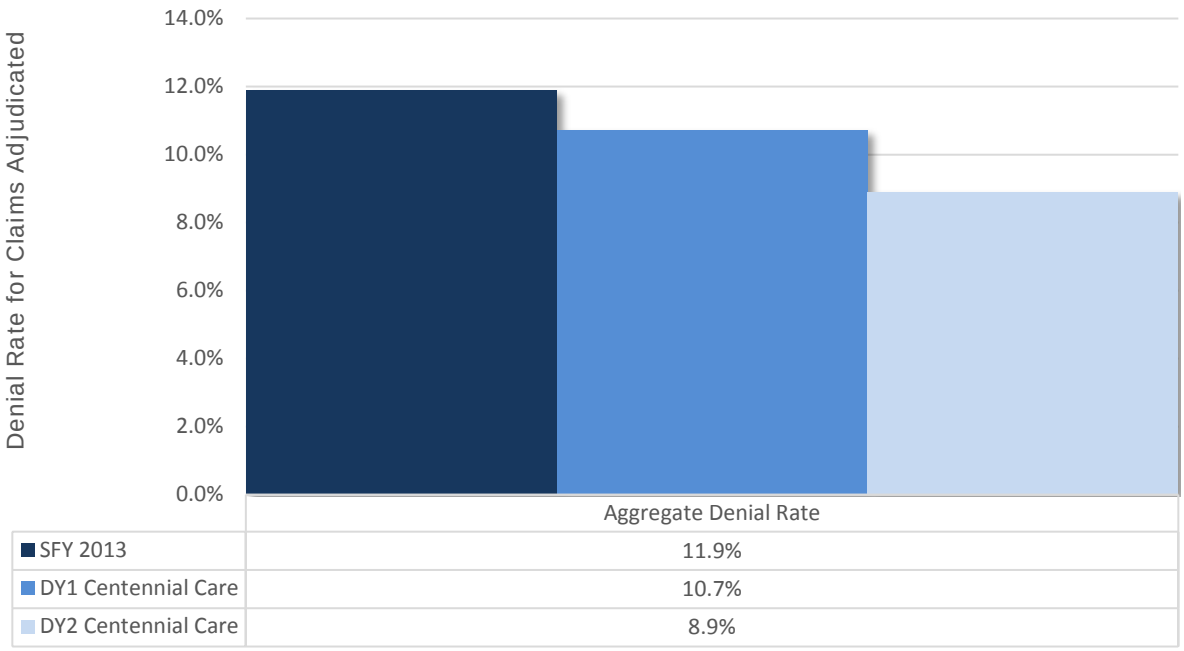
Measure 101 – Percentage of claims denied.

Exhibit 101 presents the results for SFY 2013, DY1, and DY2 of the rate at which claims were denied. As illustrated, the percentage decreased 17.0% from DY1 to DY2. From SFY 2013 to DY2, the rate at which claims were denied fell by 25.2%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 101 – Percent of Claims Denied[135]



	Aggregate Denial Rate
SFY 2013	11.9%
DY1 Centennial Care	10.7%
DY2 Centennial Care	8.9%

[135] Source: Provider Payment Timeliness Report for SFY 2013; MCO reports for 2014 (HSD 47); ad hoc claims payment and activity reports for 2015.

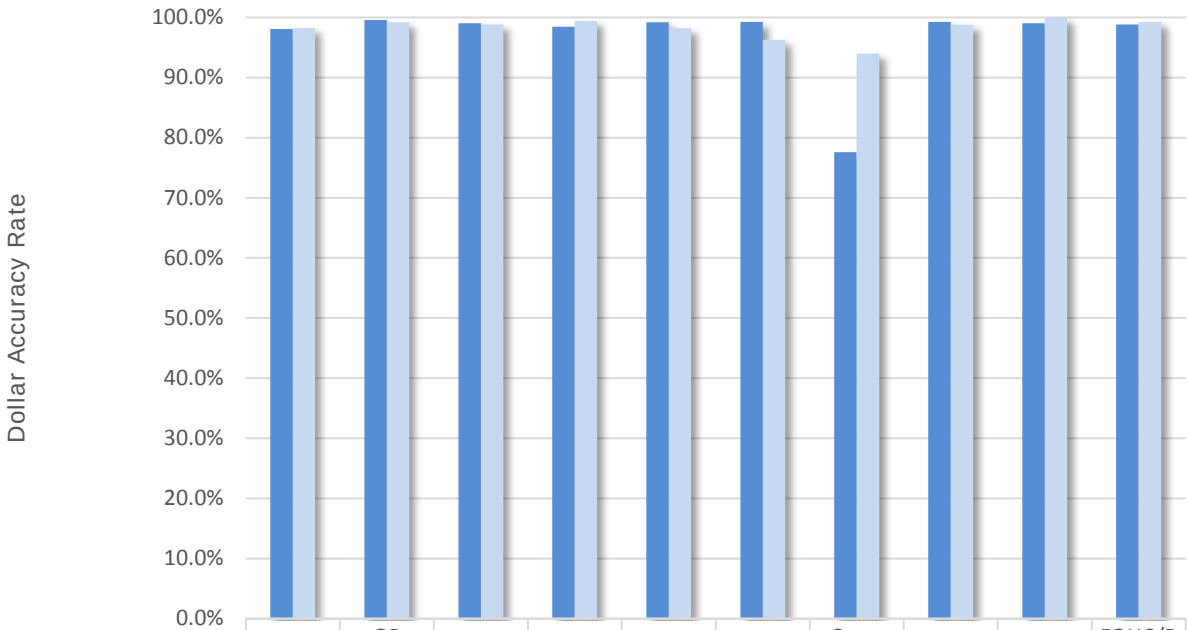
Measure 102 – Dollar accuracy rate.

Exhibit 102 presents results for dollar accuracy rates in DY1 and DY2. For the 10 types of claims reported, 5 showed increases in accuracy rates from DY1 to DY2, a positive development. The claim types that showed increases were inpatient hospital (0.1%), BH (1.0%), cross over (21.1%), dental (0.9%), and FQHC/RHC (0.5%). The claim types that experienced declines in dollar accuracy rates were outpatient hospital (-0.4%), professional (-0.2%), NF (-1.0%), I/T/U (-3.0%), and HCBS (-0.5%) type claims. These changes, whether increases or decreases, were relatively minor as accuracy rates remained high overall.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the data available.

Exhibit 102 – Dollar Accuracy Rate[136]



	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/RHC
DY1 Centennial Care	98.1%	99.6%	99.1%	98.5%	99.2%	99.3%	77.6%	99.3%	99.0%	98.8%
DY2 Centennial Care	98.2%	99.2%	98.8%	99.4%	98.2%	96.3%	94.0%	98.8%	99.9%	99.2%

[136] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate dollar accuracy rate due to data limitations; a dollar accuracy rate for each individual claim type was provided instead.

Measure 103 – Percent of grievances resolved on time.

Exhibit 103 presents rates for DY1 and DY2 of the percentage of provider grievances resolved on time. As illustrated, the rates for timely resolution remained high and were stable from DY1 to DY2, with a 0.0% change.

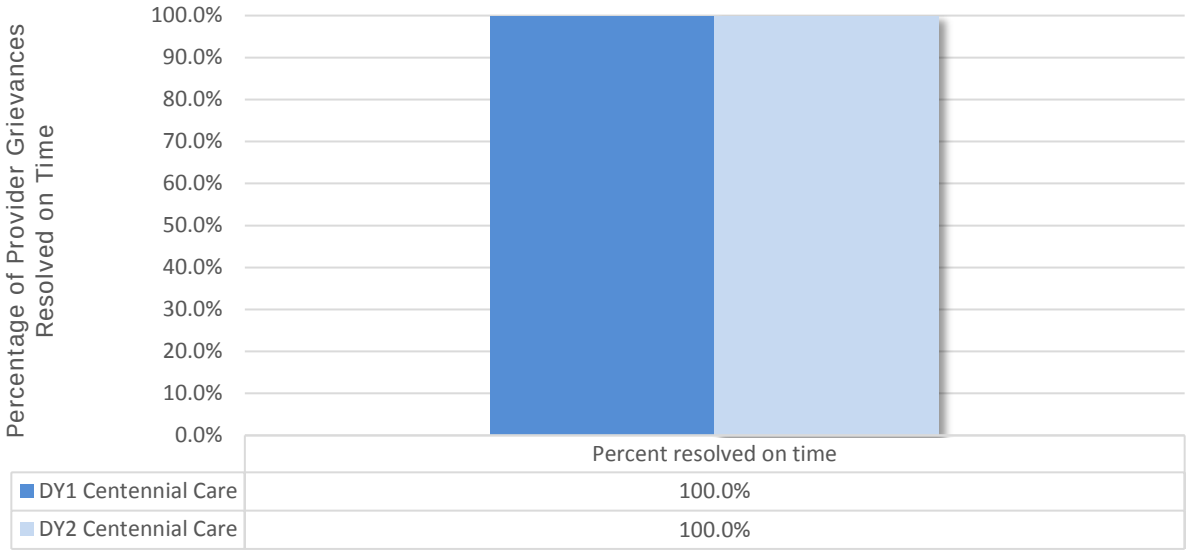
Individual MCO results were consistent with the calculated aggregate, where each MCO experienced 100% timely resolution in DY1 and DY2 with the exception of UHC, who did not produce data for this measure in DY1.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2 at 100% timely resolution.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 103 – Percent of Provider Grievances Resolved on Time[137]



[137] Source: MCO reports for 2014 – 2015 (HSD 37).

Measure 104 – Percentage of provider appeals resolved on time.

Exhibit 104 presents rates for DY1 and DY2 of the percentage of provider appeals resolved on time. As illustrated, the rate for timely resolution experienced a marginal increase from DY1 to DY2 by 0.2%.

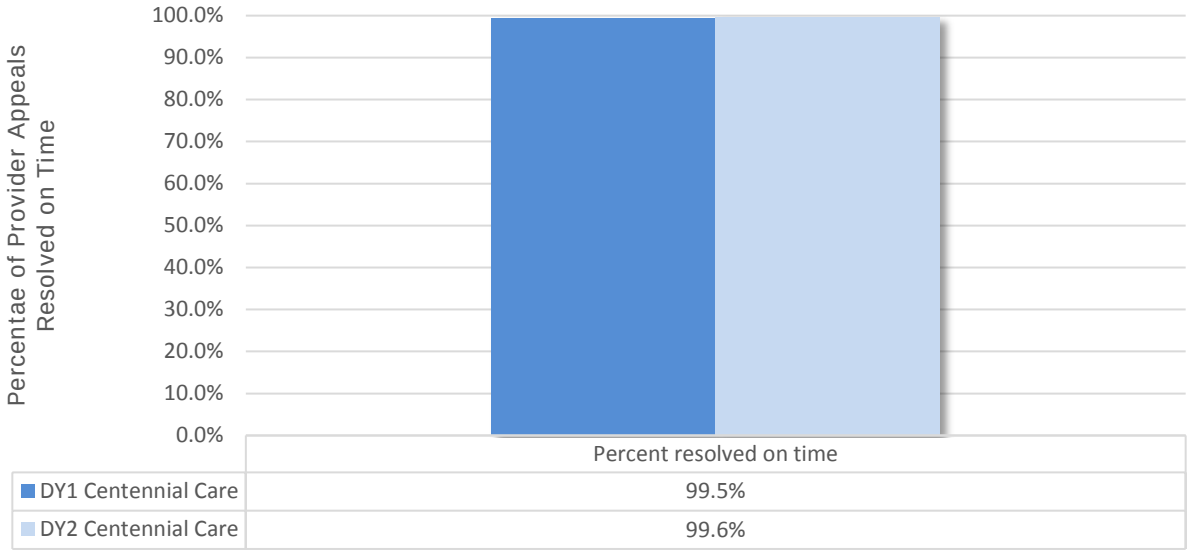
From DY1 to DY2, individual MCO results were also stable, with no MCO experiencing a change of more than 1.0%.

Provisional data is available through November of DY3, which suggests that DY3 rates will likely remain stable from DY2, with timely resolution rates at or above 99.0%.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to differences in reporting methodology across the MCOs.

Exhibit 104 – Percent of Provider Appeals Resolved on Time[138]



[138] Source: MCO reports for 2014 – 2015 (HSD 37).

Research Question 4.C

Has the state successfully implemented new processes and technologies for program management, reporting, and delivery system reform?

The Centennial Care waiver seeks to improve the efficiency and effectiveness of health care delivery through adoption of new processes and technology.

The Evaluation assesses the impact of program consolidation and adoption of new processes and technologies through analysis of three measures that address use of electronic tools for patient management, implementation of care delivery and payment reforms, claims payment accuracy and program reporting activities. One of these measures evaluates payments made for providers who demonstrate "meaningful use" of electronic health record (EHR) technology, which involves meeting a set of standards and specifications defined by CMS for how the technology is used to improve healthcare. For each measure performance is tracked over time against a baseline value and on an annual basis.

Overall through DY2 of the Centennial Care program, progress continues to be made across all three measures. The number of eligible providers receiving EHR incentive payments has remained steady for hospitals and initial payments continue to increase slightly for professionals. Follow-up payments have declined in recent years however it must be noted that both hospitals and professionals are limited to a specific number of payments within the program, so the decreasing follow-up payments may reflect "aging out" of the incentive program.

In addition, the percentage of claims paid accurately increased across all ten claim-type subcomponents, and PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms) has shown increases in members attributed to a PCMH and favorable decreases in hospital readmissions, however there were unfavorable increases in ER visits.

In addition to the discussion and exhibits provided below, a summary of measure definition and methodology can be found in Appendix A, and a summary of key data relevant to these measures can be found in Appendix B.

Measure 106 – Number of eligible providers receiving Electronic Health Record (EHR) incentive payments.

Exhibit 106.a presents rates for 2011 through 2016 of the number of hospitals that received EHR payments.

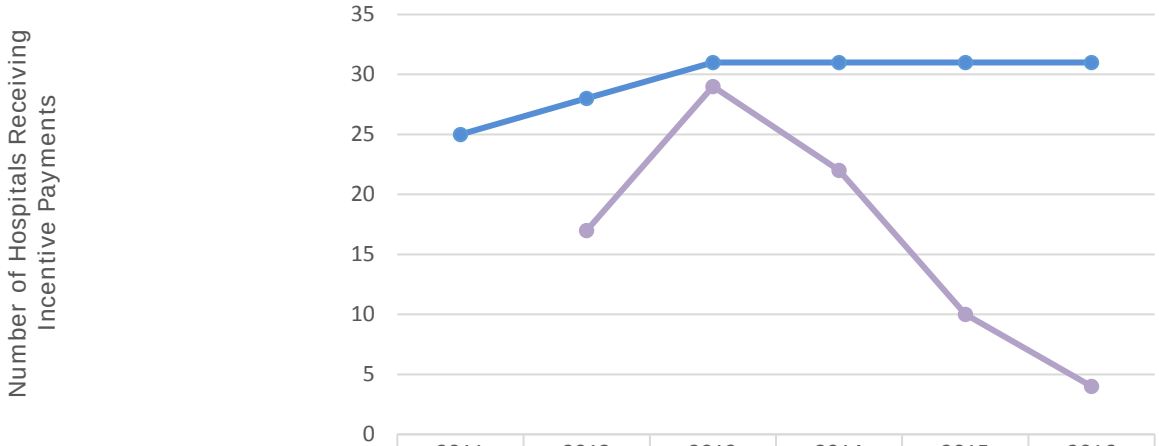
The number of initial hospital payments did not increase from 2015 to 2016. These payments are only available to new participants in their first year of the program and may not be received more than once. This year-to-year stability in the cumulative payments suggests that all hospitals interested in participating in the EHR incentive program and receiving payments have already been engaged. The majority of these hospitals (80.6%) were engaged in 2011 alone.

The number of meaningful use payments showed a 60.0% decrease from 2015 to 2016. This is not necessarily a negative development, as hospitals may only receive EHR payments for three years before they are no longer eligible. Over 88% of the meaningful use payments that could possibly be made, based on the number of providers in the program, have already been made.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 106.a – Number of Hospitals Receiving EHR Incentive Payments[139]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	25	28	31	31	31	31
Meaningful Use Payment (per year)		17	29	22	10	4

Exhibit 106.b presents the number of professional providers that received incentive payments from 2011 to 2016.

The incremental increase in the number of initial payments made to eligible professionals decreased by 47.1% from 2015 to 2016, but this decline is not necessarily negative. Similar to the hospital payments, there are limitations on the EHR payments. Each provider may receive an initial payment once, so a decrease in the number of providers receiving those payments may be reflective of the relatively smaller number of professional providers yet to be involved in the program. In addition, the University of New Mexico Medical Group came back into the EHR program in 2015, with associated eligible professionals receiving initial payments and meaningful use payments. This event greatly

[139] Source: HSD ad hoc reports for 2014 – 2016.

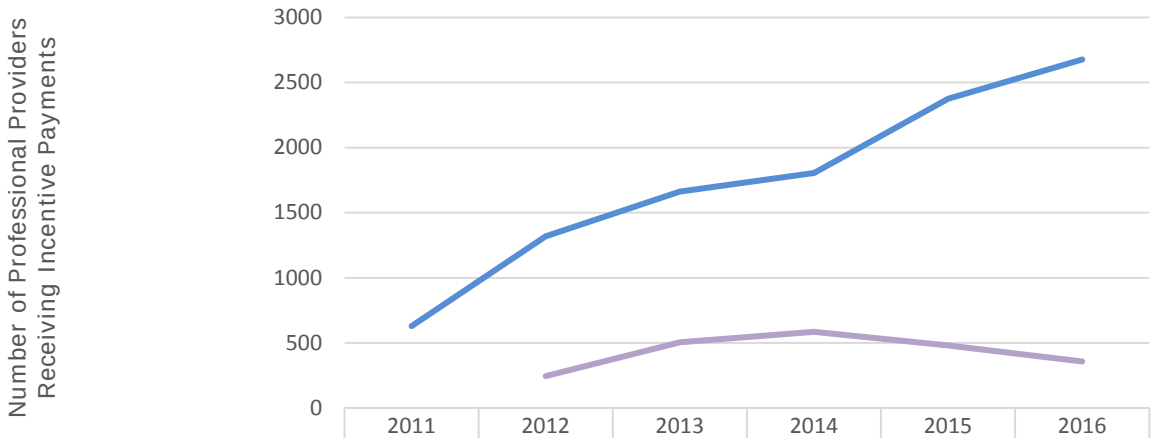
increased the number of initial EHR payments in 2015, and therefore a subsequent drop in the number of initial payments in 2016 was to be expected.

The number of meaningful use payments dropped from 2015 to 2016 by 25.6%. As with the hospital meaningful use payments, there is a six-payment limit for any one eligible professional, so a decline may be reflective of a smaller number of professionals still eligible and an overall effective program. In addition, the 2016 meaningful use count is affected by a problem encountered by the University of New Mexico Medical Group, a source of many of the eligible providers within the state. Providers of this group were unable to successfully attest and this likely affected the 2016 payment count.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 106.b – Number of Eligible Professionals Receiving EHR Incentive Payments[140]



	2011	2012	2013	2014	2015	2016
Initial Payment (cumulative)	629	1319	1662	1804	2375	2677
Meaningful Use Payment (per year)		245	504	585	480	357

[140] Source: HSD ad hoc reports for 2014 – 2016.

Measure 108 – Percentage of claims paid accurately.

Exhibit 108 presents results for DY1 and DY2 of the percentage of claims paid accurately. For each of the ten types of claims reported, accuracy rates increased from DY1 to DY2.

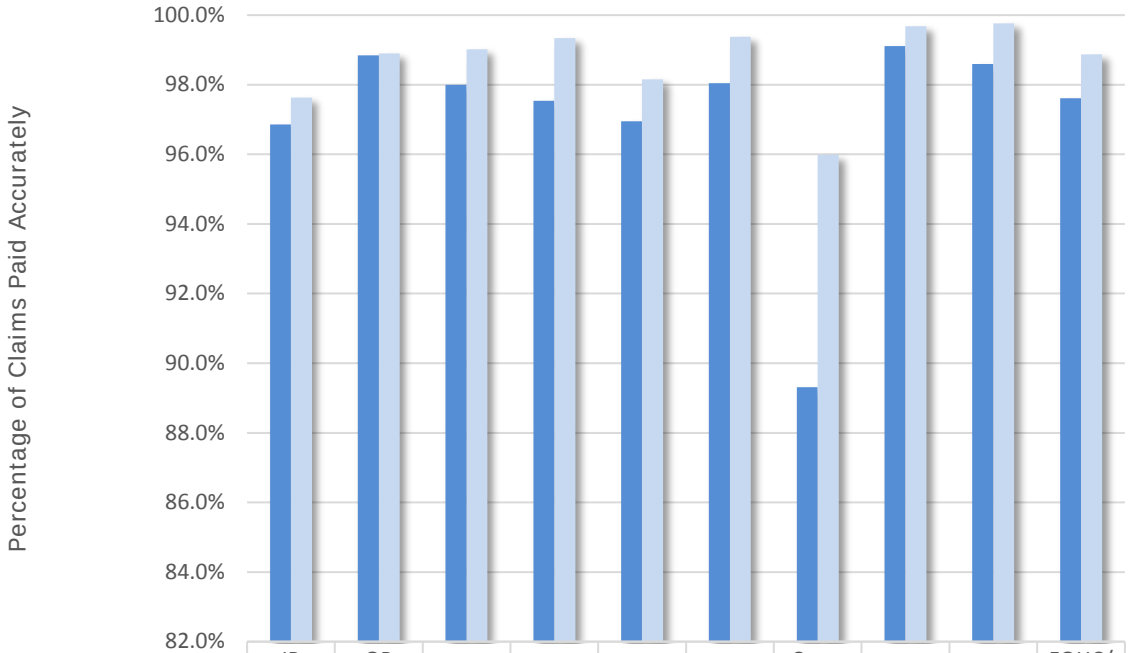
The increases were 0.8% for inpatient hospital, 0.1% for outpatient hospital, 1.0% for professional, 1.9% for BH, 1.2% for NF, 1.4% for I/T/U, 7.5% for cross over, 0.6% for HCBS, 1.2% for dental, and 1.3% for FQHC/RHC.

DY3 results were developing as this narrative was being drafted, but not in sufficient detail to merit being provisionally included in this analysis.

A national comparison rate could not be identified for this measure.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

Exhibit 108 – Percentage of Claims Paid Accurately[141]



	IP Hosp	OP Hosp	Prof	BH	NF	I/T/U	Cross over	HCBS	Dental	FQHC/ RHC
DY1 Centennial Care	96.9%	98.8%	98.0%	97.5%	97.0%	98.0%	89.3%	99.1%	98.6%	97.6%
DY2 Centennial Care	97.6%	98.9%	99.0%	99.3%	98.2%	99.4%	96.0%	99.7%	99.8%	98.9%

[141] Source: MCO reports for 2014 (HSD 46); ad hoc claims payment and activity reports for 2015. For DY2, Deloitte was unable to calculate an aggregate payment accuracy rate due to data limitations; a payment accuracy rate for each individual claim type was provided instead.

Measure 109 –PCMH member attribution and hospital/ER utilization (use and outcomes of payment reforms).

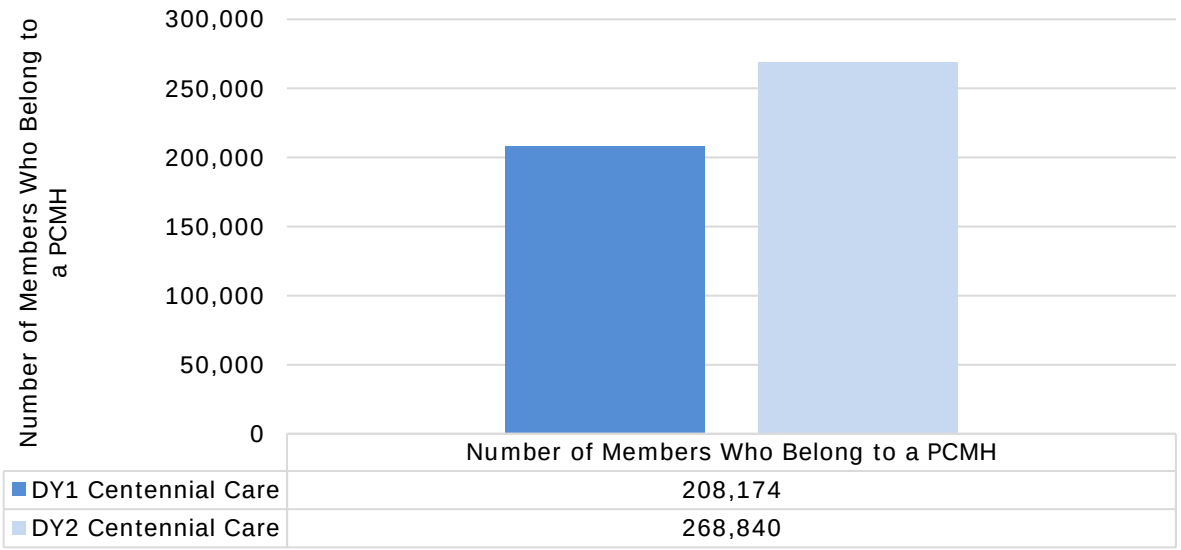
Exhibits 109.a and 109.b presents results for DY1 and DY2 for PCMH membership attribution and the Hospital/ER Utilization impact for members attributed to a PCMH. This definition is being used as an alternative for "use and outcomes of payment reforms" since the data source for this measure focuses on PCMHs and impact on member readmissions as opposed to all payment reform projects (ACOs, gainsharing, etc.).

As illustrated, the number of members who belong to PCMH increased by 29.1% from DY1 to DY2. There were declines in the percentage of PCMH members with a hospital readmission within 30 days of a pervious hospital admission (-34.5%) and in the percentage of PCMH members with one ED visit during the year (-6.3%). There were also increases in the percentage of members with a PCMH visit seven days after an ED visit (2.9%), the percentage of members with two or three ED visits (48.3%), and the percentage of members with four or more ED visits (130.9%), though the percentage with four or more visits was below 3.0%.

Statistical significance was not calculated for this measure due to the aggregate nature of the available data.

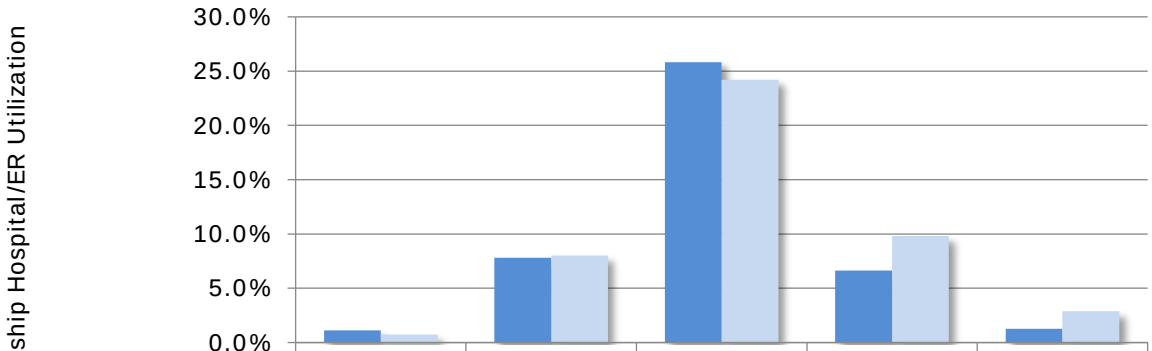
No national benchmark rate could be identified for this measure.

Exhibit 109.a – Number of Members who Belong to a PCMH[142]



[142] Source: MCO reports for 2014 – 2015 (HSD 48).

Exhibit 109.b – PCMH Membership Hospital/ER Utilization[143]



	Percent PCMH members readmitted to a hospital within 30 days of a previous hospital admission	Percent PCMH members seen at the PCMH site within 7 days following a hospital admission or emergency departme…	Percent PCMH members who visited the emergency departmen t 1 time during the reporting period	Percent PCMH members who visited the emergency departmen t 2-3 times during the reporting period	Percent PCMH members who visited the emergency departmen t 4 or more times during the reporting period
DY1 Centennial Care	1.1%	7.8%	25.8%	6.6%	1.3%
DY2 Centennial Care	0.7%	8.0%	24.2%	9.8%	2.9%

[143] Source: MCO reports for 2014 – 2015 (HSD 48).

Conclusion

The Centennial Care 1115 Waiver program is largely progressing on the major designated goals to date. One significant change to the program was that total Centennial Care member months increased by about 1,306,000, or 17.8%, from DY1 to DY3. The vast majority of this increase was driven by the Medicaid expansion group, which grew by 63.3%.

Major Centennial Care program goals include commitments to improving care access, enhancing care coordination and integration, improving the quality of care, reducing the growth trend in program expenditures, increasing member engagement and satisfaction, and implementing new processes and technologies:

- **Improving Access to Care –** The 1115 Waiver Evaluation found mixed results in timely access to care as compared to the baseline of the Centennial Care program. Improvements were found in the percentage of state population enrolled in Centennial Care, the percentage of Native Americans opting into Centennial Care, the ratio of providers to members, increased access to telemedicine, the percentage of members utilizing newly available BH services (BH respite, family support, and recovery services), and the rate of flu vaccinations.

  The Evaluation found declines in various performance measures as well. The declines were found in the number of adult members accessing preventive/ambulatory services, the percentage of members utilizing mental health services (as indicated by their principal diagnosis), the percentage of members who had an annual dental visit (although the rates across the cohorts are higher than the national averages), the percentage of members who had a PCP visit, the percentage of PCPs with open panels, breast cancer screening rates, cervical cancer screening rates, childhood and adolescent immunization rates, and prenatal and postpartum care. These declines represent potential areas for improvement in coming years, and in some cases were potentially affected by external factors such as the expansion of Medicaid and the continued influx of these members.

- **Improving Care Coordination** – The Evaluation generally noted improvements in care coordination activities. Improvements were observed in the percentage of members the MCOs were able to engage, the percentage of members for whom HRAs were completed, and the percentage of Level 2 and level 3 members who received telephonic and in-person outreach.

  There has been an increase in the number of unique members receiving Home and Community-Based services (HCBS), and an overall increase in HCBS provided. New Mexico continues to be successful in its rebalancing efforts with 84.6% of long-term care members receiving long-term services in their homes and 13.6% of members residing in nursing facilities.

- **Improving Care Integration** – The Evaluation noted mixed progress in care integration activities. Improvements were noted in the increased percentage of members who had a BH service and also received outpatient ambulatory visits and a favorable decline in the ER visit rates among members with BH needs. Rates also increased for members with LTSS who accessed BH services, and members who accessed a BH service who also accessed HCBS.

  Conversely, performance declined for ER visit rates for LTSS members, diabetes screening for members with schizophrenia or bipolar disorder, diabetes monitoring for members with diabetes and schizophrenia, and the percentage of members accessing both BH services and PCP Visits.

- **Improving Quality of Care –** The Evaluation found continued improvements in quality of care as noted in the findings for the assigned performance measures. There were

improvements in the EPSDT screening ratios; increases in monitoring rates of BMI for adults, children and adolescents; and increases in asthma medication management. Hospital admission rates also decreased across nearly all ACS measures. Finally, there was a decline in the percentage of ER visits that were potentially avoidable and fall risk intervention.

Conversely, performance declined for asthma medication ratios, smoking and tobacco use cessation, annual patient monitoring for persistent medications, and inpatient admissions to psychiatric hospitals and RTCs.

- **Reducing Expenditures and Shifting to Less Costly Services** – The Evaluation found that the program continued to demonstrate significant savings in comparison to the waiver budget neutrality threshold through DY3. Total program expenditures for DY3 alone were 21.8% below the budget-neutral limits as defined by the Special Terms and Conditions (STCs), which includes per member per month (PMPM) cost caps by MEG, uncompensated care costs, and HQII pool amounts. The total cost of Centennial Care since inception through DY3 combined is below the budget neutrality limits as defined by the STCs by about $2.5 billion, or 15.8%.

  In addition, inpatient claims exceeding $50,000 as a percentage of healthcare costs were slightly lower. There were also improvements in most subcomponents for the use of mental health services, desirable decreases in hospital readmission rates, positive increases in the use of substance abuse services and use of HCBS, positive shifts in pharmacy utilization where usage of generic drugs is more prevalent than brand drugs, and positive shifts from higher LOC NF utilization to lower LOC NF utilization.

  The Evaluation also found negative changes in utilization for certain measures. There was a decline in performance from the baseline to DY3 for diagnostic imaging costs, hospital costs, and ED utilization, all of which experienced unfavorable increases.

- **Increased Member Engagement** – There was a significant increase in the number of members becoming enrolled in the Centennial Rewards program and performing various wellness-related activities designed to earn rewards under the program; at the end of DY1, approximately 47,000, or 7.1% of eligible members, were registered for the program. At the end of DY2, approximately 156,000, or 20.2% of eligible members were registered for the program. There are over 40 activities members can perform to earn rewards from adhering to monthly prescriptions to getting an annual dental visit. In all 40 categories, the percentage of members earning rewards (i.e. performing a health/wellness activity) increased through DY2.

- **Increased Member Satisfaction** – The Evaluation found that member satisfaction results largely improved through DY2. Measures that exhibited improvements included the percentage of expedited appeals resolved on time and the percentage of appeals upheld. Improvement was also noted in the number of appeals partially overturned and overturned, marked by decreases through DY2. Satisfaction rates for care coordination and customer service satisfaction rates also increased for members from the baseline to DY2.

  Note that the Centennial Rewards program was a brand new program that required introductory member outreach for making members aware of the program and how to participate. It began April 1, 2014 and thus there were fewer months in DY1 in which members were able to register and participate in the program.

- **Implementing New Processes and Technologies** – The three measures for which there are sufficient data showed mixed results through DY2. There were improvements in the percentage of claims paid accurately increased across all claim types and the number of members attributed to a PCMH under a payment reform program. Conversely, incentive payments for EHR use either increased, decreased, or experienced little change depending on the type of provider and type of payment made.

In conclusion, the Centennial Care waiver demonstration has yielded many promising results and progress made aligning with the four hypotheses set forth in the Evaluation Design Plan. Certain areas were identified for improvement in future years, and while many aspects of the program are demonstrating positive results, the Evaluation would expect continued progress as the program matures, and as HSD continues to work with the MCOs to continue to enhance the program.

Appendix

A. Measure Definition and Evaluation Methodology

Measure	Measure Name	Definition	Evaluation Methodology	
1	Access to preventive/ambulatory services among Centennial Care members in aggregate and within subgroups	"Access to Preventive/Ambulatory Health Services" is a Healthcare Effectiveness Data and Information Set (HEDIS) measure that reports the percentage of adults ages 20 and older who had an ambulatory or preventive care visit during the measurement year. It provides important information about the accessibility of primary/preventive services for adult Centennial Care enrollees. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
2	Mental health services utilization	"Mental Health Utilization" is a HEDIS measure that reports the number and percentage of enrolled members receiving any mental health service during the measurement year with mental health as the principal diagnosis based on the HEDIS mental health diagnosis value set. It provides important information about the availability of mental health services to Centennial Care enrollees.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
		The measure applies to members of all ages. The service types counted in the measure include: • Inpatient care at either a hospital or a treatment facility (including residential care and rehabilitation facilities) with mental health as the principal diagnosis • Intensive outpatient and partial hospitalization encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician • Outpatient and ED encounters in conjunction with a principal mental health diagnosis, whether treated by a physician or non-physician.		comparison purposes only; it is not an audited HEDIS rate.
3	Number of telemedicine providers and telemedicine utilization	"Number of Telemedicine Providers and Telemedicine Utilization" is a measure that reports the number of units of service rendered via telemedicine during the measurement year. As a rural state, New Mexico has the potential to improve access to care through greater use of technology such as telemedicine/telehealth. In Amendment Number 3 to the Centennial Care Agreement, HSD defined the following Telehealth Delivery Service Improvement Target: *"A minimum of a fifteen percent (15%) increase in telehealth "office" visits with specialists, including behavioral health providers, for members in rural and*	Baseline	For the 2013 baseline rate, HSD furnished Deloitte with telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs. The MCOs followed a consistent methodology in terms of services included and excluded from the data. For example, services in urban areas and services associated with Project ECHO were not counted as telemedicine visits. However, behavioral health services in 2013 were provided by a separate behavioral health organization and one of the four MCOs reported that it did not include BHO telemedicine activity for its members in its 2013 data. Therefore, 2013 behavioral health visit count provided appears to understate total activity for the year.

Measure	Measure Name	Definition	Evaluation Methodology	
		frontier areas. At least five percent (5%) of the increase must be visits with behavioral health providers." Each of the Centennial Care Managed Care Organizations (MCOs) has undertaken steps to increase the use of telemedicine around the state. For example, one MCO recently launched an initiative to provide urgent behavioral health care through its telehealth platform. Another has begun providing tele-dermatology consultations to primary care physicians and tele-pulmonology services for clinically fragile members in rural and frontier areas. The measure examines the number of telemedicine professional services (visits) occurring each year in rural/frontier New Mexico, with behavioral and physical health visits separately reported.		For the DY1 and DY2 counts, HSD again furnished telemedicine visit data obtained through ad hoc reports filed by the four Centennial Care MCOs.
4 and 5	Number and percentage of people meeting nursing facility level of care who are in a nursing facility/receive home-and community-based services	Centennial Care members who meet financial and clinical eligibility criteria for nursing facility level of care may receive long term care services either in a nursing facility or in their home or another community setting. Members have the right to receive long term care in a community-based setting when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into	Baseline to DY3	For both NF and HCBS rates for all years, Deloitte was provided with rates by HSD with no additional data regarding numerators, denominators, or overall counts. The data is driven by membership in INF and community benefit cohorts (consisting of ADB, ANW, SDB, and SNW) and the analysis of encounter data was performed by Mercer.

Measure	Measure Name	Definition	Evaluation Methodology	
		account the resources available to the public entity and the needs of others who are receiving services from the entity. Although nursing facilities remain an essential care setting, HCBS settings are often preferred by members and are, on average, less costly than nursing facilities. One of the objectives of Centennial Care is to gradually "re-balance" where members are served, from institutional to HCBS settings. This combined measure identifies the portion of the population at the nursing facility level of care that resides in a nursing facility and the portion residing at home or in the community and receiving HCBS. (Measures 1.4.A and 5 have been combined to avoid redundancy.)		
6	Number and percentage of people with annual dental visit	"Annual Dental Visit" is a HEDIS measure defined as the percentage of members 2–21 years of age who had at least one dental visit during the measurement year. It provides important information about the accessibility of dental services for younger Centennial Care members. To be counted under this measure, members must fall into the range of 2–21 years of age on December 31 of the measurement year and must have had no more than one gap in coverage of up to 45 days.	Baseline to DY2	For the Baseline calculation, HSD furnished Deloitte with audited HEDIS data for three of the four plans contracted under the Salud! program and one of the two plans contracted under the CoLTS program. The total enrollment in 2013 of the four plans provided represented 75% of total combined Salud!/CoLTS membership. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for

Measure	Measure Name	Definition	Evaluation Methodology	
				comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, a 2015 National Medicaid HMO rate as reported by the National Committee for Quality Assurance (NCQA) was used. For this rate, neither numerator nor denominator was provided. Instead, individual rates were provided for each age group (2 – 3 years; 4 – 6 years; 7 – 10 years; 11 – 14 years; 15 – 18 years; and 19 – 21 years). Each rate was weighted based on the number of years the rate measured (two, three, four, four, four, and three, respectively) and took the average using the total number of years accounted for in the measurement (twenty). This methodology assumes that the program has approximately an even distribution of members across ages two to twenty-one. If this is not the case, the average rate reported could be either lower or higher.
7	Enrollment in Centennial Care as a percentage of state population	"Enrollment in Centennial Care" is a measure that reports the percentage of New Mexico residents who were enrolled in Centennial Care during the measurement year. New Mexico is one of 31 states and the District of Columbia to expand eligibility for Medicaid under the terms of the Affordable Care Act. Centennial Care's potential for improving the health of New Mexicans is dependent on the state's success in enrolling and recertifying timely persons eligible for the program. To be counted under this measure, members had to be included in enrollment reported by MCOs. State	DY1	HSD furnished Deloitte with statewide analyses developed by Mercer that included member months for the Centennial Care population. This count was divided by 12 to estimate an average annual membership over the calendar year and served as the numerator for this measure in each respective year. For the denominator, Deloitte used publicly available population estimates from the United States Census Bureau. Annual state population estimates are made on July 1 of the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		population estimates are from the U.S. Census Bureau.		
8	Native American members opting-in and opting-out of Centennial Care	Enrollment in managed care is only mandatory for Native Americans who are nursing facility level of care eligible; other Native Americans have the right to opt-out of managed care and to receive care through the fee-for-service system. The opt-out rate is a useful proxy for assessing the managed care program's perceived value among Native Americans who have a choice of systems for their care. Centennial Care plans provide monthly data to HSD on the number and percentage of Native Americans opting-in and out of the program. Note that this measure does not control for changes in size of the Centennial Care-eligible Native American population. Deloitte did not use Q1 2014 data to construct a baseline as it did in some other measures because Native American enrollment may have been significantly different under predecessor programs, a distinction which a baseline constructed from 2014 data would have been unable to capture. Using the count from an individual month (December) was appropriate because this measure reflects a distribution of potential	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with the monthly reports submitted by the four Centennial Care plans in DY1, DY2, and DY3. Therefore, we used the December reports for each year, which captured the opt-in/opt-out rate at the end of the calendar year. (The rate varied only slightly from month-to-month.) For the opt-in figure, the numerator was the number of Native Americans electing to be a part of the Centennial Care program, while the opt-out number was the number of Native Americans who chose not to be included. The denominator was the sum of the opt-in and opt-out counts across the four plans.

Measure	Measure Name	Definition	Evaluation Methodology	
		members at a point in time. December was the most appropriate month because it is furthest in time from the commencement of services.		
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	The Centennial Care program expanded behavioral health coverage by adding three services intended to support the program's person-and family-centered care model. The services are respite, family support, and recovery. HSD requires Centennial Care plans to submit encounter data on service activity. The data can be used to profile service utilization, by service type, at the member level.	DY1 to DY3	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with a count of members who received both BH services and the enumerated specialty services as well as a count of total managed care population in each year. Deloitte calculated resulting percentages by dividing the former by the latter.
11	Number and percentage of unduplicated participants with at least one PCP visit	Regular visits with a PCP is a central feature of delivering coordinated care. PCPs fill many important roles in the care coordination process, including ensuring continuity of care, identifying health problems early, delivering preventive care, and referring members to appropriate specialists. Centennial Care encourages members to visit their PCP at least once annually.	Baseline to DY3	HSD furnished Deloitte with MMIS reports that included a count of the entire managed care population and a count of members that had at least one PCP visit during the measurement year. The visit count was divided by the population count for an overall rate for each year.
12	Number/ratio of participating providers to enrollees	The number of available providers relative to members is an important ratio that provides insight into whether the provider network is growing or shrinking relative to membership. A lower member-to-provider ratio indicates a greater available capacity in	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of providers based on unique provider names/IDs across the MCOs in each quarter (to avoid double-counting providers that operate in multiple MCO networks). The unique quarterly providers were summed and divided by

Measure	Measure Name	Definition	Evaluation Methodology	
		the provider network to provide services.		four to arrive at an average annual number of providers as the denominator. The numerator was member months from the Mercer dashboard data that supports Measure 7, divided by twelve to arrive at the average annual members.
13	Percentage of primary care providers with open panels	The ease with which Centennial Care members are able to access primary care is partly dependent on the percentage of PCPs who have open panels and are able to accept new patients into their practices. If a large percentage of panels are closed, members may find it difficult to locate a PCP near where they live or work, reducing their ease of access to preventive care and increasing the risk that they will go to an emergency room for a non-emergent problem. HSD requires Centennial Care plans to report quarterly on the number of PCPs with open and closed panels.	DY1 to DY2	HSD furnished Deloitte with quarterly HSD 3 reports for the four Centennial Care MCOs. Deloitte calculated an average number of open and closed panels based on quarterly count data. The denominator for the measure was the sum of the open and closed panel counts.
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	"Number and Percentage of Substance Use Disorder Participants with follow-up 7 and 30 days after Leaving Residential Treatment Center (RTC)" is a HSD measure that reports the number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC. These are reported as two separate rates and closely resemble the HEDIS measure that reports "Follow-up after hospitalization of mental illness."	DY1 to DY2	HSD furnished Deloitte with HSD5 reports containing the count of RTC discharges as well as follow-up visits within 7 and 30 days of discharge in each year.

Measure	Measure Name	Definition	Evaluation Methodology	
15	Number and percentage of BH participants with follow-up after hospitalization of mental illness	"Number and Percentage of BH Participants with Follow-up after Hospitalization of Mental Illness" is a HEDIS measure that assesses adults and children six years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge.	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, CY 2014 Centennial Care data will be utilized as the baseline. HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
16	Childhood immunization status	"Childhood Immunization Status" is a HEDIS measure that reports the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (UHC did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
17	Immunizations for adolescents	"Immunizations for Adolescents" is a HEDIS measure that reports 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. The measure calculates a rate for each vaccine and one combination rate. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (BCBS did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
18	Well-child visits in first 15 months of life	"Well-Child Visits in First 15 Months of Life" is a HEDIS measure that reports the percentage of child members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits • One well-child visits • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013 and 2014, and four MCOs in 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
19	Well-child visits in third, fourth, fifth and sixth years of life	"Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life" is a HEDIS measure that reports the percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in 2013, and four MCOs in 2014 and 2015. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.
20	Adolescent well care visits	"Adolescent Well Care Visits" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for four MCOs in each year. Deloitte compared individual rates (and did not calculate aggregate rates) for the MCOs since two MCOs used a hybrid reporting methodology while two used an administrative reporting methodology in 2014 and 2015.

Measure	Measure Name	Definition	Evaluation Methodology	
21	Prenatal and postpartum care	"Prenatal and Postpartum Care" is a HEDIS measure that reports the percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year. It provides important information about the timeliness of primary care/preventive services for Centennial Care children.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
22	Frequency of ongoing Prenatal care	"Frequency of Ongoing Prenatal Care" is a HEDIS measure that reports the percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • ≥81 percent of expected visits This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
23	Breast cancer screening	"Breast Cancer Screening" is a HEDIS measure that reports the percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
24	Cervical cancer screening for women	"Cervical Cancer Screening for Women" is a HEDIS measure that reports the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21 to 64 who had cervical cytology performed every 3 years; or • Women age 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. This measure provides important information about the timeliness of primary care/preventive services for pregnant Centennial Care members.	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for four MCOs. Deloitte only combined the numerator and denominator values of three plans that used the same reporting methodology to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
25	Flu vaccinations for adults	"Flu Vaccinations for Adults" is a HEDIS-based measure that assesses the percentage of adults 18–64 years of age who report receiving an influenza vaccination. To be counted under this measure, members must be adults age 18-64 as of December 31 of the measurement year.	Baseline to DY3	HSD furnished Deloitte with MMIS reports containing counts of the total managed care adult population and unique members who had a flu vaccination.
26	Initiation and engagement of alcohol and other drug (AOD) dependence treatment	"Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment" is a HEDIS measure that assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care: • Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The measure reports two age stratifications (13–17 years and 18+ years) for both initiation and engagement of AOD treatment, as well as a total rate. It is meant to provide important information about the	DY1 to DY2	No MCO reported on this measure in 2013, and thus 2014 data is used as the baseline. HSD furnished Deloitte with audited HEDIS data for three MCOs (UHC did not report on this measure) in each year. Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		timeliness of substance abuse treatment services for Centennial Care members.		

Measure	Measure Name	Definition	Evaluation Methodology	
27	Geographic Access Measures	"Geographic Access Measures" is a measure developed by HSD as a way to evaluate access to primary care for Centennial Care enrollees across the State of New Mexico. HSD has developed standards for measuring geographic-based access to care which MCOs reported by quarter in quarterly geographic access reports (Report 55): • Urban Counties = 90% of members have access to a PCP within 30 miles • Rural Counties = 90% of members have access to a PCP within 45 miles • Frontier Counties = 90% of members have access to a PCP within 60 miles	DY1 to DY2	HSD furnished Deloitte with HSD 55 quarterly reports containing member counts, percentage of members with access to PCPs, and PCP counts by county type. Deloitte combined quarterly counts of total members, members with access to PCPs, and PCP counts across MCOs to produce aggregate annual results of percentage of members with access to PCPs and member to PCP ratios by county type.

Measure	Measure Name	Definition	Evaluation Methodology	
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	"Number and Percentage of Members with HRAs Completed within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. It calculates the percentages based on: • A Q4 cumulative total of HRAs completed compared to the number of HRAs required for transition members • The number of HRAs completed during the quarter compared to the number of HRAs required for new members • The number of HRAs completed within 30 days of enrollment compared to those completed during the quarter for new members • HSD agreed to use the timeline of "during the quarter" and "within 30 calendar days of enrollment" reported by the MCOs as surrogates for "within contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing counts of HRAs required and completed for transition and new Medicaid members in each year. For the percentage of required HRAs completed for transition members within the quarter, Deloitte summed the fourth quarter cumulative counts of HRAs completed by transition members as well as the fourth quarter cumulative counts of HRAs required for transition members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed for new members during the quarter, Deloitte summed quarterly counts of HRAs completed for new members as well as quarterly counts of HRAs required for new members across MCOs then divided the former by the latter for each year. For the percentage of required HRAs completed within 30 days of enrollment for new members, Deloitte summed quarterly counts of HRAs completed within 30 days of enrollment for new members across MCOs then divided that by the sum of the number of HRAs completed for new members previously calculated. PHP did not report a rate for HRAs completed for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes.	"Number and Percentage of those Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to members covered under Centennial Care. The data elements required for this measure are not included in the HSD Care Coordination reports, therefore, HSD agreed to use the metric "Number of Medicaid Members who were Provided Care Coordination Level Assignment Package within 10 Calendar Days of HRA" as an alternative definition based on the assumption that if a member receives a care coordination packet, then the MCO would have also designated the member to care coordination and assigned a care coordinator.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received care coordination level assignment packages within 10 days of HRA. Numerators and denominators were developed by summing the quarterly counts across MCOs.
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 2 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
		Coordination Report 6: The "Number and Percentage of Level 2 Assignments Based on the CNA." Measure calculated using "Level 2 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.		
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Based on the Comprehensive Needs Assessment" is a measure developed by HSD as a way to evaluate the timeliness of care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. However, the data elements required to measure this activity were not included in HSD reports, including "within contract timelines." An alternative definition was developed to align the intent of the Evaluation Plan with the information available in HSD Care Coordination Report 6: The "Number and Percentage of Level 3 Assignments Based on the CNA." Measure calculated using "Level 3 Assignments based on the CNA as a percentage of the CNAs completed for both transition and new members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of Level 3 assignments given and CNAs completed for both transition and new members during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 2 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees, both members transitioning from Salud and CoLTS programs and new members covered under Centennial Care. This measure is calculated using: • Number of Level 2 members who completed semi-annual in person visit this quarter compared to the number of Level 2 members who required semi-annual in person visit this quarter • Number of Level 2 members who completed quarterly telephone contacts this quarter compared to the number of Level 2 members who required quarterly telephone contacts this quarter HSD agreed to use required "semiannual visits" and "quarterly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	"Number and Percentage of Participants in Care Coordination Level 3 Who Received In-Person Visits and Telephone Contact within Contract Timeframes" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees This measure is calculated using: • Number of Level 3 members who completed quarterly in person visit during the quarter compared to the number of Level 3 members who required quarterly in person visits during the quarter • Number of Level 3 members who completed monthly telephone contacts during the quarter compared to the number of Level 3 members who required monthly telephone contacts during the quarter HSD agreed to use required "quarterly visits" and "monthly telephone contact" listed in HSD Report 6 as the timelines that fulfill "contract timelines" listed in the Evaluation Plan.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that received in-person visits and telephone contact as well as the number of in-person visits and telephone contacts required for the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
34	Number and percentage of participants the MCO is unable to locate for care coordination	"Number and Percentage of Participants the MCO is Unable to Engage for Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The data element specifically citing "unable to locate for care coordination" was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members for whom a CNA was required but the MCO was "unable to engage." This differs from those members who refused a CNA which is reflected in measure 36. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the fourth quarter counts across MCOs. PHP did not report data for transition members in DY2.
35	Number and percentage of members transitioning from HCBS to a NF; number and percentage of participants in NF transitioning to community (HCBS)	"Number and Percentage of Participants in Nursing Facility (NF) Transitioning to Community (HCBS)" is a measure developed by HSD as a way to evaluate efforts to appropriately avoid nursing home admissions. The specific data elements required to measure this activity were not included in MCO reports; instead, MCOs reported the number of members who left a nursing facility and moved to the community and the number of members readmitted to a nursing facility during the quarter. Therefore, an alternative definition was developed to align the	DY1 to DY3	HSD furnished Deloitte with HSD 7 reports containing quarterly counts of unique members in NF, members that left NF and moved to community, and members readmitted to NF during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs.

Measure	Measure Name	Definition	Evaluation Methodology	
		intent of the Evaluation Plan with the information available in HSD Care Coordination Report 7. The data contained in the plans' reporting of these data points under the assumption that moving to the community from a NF means members will require HCBS. HSD also agreed to use NF readmissions (as a percentage of members transitioned to the community) as an alternative for "members transitioning from HCBS to a NF".		
36	Number and percentage of participants who refuse care coordination	"Number and Percentage of Participants who Refused Care Coordination" is a measure developed by HSD as a way to evaluate care coordination activities delivered to Centennial Care enrollees. The specific data element required to measure this activity was not included in MCO reports, instead, MCOs reported the number of transition and new Medicaid members who "refused a CNA," based on the assumption that if the member refused the process to screen for care coordination, then they would also refuse to participate in care coordination. To calculate this measure, a four-quarter cumulative total for transition members and an annual total for new members was calculated as a percentage of the number of CNAs required for Medicaid members.	DY1 to DY2	HSD furnished Deloitte with HSD 6 reports containing quarterly counts of members that the MCO was unable to engage during the quarter. Numerators and denominators were developed by summing the quarterly counts across MCOs. PHP did not report data for transition members in DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
37	EPSDT screening ratio	"EPSDT Screening Ratio" measures the actual number of screenings children under the age of 21 were provided with against the number of screenings that all children enrolled in Medicaid should have received. Each state that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. The actual number of screenings is based on the number of initial and periodic screening services required by the state's periodicity schedule and prorated by the proportion of the year for which they were EPSDT eligible. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services. To be counted under this measure, members must have been enrolled for at least 90 continuous days during the reporting period. The EPSDT Screening Ratio is one of several measures required to be included in the federally required Annual EPSDT Participation Report (Form CMS-416). The CMS-416 Report provides basic information on participation in the Medicaid child health program.	FFY 2013 Baseline to FFY 2015	HSD furnished Deloitte with CMS-416 reports for each FFY that contained a combined EPSDT screening ratio for the four MCOs participating in Centennial Care. For the national comparison rate, the CMS-416 Annual EPSDT Participation Report for FFY 2015 was used.

Measure	Measure Name	Definition	Evaluation Methodology	
38	Annual monitoring for patients on persistent medications	"Annual Monitoring for Patients on Persistent Medications" is a HEDIS measure that reports the percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year, and received at least one therapeutic monitoring event for the therapeutic agent in the measurement year: • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Total rate (sum of the three numerators divided by the sum of the three denominators) To be counted towards this measure, members may not have more than one gap in enrollment of up to 45 days during the measurement year. In addition, members must have had at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. For the digoxin measure, members must have had at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year. Adverse	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		drug events contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events. This HEDIS measure evaluates whether adult members receiving medication therapy were monitored while on the medication.		
39	Medication management for people with asthma	"Medication Management for People with Asthma" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age during the measurement year who were identified as having persistent asthma and who were dispensed an asthma controller medication that they remained on for at least 50% of their treatment period. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the national comparison rate, Deloitte used the 2016 National Medicaid MCO rate as reported by NCQA in "The State of Health Quality – 2016." The 2016 national rate represents activity in 2015.
40	Asthma medication ratio	"Asthma Medication Ratio" is a HEDIS measure that reports the percentage of adults and children 5 – 64 years of age who were identified as having persistent asthma and who had a ratio of controller medications to total asthma medications of 0.50 or greater during	Baseline – DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting

Measure	Measure Name	Definition	Evaluation Methodology	
		the measurement year. The NCQA reports an overall ratio, as well as a separate ratio for children age 5 – 11, children age 12 – 18, adults age 19 – 50, and adults age 51 – 64. The Asthma Medication Ratio evaluates whether people diagnosed with persistent asthma were adequately using controller medications.		the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
41	Adult BMI assessment and weight assessment for children/adolescents	"Adult BMI Assessment" is a HEDIS measure that reports the percentage of adults 18 – 74 years of age who had an outpatient visit and whose BMI was documented in the past two years. "Weight Assessment for Children/Adolescents" is a HEDIS measure that reports the percentage of children and adolescents 3 – 17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and who had evidence of: • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity "Obesity" is defined as an amount of body fat higher than what is considered healthy for an individual's weight. Obesity contributes to nearly one in five deaths in the United States. Obesity ranges are determined by using a commonly used weight-for-height screening tool called the "BMI", which	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		correlates with the amount of body fat. BMI provides the most useful population-level measure of overweight and obesity. The Adult BMI Assessment rate is based on the assumption that careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight. The Weight Assessment for Children/Adolescents measure recognizes that obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents under the age of 18 and provide guidance for maintaining a healthy weight and lifestyle.		
42	Comprehensive diabetes care	"Comprehensive Diabetes Care" is a HEDIS measure defined as the percentage of adults 18 – 75 years of age with diabetes (Type One or Type Two) who had each of the following: • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg) A separate rate is reported for each of the six factors included in the above	Baseline to DY2	HSD furnished Deloitte with HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		measure definition. One additional rate associated with this measure, HbA1c Control (<7.0%) for a Selected Population, was not reported by any of the MCOs in either any reported data year.		
43	Ambulatory Care Sensitive admission rates: diabetes short and long term complications, uncontrolled admission rates	The "ACS Diabetes Short-Term Complications Admission Rate (PQI-01)" is defined as the number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees ages 18 years and older. The "ACS Diabetes Long-Term Complications Admission Rate (PQI-03)" is defined as the number of admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 Medicaid enrollees 18 years and older. Both measures are PQI measures sponsored by the AHRQ. The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early	Baseline	For the baseline calculation, HSD furnished Deloitte with two MMIS reports (Diabetes Short Term and Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
		intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates. With high-quality, community based primary care, hospitalization for these illnesses often can be avoided. The PQIs provide a good starting point for assessing quality of health services in the community. To be counted in the numerator for the ACS Diabetes Short-Term Complications Admission Rate, members must be 18 years and older and have had an admission during measurement year for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma). To be counted in the numerator for the ACS Diabetes Long-Term Complications Admission Rate, members must be 18 years and older and have had an admission during the measurement year for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). For both measures, the denominator consists of all members 18 years and older. The measure is reported as a rate per 100,000.	DY1 to DY2	HSD furnished Deloitte with two reports based on encounters (i.e., PQI report for Diabetes Short Term and MMIS ad hoc report for Long Term Complications) containing combined numerator and denominator counts for the four MCOs contracted under Centennial Care. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated. Separate short-term diabetes complication admission rates were calculated for members 18 – 64 years of age and members age 65 and over. Long-term diabetes complication admission rates were aggregated for all members 18 years and older.

Measure	Measure Name	Definition	Evaluation Methodology	
44	Ambulatory care sensitive admission rates for COPD or asthma in older adults; asthma in younger adults	The "Asthma in Younger Adults Admission Rate (PQI-15)" is defined as the number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees 18 – 39 years of age. The "COPD or Asthma in Older Adults Admission Rate (PQI-05)" is defined as the number of inpatient hospital admissions for COPD or asthma per 100,000 enrollee months for Medicaid enrollees 40 years and older. Both measures are PQI measures. To be counted in the "Asthma in Younger Adults Admission Rate" measure, members must be 18 – 39 years of age and have had an admission during the measurement year for a principal diagnosis of asthma, excluding admissions with an indication of cystic	Baseline	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. To be counted in the "COPD or Asthma in Older Adults Admission Rate" measure, members must be 40 years and older and have had an admission with a principal diagnosis of COPD or asthma, excluding obstetric admissions and transfers from other institutions. To be included in the denominator, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	HSD furnished Deloitte with two MMIS reports (i.e., Asthma in Younger Adults and COPD or Asthma in Older Adults) containing combined numerator and denominator counts for the four MCOs contracted under the Centennial Care program for Claims Type A and Claims Type I. For each report, the numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
45	Ambulatory care sensitive admission rates for hypertension	The "ACS Admission Rate for Hypertension (PQI-7)" is defined as the number of inpatient hospital admissions with a principal diagnosis of hypertension per 100,000 enrollee months for Medicaid enrollees 18 years and older. The measure excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, obstetric admissions, and transfers from other	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program for CY 2013 for Claims Type A and Claims Type I. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.

Measure	Measure Name	Definition	Evaluation Methodology	
		institutions. The measure is a PQI measure. To be counted under this measure, members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage.	DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care. The numerator and denominator counts for both claims types were combined and a combined rate per 100,000 was calculated.
46	ACS admission rates for pediatric asthma	Evaluates the number of inpatient hospital admissions per 100,000 member months with a principal diagnosis of asthma in children 2 – 17 years of age. The measure excludes cases with a diagnosis code for cystic fibrosis and anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	Baseline to DY2	The unique managed care encounter claim count is summed across MCOs and divided by the member month count (also summed across MCOs) as a denominator.
47	Number and percentage of potentially avoidable ER visits	The "Number and Percentage of Potentially Avoidable ER Visits" examines the number and percentage of unduplicated members with an ER visit for a non-emergent condition relative to the number of unduplicated members with an ER visit for any reason. This measure applies to any member who presents at an ER, has a claim is submitted and for which the condition is non-emergent. Per the Centennial Care contract, an emergency medical condition means a medical or behavioral health condition manifesting itself through acute	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with MCO reports (HSD 40: Over-Under Utilization Report) submitted by three of the four MCOs (MHC did not have reportable data in 2014 or 2015). The reports covered the four quarters of their respective calendar years (DY1 and DY2) and contained the total number of unduplicated members by care coordination levels one through seven. To calculate the percent of potentially avoidable ER visits in each year, Deloitte combined the three plans' total number of unduplicated members with

Measure	Measure Name	Definition	Evaluation Methodology	
		symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the members' health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the member. Conditions that do not meet the criteria of an emergency medical condition are considered to be potentially avoidable ER visits. This measure examines potentially avoidable ER visits per care coordination level and in total. MCOs are also required to identify the 10 most frequent ICD codes for members with non-emergent ER visits during the quarterly reporting period.		an ER visit for non-emergent conditions and divided this by the total number of unduplicated members with an ER visit for any condition.
48	Medical assistance with smoking and tobacco use cessation	"Medical Assistance with Smoking and Tobacco Use Cessation" is a HEDIS measure that uses survey data to assess the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit smoking during the measurement year. This measure is one component of a three-part CAHPS survey measure that assesses different facets of providing medical assistance	Baseline	HSD furnished Deloitte with CY 2013 CAHPS data for three of the four MCOs contracted under the Salud program and one of the two MCOs contracted under the CoLTS program. The total enrollment in 2013 of the four plans represented 75% of total combined Salud/CoLTS membership. Deloitte took an unweighted average of each plan's summary rate (which is a two-year rolling average for smoking cessation measures) for each subcomponent.

Measure	Measure Name	Definition	Evaluation Methodology	
		with smoking and tobacco cessation. The three components include: • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies.	DY1 to DY2	HSD furnished Deloitte with CY 2014 and CY 2015 CAHPS data for the four Centennial Care MCOs. Deloitte took an unweighted average of each plan's summary rate (again, a two-year rolling average) to compute the aggregate rate for each subcomponent.
49	Number of critical incidents by reporting category	The "Number of Critical Incidents by Reporting Category" measure determines the number and percentage of critical incidents reported in the following categories: • Abuse; • Neglect; • Exploitation; • Environmental hazard; • Emergency services; • Law enforcement; • Elopement/missing; and • Death (Natural/expected; Unexpected; Homicide; and Suicide). The standard definition of a "critical incident" is "an occurrence that represents actual or potential serious harm to the well-being of a member or to others by members." A reportable incident for the behavioral health provider community is defined as "any known, alleged or suspected event of abuse, neglect, exploitation, injuries of	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 data will be utilized as the baseline. HSD furnished Deloitte with critical incident reports submitted for the four MCOs. The reports covered the 12 months of each year. The results are aggregated across MCOs by incident category for the purposes of reporting. Results are presented separately for Centennial Care total, Behavioral Health, and Self-directed.

Measure	Measure Name	Definition	Evaluation Methodology	
		unknown origin, death, environmental hazard, which involve some level of reporting or intervention with other state or service entities including law enforcement, crisis or emergency services, and present actual or potential serious harm to the well-being of a consumer or to others by the consumer. MCOs are required to submit critical incident reports on a quarterly basis. Each contracted MCO has access to the web-based Critical Incident Reporting System. MCO access to the website includes access to all critical incident reports submitted by the MCO. It also includes all critical incidents submitted by providers of authorized services for the members of that MCO.		
50	Antidepressant medication management	"Antidepressant Medication Management" is a HEDIS measure defined as the percentage of adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on an antidepressant medication treatment. Two rates are reported: • Effective Acute Phase Treatment; and • Effective Continuation Phase Treatment. This measure recognizes that effective medication treatment of major depression can improve a person's daily	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well. To be included in the numerator for the two measures, members must have received: • Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114 -day period following the Index Prescription Start Date. • Effective Continuous Phase Treatment: At least 180 days (six months) of continuous treatment with antidepressant medication during the 231 day period following the Index Prescription Start Date. To be counted in the denominator, members must be 18 years of age and older as of April 30 of the measurement year, have a negative medication history, have a diagnosis of major depression during the intake period, and have been treated with antidepressant medication. Members must have been enrolled on the last day of the measurement year and must not have had more than one gap in enrollment of up to 45 days during each year of continuous enrollment.		

Measure	Measure Name	Definition	Evaluation Methodology	
51	Inpatient admissions to psychiatric hospitals and RTCs	The "Inpatient Admissions to Psychiatric Hospitals and RTCs" measure provides separate counts for the number of members admitted to either a psychiatric hospital or RTC. The counts may be duplicated when a member has multiple claims during the report period with different billing providers. This measure is based on the premise that effective care management should reduce the number of admissions through the use of appropriate early interventions. To be counted for the psychiatric hospital measure, members must have a paid claim type A or I for the measurement year for admission to a hospital, psychiatric unit within an acute care hospital, or a psychiatric hospital. To be counted for the RTC measure, members must have a paid encounter for admission to an RTC during the measurement year.	Baseline	For the baseline calculation, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report for CY 2013, which was derived from MMIS data. The report contained data for the four MCOs contracted under the Salud program and two MCOs contracted under the CoLTS program. The total number of Paid Psychiatric Hospital encounters with a date of service in CY 2013 was reported. The total number of Paid Residential Treatment Center encounters with a date of service in CY 2013 was reported.
			DY1 to DY2	For DY1 to DY2, HSD furnished Deloitte with the Inpatient Admissions to Psychiatric Hospitals (Claims Type A and I) and Residential Treatment Centers Report, which was derived from claims data. The report data contained data submitted by the four MCOs.
52	Percentage of NF members who transitioned from a low NF to a high NF	The "Percentage of Nursing Facility Members Who Transitioned from a Low Nursing Facility to a High Nursing Facility" is intended to determine to what extent care management assists members in remaining in the least restrictive setting that meets their needs. This measure counts all Centennial Care members who were receiving either	DY1 to DY3	The MCOs did not report on this measure in 2013. Therefore, 2014 data is utilized as the baseline. HSD furnished Deloitte with HSD8 reports containing monthly data for the four Centennial Care plans in each year. Deloitte took the sum of all 12 months of data of members in high and low nursing facilities and combined this number into a denominator. The counts of high and low nursing facility enrollees were divided by this denominator to get a rate for each MCO. These numerators were

Measure	Measure Name	Definition	Evaluation Methodology	
		high or low nursing facility services during one or more months of calendar year 2014.		summed and divided by the denominators for an aggregate rate in each calendar year.
53	Fall risk intervention	The percentage of members 65 years of age and older who have had a fall or problem with balance in the 12 months prior to the measurement date, who were seen by a practitioner during that same time period, and who received a fall risk intervention. This HEDIS measure is collected using the Medicare Health Outcome Survey (HOS). The two components of this survey measure assess different facets of fall risk management: discussing fall risk and managing fall risk.	DY1 to DY2	HSD furnished Deloitte with ad hoc reports containing the FRM rates and denominators for each year.
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	The "Percentage of the Population Accessing both a Behavioral Health Service and a PCP Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service (defined by provider types and/or services on the claim) and at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed both a behavioral health service and at least on PCP visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.

Measure	Measure Name	Definition	Evaluation Methodology	
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a PCP Visit in the Same Year" is defined as the percentage of the LTSS population that received at least one PCP visit during the measurement year. To be counted under this measure, members must have been enrolled on the last day of the measurement year. This measure examines the percentage of unduplicated members with at least one PCP visit. The numerator is the number of members (any age) that accessed at least one PCP visit in the year. The denominator is the LTSS population as defined by LTSS services received during the year.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for the baseline.
			DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with MMIS reports containing combined numerator and denominator counts of unique individuals that accessed the specified services for the four MCOs participating in Centennial Care.
56	Percentage of participants who accessed an LTSS service and a behavioral health visit in the same year	The "Percentage of the Population Accessing an LTSS Service and a Behavioral Health Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both an LTSS service and a behavioral health visit during the measurement year. The population accessing LTSS is defined as: members who are nursing facility level of care; members who are dually eligible for Medicare and Medicaid; members are developmentally disabled or medically fragile and who	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		are in the Mi Via Self-Directed Waiver; members with HIV/AIDs; and members who are in the physically disabled or frail elderly category. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed an LTSS service and a behavioral health service in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
57	Percentage of population with behavioral health needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with behavioral health needs that has any type of ER visit with a behavioral health diagnosis during the measurement year, which is broken down by the following types of ER visits: • Emergency Medical Treatment and Labor Act (EMTALA) • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the behavioral health needs and all emergency department visits for each type of ER visit. This count is then divided by the total behavioral health needs population for a rate for each type of visit.

Measure	Measure Name	Definition	Evaluation Methodology	
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	The percentage of the Centennial Care population with LTSS needs that has any type of ER visit during the measurement year, which is broken down by the following types of ER visits: • EMTALA • Urgent care • Limited to minor • Low to moderate • Moderate • High severity • Life threatening • Admitted through the ER	Baseline to DY2	HSD furnished Deloitte with MMIS reports containing a count of the LTSS needs and all emergency department visits for each type of ER visit. This count is then divided by the total LTSS needs population for a rate for each type of visit.
59	Percentage of the population at risk for nursing facility placement who remain in the community	The "Percentage of the Population at Risk for Nursing Facility Placement Who Remain in the Community" is defined as the number of consumers who transition from nursing facilities and who are served and maintained with community-based services for six months. This measure is intended, for future years, to determine whether there are trends identified in the number of members who transition from nursing facilities and who are served in the community. Members with LTSS needs who receive care coordination services should be able to remain safely in their homes as an alternative to nursing home care. This outcome is desirable both from a quality-of-life perspective for members	Baseline	For the baseline calculation, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 14 HSD Performance Measures Report. The MAD report contained the quarterly and annual numbers of members who transition from nursing facilities and who are served and maintained with community-based services. The reports covered the 12 months of SFY 2013 for the two MCOs contracted under the CoLTS program. The report was derived from quarterly MMIS reports containing the number and service longevity of members who transitioned from a nursing facility into a community-based service. The MMIS reports are run 30 days after the end of each quarter. The total number of members who transitioned into community services is current with the last month of each quarter when reported, but the number maintained for six months has a nine month reporting lag.

Measure	Measure Name	Definition	Evaluation Methodology	
		and also from a cost-effectiveness perspective for the state. The numerator for this measure is the number of members who receive community-based services for six or more months without a readmission to a nursing facility.	DY1 to DY2	For DY1 and DY2, HSD furnished Deloitte with the HSD Medical Assistance Division (MAD) Fourth Quarter SFY 15 HSD Performance Measures Report. The reports covered the 12 months of SFY 2014 and SFY 15, which included six months of data for the four MCOs participating in Centennial Care.
60	Number and percentage of participants who accessed a behavioral health service that also accessed HCBS	The "Number and percentage of Members Who Accessed a Behavioral Health Service That Also Accessed HCBS in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and HCBS during the measurement year. The population accessing HCBS is defined as all members who are enrolled in managed care who accessed both a behavioral health and HCBS service.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program for CY 2013.

Measure	Measure Name	Definition	Evaluation Methodology	
		Under Centennial Care, these members include individuals who are enrolled in the Developmentally Disabled waiver or the Medically Fragile waiver. To be counted under this measure, members must have been enrolled on the last day of the measurement year. The numerator is the number of members (any age) that accessed a behavioral health service and HCBS in the same year. The denominator is the entire managed care population.	DY1 to DY3	For DY1 through DY3, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
61	Number and percentage of members that maintained their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	The "Number and Percentage of Members Who Maintain Their Care Coordination Level or Move to a Different Level" measure determines the number and percentage of members receiving care coordination services who: • Remain at their current level - The number of unduplicated active members who are receiving Care Coordination as of the last day of the reporting period and are assigned the same Care Coordination Level (CCL2 or CCL3) as of the last day of the prior reporting period; • Move to a lower level - the number of unduplicated active members who, as a result of a CNA, are determined to no longer meet the requirements for CCL3 but still meet the requirements of CCL2 during the month reporting period; plus the number of unduplicated active members who, as a result of a CNA, are determined to no longer	DY1 to DY3	HSD furnished Deloitte with ad hoc care coordination reports for the four MCOs for each year. The membership counts are reported by month, and Deloitte averaged the monthly count for each MCO and combined the four plans' numerator and denominator values to calculate an average aggregate rate for each year. The counts presented in the exhibit are the average member months, or an estimate for unduplicated member counts over the measurement year.

Measure	Measure Name	Definition	Evaluation Methodology	
		meet the requirements for CCL2 during the monthly reporting period but were receiving CCL2 as of the last day of the prior monthly reporting period on the last day of the reporting period, the members is no longer receiving Care Coordination; and • Move to a higher level - The number of unduplicated active members who, as a result of a CNA, are determined to meet the requirements for CCL2 during the monthly reporting period. On the last day of the prior reporting period the member was enrolled but not receiving Care Coordination; plus, the number of unduplicated active members who, as a result of a CNA, were determined to meet the requirements for CCL3 during the monthly reporting period. On the last day of the prior reporting period, the member was enrolled, but either receiving CCL2 or was not receiving Care Coordination.		

Measure	Measure Name	Definition	Evaluation Methodology	
62	Percentage of population accessing a behavioral health service that received an outpatient ambulatory visit in the same year	The "Percentage of the Population Accessing a Behavioral Health Service That Received an Outpatient Ambulatory Visit in the Same Year" is defined as the percentage of the entire managed care population that accessed both a behavioral health service and an outpatient ambulatory visit during the measurement year, based on a review of provider IDs and procedure codes found on the claims. To be counted under this measure, members must have been enrolled during the measurement year. The numerator is the number of members (any age) that accessed both a behavioral health service and an outpatient ambulatory visit in the same year. The denominator is the entire managed care population.	Baseline	For the baseline calculation, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs contracted under the Salud! program and two MCOs contracted under the CoLTS program.
			DY1 to DY2	For DY1 through DY2, HSD furnished Deloitte with an MMIS report containing combined numerator and denominator counts for the four MCOs participating in Centennial Care.
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	"Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage. The denominator for this measure includes members 18 – 64 years of age by December 31 of the measurement year who have schizophrenia or bipolar disorder who were dispensed an antipsychotic medication. The numerator consists of members who had a glucose test or an HbA1c test performed during the measurement year.		
64	Diabetes monitoring for members with diabetes and schizophrenia	"Diabetes Monitoring for Members with Diabetes and Schizophrenia" is a HEDIS measure defined as the percentage of members 18 – 64 years of age with diabetes and schizophrenia who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year. To be counted under this measure, members must have been continuously enrolled during the measurement year and must not have had more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one month gap in coverage.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The denominator for this measure includes members 18 – 64 years of age as of December 31 of the measurement year with schizophrenia and diabetes. The numerator consists of members who had an HbA1c test and an LDL-C test performed during the measurement year.		
65	Total program expenditures	"Total Program Expenditures" is intended to summarize all costs of providing services to eligible Medicaid beneficiaries enrolled in the Centennial Care program, including: • Total computable costs of providing Medical Assistance Program services to the populations covered under Centennial Care, • Tracked and recorded uncompensated care costs of approximately $68.9 million, and • Fee-for-service, managed care, and other associated costs for the covered Native American Indian population.	Baseline	HSD furnished Deloitte with the quarterly CMS-64 Schedule C expenditure reports as well as the quarterly Centennial Care reports submitted to CMS which summarize member months by MEG each quarter. Deloitte calculated a baseline program cost for each MEG using the respective member months from the quarterly reports HSD submitted to CMS and the estimated per-member per-month (PMPM) costs without waiver thresholds set under STCs 106 – 108. Per STCs 106 – 108, these cost thresholds were defined for each of the six MEGs covered under Centennial Care and vary annually for the five years of the waiver demonstration. The member months from HSD's quarterly reports were used to convert the PMPM cost thresholds from STCs 106 – 108 into total program expenditures.
			DY1 to DY3	The total program costs for each year as provided in the CMS-64 Schedule C reports.

Measure	Measure Name	Definition	Evaluation Methodology	
66	Costs per member	The "Costs per Member" measure is the per-member per-month cost calculated as the total expenditure of each MEG divided by the corresponding total member months of that MEG.	Baseline	The baseline PMPMs were taken directly from STCs 106 – 108 for each MEG.
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the member months provided in each of the quarterly Centennial Care submissions to CMS.
67	Costs per user of services	The "Costs per User of Services" measure is a per-user per-month representation of the total expenditures reported from Measure 65.	Baseline	Deloitte received an MMIS data extraction from HSD which calculated the number of Centennial Care members with paid capitation and a service encounter in the same month, for each month. The user PMPM without waiver is calculated by multiplying the estimated PMPM by MEG from the STCs by the given member months divided by their corresponding user member months.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY1 to DY3	The PMPM cost for each MEG were calculated by using the total program costs for each year as tracked in measure 65 divided by the number of users by MEG provided in the MMIS data extraction described above.

Measure	Measure Name	Definition	Evaluation Methodology	
68	Utilization by category of service	"Utilization by Category of Service" tracks the utilization of selected services for physical health, behavioral health, and long term services and supports.	Baseline	The utilization across various service categories were reported in quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The reported utilization units were divided by annualized member months found in the same quarterly submissions to report the sub-measures on a "units per 1,000" basis. For certain measures where applicable, the average length of stay was calculated as days per admit. The baseline utilization measures are based on the first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of DY1, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized utilization rates in each year was calculated by summing the utilization units for the year and dividing by the total member months for the year. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.
69	Hospital costs	The "Hospital Costs" measure tracks the PMPM program expenditures of categories that are associated with	Baseline	The costs across various categories related to hospitals, clinics, and facilities, as well as member months, were reported in quarterly MCO financial

Measure	Measure Name	Definition	Evaluation Methodology	
		hospital, clinic, and facility visits. The categories of service included in hospital costs by program are: • PH: Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHCs, Freestanding Clinics • BH: Outpatient Hospital (Evaluations, Therapies, and BH Physical Evaluations), Hospital Outpatient Facility (BH Treatment Services), Hospital Inpatient Facility (Psychiatric Hospitalization Services), Rural Health Clinics, FQHCs • LTSS: Nursing Facility State Owned - High Level of Care, Nursing Facility State Owned - Low Level of Care, Nursing Facility Private - High Level of Care, Nursing Facility Private - Low Level of Care, Nursing Facility Professional Charges, Other Nursing Facility Payments, Hospital Swing Bed - High Level of Care, Hospital Swing Bed - Low Level of Care, Inpatient Hospital – Acute, Inpatient - Specialty Hospital, Outpatient Hospital - Emergency Room, Outpatient Hospital - Urgent Care, Outpatient Facility – Other, Rural Health Clinics, FQHC's, Freestanding Clinics		submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. Reported costs from these files were aggregated on categories of service determined to be related to hospital services. For the baseline calculation, the hospital costs measure utilizes the sum of the costs for the hospital services reported in the first quarter of 2014 divided by the total member months in the same timeframe.
			DY1 to DY3	The annual PMPM for each demonstration year was calculated by summing the costs for the hospital services for the year and dividing by the total member months in the year.

Measure	Measure Name	Definition	Evaluation Methodology	
70	Use of HCBS	"Use of HCBS" tracks the utilization for Home and Community-Based Services (HCBS).	Baseline	The utilization for HCBS was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. For the baseline calculation, the use of HCBS measure utilizes the sum of the costs for the HCBS reported in the first quarter of 2014 divided by the total member months in the same timeframe, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
71	Use of institutional care (skilled nursing facilities)	The "Use of Institutional Care (Skilled Nursing Facilities)" measure tracks the utilization for non-acute long term care and skilled nursing services.	Baseline	The utilization for skilled nursing was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
72	Use of mental health services	The "Use of Mental Health Services" measure tracks the utilization for behavioral health services and related facility visits.	Baseline	The utilization for mental health services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
73	Use of substance abuse services	"Use of Substance Abuse Services" tracks the utilization for methadone treatment.	Baseline	The utilization for substance abuse services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
74	Use of pharmacy services	This measure tracks the number of scripts per 1,000 for brand name, generic, and other drugs.	Baseline	The utilization for drug prescriptions services was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
75	Inpatient services exceeding $50,000	"Inpatient Services Exceeding $50,000" tracks the annual cost of inpatient services exceeding $50,000 in a given calendar year. The measure is calculated in two ways; first, as the inpatient cost on a PMPM basis, and second, as a percentage of total health-related expenditures.	DY1 to DY3	High claims were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. To calculate the inpatient claims cost PMPM, the sum of the inpatient high cost claims were divided by the total member months as reported in the MCO quarterly submissions. To calculate the cost as a percentage of health-related expenditures, the sum of the claims was divided by total healthcare costs, not inclusive of administrative expenses. The baseline was determined using full DY1 experience since costs associated with inpatient services were tracked and reported on an aggregate, cumulative basis in the legacy programs (Salud!, CoLTS, and Behavioral Health).
76	Diagnostic Imaging Costs	The "Diagnostic Imaging Costs" measure tracks the PMPM costs associated with diagnostic imaging procedures. It was amended from its original measure, "Use of Diagnostic Imaging", as utilization data on diagnostic imaging was not available for DY1 for the purposes of tracking in this report. Deloitte will continue working with HSD to explore ways for diagnostic imaging utilization to be reported.	Baseline	The PMPM costs for diagnostic imaging were reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO

Measure	Measure Name	Definition	Evaluation Methodology	
				submissions, divided by the member months as of the first quarter of 2014.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months.

Measure	Measure Name	Definition	Evaluation Methodology	
77	Emergency department use	"Emergency Department (ED) Use" tracks the utilization for ED visits for the physical health and LTSS services covered under the Centennial Care program.	Baseline	ED use was reported in the quarterly MCO financial submissions. These reports only contain information for membership under managed care and are not inclusive of fee-for-service membership; it was determined that these reports would provide the most standardized information for the purposes of evaluating the waiver program. Furthermore, the fee-for-service membership represents a small proportion of the total Centennial Care population. The baseline utilization measure is based on the 2014 first quarter reported utilization from the MCO submissions, divided by the member months as of the first quarter of 2014, and scaled to an annual units per 1,000 basis by multiplying by 12,000.
			DY1 to DY3	The annualized rate for each demonstration year was calculated by summing the utilization units for the year and dividing by the same year's total member months. The measure was then scaled to an annual units per 1,000 basis by multiplying by 12,000.

Measure	Measure Name	Definition	Evaluation Methodology	
78	All cause readmissions	The "All Cause Readmissions" measure reports the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of readmission. To be counted under this measure, acute inpatient discharges within 30 days of previous acute inpatient discharges are tracked during the measurement year.	Baseline to DY2	HSD furnished Deloitte with MMIS data for the four MCOs. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate 2014 rate.
79	Inpatient mental health/substance use services	The "Inpatient Mental Health/Substance Use" measure tracks the utilization for mental health and substance abuse services rendered in an inpatient setting.	Baseline to DY2	HSD furnished Deloitte with MMIS data where encounters and claims were summarized for psychiatric hospitals and residential treatment centers. The number of encounters are divided by the number of clients for the entire calendar year to arrive at the final rate in each demonstration year.
80	Asthma controller medication compliance (children)	"Asthma Controller Medication Compliance" is a HEDIS measure that reports the percentage of children with persistent asthma and who were dispensed appropriate medications that they remained on for the treatment period. Two rates of medication compliance are reported; those that remained on their medication for 50% of the treatment period, and those that	Baseline	HSD furnished Deloitte with audited HEDIS data for three of the four MCOs (PHP did not report on this measure in 2013). Deloitte combined the three plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the three MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		remained on their medication for 75% of the treatment period. To be counted under this measure, members must be identified as having persistent asthma in the measurement year or the year prior to the measurement year through claim encounter data and/or pharmacy data in either the current year or the prior year. The frequency of Centennial Care members earning and redeeming points for activities performed to manage their child's asthma is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for refilling their child's asthma as prescribed.	DY1 to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	"Comprehensive Diabetes Care" is a HEDIS measure that reports the percentage of members ages 18 – 75 with Type 1 or Type 2 diabetes who had the applicable tests performed and whose health indicators aligned with the indicator category being tracked. To be counted under this measure, members must have been identified as having diabetes in the measurement year or the year prior to the measurement year via claim encounter data or pharmacy data. The frequency of Centennial Care members earning and redeeming points for activities to manage diabetes is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $80 (800 points) for taking steps to manage their diabetes.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
82	Prenatal program	The “Prenatal Program" measure was based on a collection of HEDIS measures on the frequency of ongoing prenatal care and postpartum care. The measures report on the percentage of deliveries that received various ranges of expected percentages of visits, the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery, and the percentage of deliveries that received a prenatal visit during the first trimester. To be counted under this measure, female members must be identified as having a live birth between November 6 of the prior year and November 5 of the measurement year. The frequency of Centennial Care members earning and redeeming points for activities to manage prenatal care is also tracked under this measure. According to the Centennial Rewards website, members who are pregnant may earn up to $100 (1,000 points) for joining the prenatal program sponsored by its health plan.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans’ numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
83	Treatment adherence - schizophrenia	"Treatment Adherence – Schizophrenia" is a HEDIS measure that reports the percentage of members diagnosed with schizophrenia that remain on their medication for at least 80% of the treatment period. To be counted under this measure, members ages 19 – 64 must be diagnosed with schizophrenia by having at least one acute inpatient claim with the diagnosis of schizophrenia or must have at least two outpatient, partial hospitalization, ED, or non-acute claims on different dates of service with the diagnosis of schizophrenia. The frequency of Centennial Care members earning and redeeming points for activities to manage their schizophrenia is also tracked under this measure. According to the Centennial Rewards website, members may earn up to $75 (750 points) for taking steps to manage their schizophrenia.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
84	Treatment adherence - bipolar	The "Treatment Adherence – Bipolar" measure was intended to track treatment adherence for bipolar disorders. However, there are no known HEDIS measures related to the tracking of health status for bipolar individuals and MCOs were not required to track this activity. Therefore, this measure has been modified to track the frequency of Centennial Care members earning and redeeming points for activities to manage bipolar disorder. According to the Centennial Rewards website, members may earn up to $75 (750 points) per calendar year for taking steps to manage their bipolar condition. If, in the future, appropriate data and reporting become available, Deloitte will reassess this measures at that time.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
85	Osteoporosis management in elderly women - females aged 65+ years	"Osteoporosis Management In Elderly Women – Females Age 65 and Over" is a measure that tracks the number of unique members and unique encounters related to osteoporosis over the course of the measurement year. The frequency of Centennial Care members earning and redeeming points for testing bone density, a test commonly performed to prescreen for osteoporosis, is also tracked under this measure. According to the Centennial Rewards website, members may earn up a one-time reward of $35 (350 points) by getting a bone density test.	Baseline to DY2	HSD provided an MMIS data extract for calendar years 2013 through 2015 to track the number of unique members and unique encounters related to osteoporosis in elderly women. This information was used to calculate an encounter rate by dividing encounters over clients. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
86	Annual dental visit - adult	The "Annual Dental Visits – Adults" measure tracks the percentage of adult members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the 19 – 21 age range. The frequency of Centennial Care adult members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
87	Annual dental visit - child	The "Annual Dental Visits – Child" measure tracks the percentage of child members that had at least one dental visit during the measurement year. The annual dental visit HEDIS measure was used to track this rate and was reported specifically for the following age groups: 2-3 years, 4-6 years, 7-10 years, 11-14 years, and 15-18 years. The frequency of Centennial Care child members earning and redeeming points for having their annual dental visit is also tracked under this measure. According to the Centennial Rewards website, the Healthy Smiles program rewards members up to $25 (250 points) per calendar year.	Baseline to DY2	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate. For the rewards component, HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.

Measure	Measure Name	Definition	Evaluation Methodology	
88	Number of members spending credits	The "Number of Members Spending Credits" measure tracks the number of members redeeming and spending credits, or points, earned in the Centennial Rewards program relative to the number of people registered in the Centennial Rewards program. In previous measures described in this report, this information was also provided for specific points-earning activities that were applicable to the health condition under discussion. Here, this measure reports the total number of members earning or redeeming credits in the Centennial Rewards program, regardless of points-generating activity.	DY1 to DY2	HSD furnished Deloitte with Finity member rewards reports, which are summaries of the Centennial Rewards program that include the number of members registered in the program, number of members earning rewards, and number of members redeeming rewards in DY1 and DY2.
88	Percentage of expedited appeals resolved within three business days	HSD requires MCOs to establish and maintain an expedited review process for appeals and adhere to the allowed timeframe. Specifically: *"The contractor shall establish and maintain an expedited process for Appeals in accordance with 42 C.F.R. § 438.410. The contractor shall ensure that the expedited review process is convenient and efficient for the Member. The contractor shall resolve the expedited Appeal in accordance 42 C.F.R. § 438.408(b)(3) and (d)(2)…"*[144][145] The New Mexico Human Services Department (HSD) requires MCOs to track and	DY1 to DY2	The MCOs under the Salud and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with the Grievances and Appeals reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of expedited appeals resolved, as well as the number and percent resolved within the three day standard. Deloitte combined the four plans' total resolved expedited appeals to establish a denominator for each year. Deloitte then combined the count of expedited appeals resolved within three days to establish a numerator for each year.

[144] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).
[145] Centennial Care Contract, Section 4.16.3 – Expedited Resolution of Appeals.

Measure	Measure Name	Definition	Evaluation Methodology	
		report on appeals and grievance activity on a monthly basis. This includes the number of new appeals filed and the number resolved timely or untimely that month. The acceptable time period for resolution is seventy-two hours after the receipt of the appeal. Timely resolution of expedited appeals is essential for ensuring members do not experience a delay in receiving urgently needed care (in situations where the initial denial is overturned). The measure examines the percentage of expedited appeals resolved within three days of receipt by the MCO.		
89	Percentage of grievances resolved within 30 days	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances were defined in the Centennial Care managed care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."*[146]	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish a denominator for each year. Deloitte then combined the count of grievances resolved

[146] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.

Measure	Measure Name	Definition	Evaluation Methodology	
		HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within 30 calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[147][148] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report). MCOs report member grievance activity as a distinct category. Failure to resolve member grievances timely could contribute to dissatisfaction with the program and have a negative impact on member access to care. The measure examines the percentage of grievances		within 30 days to establish a numerator for each year.

[147] Contractors may request an extension from HSD in accordance with 42 CFR § 438.408(c).
[148] Centennial Care Contract, Section 4.16.2 – Grievances, page 137.

Measure	Measure Name	Definition	Evaluation Methodology	
		resolved within 30 days of receipt by the MCO.		
90 91 92	Percentage of appeals upheld, partially overturned, and overturned	In conformance with federal regulations, HSD requires Centennial Care MCOs to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action to the member or provider in accordance with the procedures and timeframes of 42 C.F.R. §438.404 and 431.200 unless such timeframe is prescribed in this section 4.16.2… The contractor may mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, 2014 data will be utilized as the baseline. HSD furnished Deloitte with Grievances and Appeal reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of appeals resolved and the disposition of the appeals. Appeals that were listed as "pending" at the time the report was compiled were not included in the calculations of this measure.

Measure	Measure Name	Definition	Evaluation Methodology	
		that this must be the result of supplying that information); • *The member has been admitted to an institution where he or she is ineligible for further services;* • *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[149]. *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."* [150] Appeals may be upheld (affirming the original determination), partially overturned, or overturned in full. HSD requires MCOs to track and report		

[149] Section relates to transfers and discharges from long term care facilities.
[150] Centennial Care Contract, Section 4.16.3 –Appeals, pages 147 – 148.

Measure	Measure Name	Definition	Evaluation Methodology	
		appeal activity, including the nature of the resolution. A high rate of overturned denials could indicate that MCOs' are applying too stringent a standard when making initial determinations. (Measures 90, 91, and 92 have been combined to eliminate redundancy in reporting results.) The measure examines the percentage of appeals that were upheld, partially overturned, and overturned in full upon review.		
93	Number and percentage of calls answered within 30 seconds	"Call answer timeliness" is a HEDIS measure that reports the frequency with which calls are answered within the NCQA standard of 30 seconds. HSD requires that the participating MCOs operate a toll-free Member Services Call Center. HSD also defines performance standards for the call centers: *"The contractor shall adequately staff the Member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed two (2) minutes."*	Baseline to DY1	HSD furnished Deloitte with audited HEDIS data for the four MCOs in each year. Deloitte combined the four plans' numerator and denominator values to calculate an aggregate rate each year. Although to our knowledge the four MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.
			DY2	HSD furnished Deloitte with audited HEDIS data for two of the four MCOs (MHC and BCBS did not report on this measure in 2015). Deloitte combined the two plans' numerator and denominator values to calculate an aggregate rate. Although to our knowledge the two MCOs adhered to the same methodology in developing their individual rates, we are reporting the aggregate value for comparison purposes only; it is not an audited HEDIS rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		The call centers are an important resource for members in understanding program benefits and accessing services. If members have difficulty getting through to the call center, their overall satisfaction with the plan is likely to be affected. HSD requires contracting MCOs to report call center performance as a component of their annual HEDIS submissions.		
94	Number and percentage participants satisfied with care coordination	Many Centennial Care members have complex health care needs for which they receive care from multiple physicians. "How often personal doctor informed about care from other doctors" is a CAHPS measure that rates member satisfaction with how well his or her personal doctor is kept informed by other doctors. Although care coordination encompasses more than communication between physicians, it is an important component of the process and one that is visible to the member. If a member finds his or her personal doctor is not well-informed about the member's interaction with specialists, it is likely to negatively affect the member's satisfaction with his or her doctor and plan. The CAHPS survey asks members to rate how often their personal doctor is informed about care from other doctors using a scale of one to four, where one	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results. Deloitte used the 2016 SPH Analytics Benchmark rate for the adult and general child populations. For the children with chronic conditions population Deloitte used the 2015 Quality Compass All Plans benchmark rate, as the 2016 SPH Analytics Benchmark rate could not be identified for this population.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		is “never,” two is “sometimes,” three is “usually” and four is “always.” There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and children with chronic conditions (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses could produce materially different results.		

Measure	Measure Name	Definition	Evaluation Methodology	
95	Rating of personal doctor	"Rating of Personal Doctor" is a CAHPS measure that evaluates member satisfaction with their PCP. The PCP is a central figure in the member's care; the member's rating of his or her doctor can be expected to influence the member's overall perception of plan quality. The CAHPS survey asks members to rate their personal doctor on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine, or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
96	Rating of health care	"Rating of Health Care" is a CAHPS measure that evaluates overall member satisfaction with their care. The CAHPS survey asks members to rate their health care on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and (CCC). (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CY 2013 CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the percentage of respondents answering eight, nine or ten. Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
97	How well doctors communicate	"How Well Doctors Communicate" is a CAHPS composite measure that combines data from responses to four survey items: • Doctors explained things in a way that was easy to understand • Doctors listened carefully • Doctors showed respect for what you had to say • Doctors spent enough time with you. The CAHPS survey asks members to rate their doctors on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		calculate an overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30% percent, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
98	Customer service satisfaction	"Customer Service Satisfaction" is a CAHPS composite measure that combines data from responses to four survey items: • Found needed information in written materials and on the internet • Health plan forms were easy to fill out • Received needed information from the health plan's customer service • Customer service staff treated you with courtesy and respect. The CAHPS survey asks members to rate their customer service experience on each item using a scale of one to four, where one is "never," two is "sometimes," three is "usually," and four is "always." In the CAHPS report the answers to these questions are combined and used to calculate an	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
		overall satisfaction rate with doctor communication. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
99	Rating of specialist seen most often	"Rating of Specialist Seen Most Often" evaluates member satisfaction with the provider most critical to the member's care, in addition to the member's PCP. The CAHPS survey asks members to rate their specialist on a scale of zero to ten, where zero is the worst and ten is the best. A score of eight, nine, or ten is typically considered to indicate member satisfaction. There are separate CAHPS surveys for adults and children. The data for children is further segmented into the general population and CCC. (Parents/guardians complete the latter surveys on behalf of their enrolled children.) These surveys are voluntary, and thus the data they collect are vulnerable to non-response bias and selection bias. These results should be reviewed keeping in mind that they will not reflect the responses of those members who elected not to fill out a survey. A more complete response from all members could have resulted in numbers either higher or lower than reported here. The response rate from the selected sample usually hovers between 20% and 30%, leaving open the possibility that more consistent responses would produce materially different results.	Baseline	HSD furnished Deloitte with audited CAHPS data for the four MCOs. One plan submitted data only for the adult population. The other three plans submitted data for all three populations (adults, children – general, and – CCC). Each plan provided a rate that documented the composite percentage of respondents answering "usually" or "always." Deloitte calculated an unweighted average of the plans' survey results.
			DY1 to DY2	For the DY1 and DY2, HSD furnished Deloitte with audited CAHPS data for the four MCOs. Deloitte received data for all three populations from all MCOs. Deloitte calculated an unweighted averages of the plans' survey results.

Measure	Measure Name	Definition	Evaluation Methodology	
100	Percentage of clean claims adjudicated in 30/90 days	HSD requires MCOs to adhere to timeliness standards for adjudication of clean claims. The standards also apply to any capitated subcontractors responsible for processing provider claims. Clean claims are defined in the Centennial Care contract as follows: "Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity." HSD defined two sets of timeliness standards, the first of which applies to Indian Health Service/Tribal/Urban Indian (I/T/U) and long term care providers, and the second of which applies to all other providers. Specifically: "For claims from I/T/Us, day activity providers, assisted living providers, nursing facilities and home care agencies, including community benefit providers, ninety-five percent (95%) of clean claims must be adjudicated within a time period of no greater than fifteen (15) calendar days of receipt and ninety-nine percent (99%) or more of clean claims must be adjudicated within	SFY 2013	For the baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the Behavioral Health Organization (BHO) contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within 30 and 90 calendar days. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent adjudicated within program timeliness standards. The MCOs provided separate data for providers falling under the 15/30 day standard and providers falling under the 30/90 day standard. Deloitte combined the four plans' total clean claim counts for CY 2014 to establish a denominator. Deloitte then combined the 30 and 90 day adjudication counts to establish numerators for calculation of 30 and 90 day rates. Deloitte was able to compare SFY 2013 and DY1 performance with respect to the 30/90 day standard, which was captured in both sets of

Measure	Measure Name	Definition	Evaluation Methodology	
		a time period of no greater than thirty (30) calendar days of receipt; *"For all other claims, ninety percent (90%) of all clean claims must be adjudicated within thirty (30) calendar days of receipt, and ninety-nine percent (99%) of all clean claims must be adjudicated within ninety (90) calendar days of receipt."* [151] The measure examines claims that have been adjudicated (i.e., paid in full), paid in part and denied in part, or denied in full.		reports. Data for the 15/30 day standard was reported only in 2014 and will serve as a baseline for longitudinal analysis.
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2 the rates could not be weighted in their aggregate. Deloitte produced the DY2 30/90 day standard rate by calculating the straight average for the three categories of providers whose claims are adjudicated under the 30/90 day standard. For the DY2 15/30 day standard rate, Deloitte calculated the straight average of the two types of claims that adjudicated under that standard. The variations in calculation methodologies should be noted year-to-year when comparing results.

[151] Centennial Care contract, Section 4.19 – Claims Management, page 168.

Measure	Measure Name	Definition	Evaluation Methodology	
101	Percentage of claims denied	HSD requires MCOs to track and report the percentage of clean claims denied for payment. A high denial rate can be an indication of confusion among providers regarding coverage guidelines, prior authorization requirements and/or proper billing procedures. Clean claims are defined in the Centennial Care contract as follows: *"Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."*[152] The measure examines clean claims that have been adjudicated and denied.	SFY 2013	For the Baseline calculation, HSD furnished Deloitte with monthly standardized claims timeliness reports submitted by the four MCOs contracted under the Salud! program, the two MCOs contracted under the CoLTS program and the BHO contracted to provider behavioral health benefits to both Salud! and CoLTS members. The reports covered the 12 months of SFY 2013 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the seven plans' total clean claim counts for SFY 2013 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.
			DY1	For the DY1 rate, HSD furnished Deloitte with standardized claims timeliness reports submitted by the four MCOs. The reports covered the 12 months of calendar year 2014 and contained counts of the total number of clean claims processed, as well as the number and percent denied upon adjudication. Deloitte combined the four plans' total clean claim counts for CY2014 to establish a denominator. Deloitte then combined the denial counts to establish a numerator.

[152] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 9.

Measure	Measure Name	Definition	Evaluation Methodology	
			DY2	For DY2 HSD supplied Deloitte with rates from each MCO for several types of rendering providers (BH providers, PH providers, BH and PH providers, I/T/Us, specialty-pay providers, and an aggregate rate of all providers). These rates did not come with numerators and denominators, so for DY2, Deloitte calculated the straight average of each MCO's aggregate claim denial rate. The variations in calculation methodologies should be noted year-to-year when comparing results.
102	Dollar accuracy rate	HSD requires MCOs to track and report the dollar accuracy of paid claims, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims, and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY2014[153]. Deloitte combined the four plans' total paid amounts, by claim type, to establish claim type-specific denominators. Deloitte then combined the dollar error amounts, by claim type, and subtracted these amounts from the totals to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

[153] Deloitte received all four quarterly reports for three of the four Centennial Care MCOs and three of the quarterly reports for the fourth MCO. Deloitte does not believe that the absence of one quarterly report is of material importance in calculating a percentage accuracy rate.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • I/T/U • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate. The measure examines percentage of total dollars paid correctly (no overpayment or underpayment) out of the total paid dollars for audited claims.	DY2	For DY2 HSD supplied Deloitte with dollar accuracy rates from each MCO by claim type. These rates did not include underlying dollar amounts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

Measure	Measure Name	Definition	Evaluation Methodology	
103	Percentage of grievances resolved on time	HSD requires MCOs to adhere to timeliness standards for resolution of grievances, whether filed by members or providers. Grievances are defined in the Centennial Care contract as follows: *"Grievance means an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor action."* [154][155] HSD also defines the allowable time period for resolution of grievances. Specifically: *"The contractor shall complete the investigation and final resolution process for grievances within thirty (30) calendar days of the date the grievance is received by the contractor or as expeditiously as the member's health condition requires…"*[156][157] HSD requires MCOs to track and report grievance activity on a monthly basis. This includes the number of new grievances filed, the number carried over from the previous month, the number resolved timely or untimely that month, and the number still pending (for carry over to the next month's report).	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered 12 months of each year and contained counts of the total number of grievances resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

[154] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, page 13.
[155] Actions refer to service reductions or denials and are addressed through the appeals, rather than grievance, process.
[156] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 146.
[157] Contractors may request an extension from HSD in accordance with 42CFR Section 438.408(c).

Measure	Measure Name	Definition	Evaluation Methodology	
		MCOs report provider grievance activity as a distinct category. Failure to resolve provider grievances timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of grievances resolved within 30 days of receipt by the MCO.		
104	Percentage of provider appeals resolved on time	In conformance with federal regulations, HSD requires Centennial Care MCOs (contractors) to adhere to the following procedures with respect to notices of action and appeals: *"The contractor shall mail a notice of action no later than the date of the action for the following:* • *The contractor has factual information confirming the death of a member;* • *The contractor receives a signed written member statement requesting service termination or giving information requiring termination of covered services (where the member understands that this must be the result of supplying that information);* • *The member has been admitted to an institution where he or she is ineligible for further services;*	DY1 to DY2	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, calendar year 2014 Centennial Care data was utilized as the baseline. HSD furnished Deloitte with grievance resolution reports submitted by the four MCOs in each year. The reports covered the 12 months of each year and contained counts of the total number of appeals resolved, as well as the number and percent resolved within the 30 day standard. Deloitte combined the four plans' total resolved grievances to establish respective denominators for each year. Deloitte then combined the count of grievances resolved within 30 days to establish a numerator for each year.

Measure	Measure Name	Definition	Evaluation Methodology	
		• *The member's address is unknown and mail directed to him or her has no forwarding address;* • *The member has been accepted for Medicaid services in another state or US territory;* • *The member's physician prescribes a change in the level of medical care;* • *An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions; and* • *In accordance with 42 CFR Section 483.12(a)(5)(ii)*[158]*.* *A member may file an appeal of a contractor action either orally or in writing within (90) calendar days of receiving the contractor's notice of action. The representative or a provider acting on behalf of the member with the member's written consent, has the right to file an appeal of an action on behalf of the member."*[159] HSD requires MCOs to adhere to timeliness standards for resolution of standard and expedited appeals. Specifically: *Standard appeals - "The contractor has thirty (30) calendar days from the date the initial oral or written appeal is*		

[158] Section relates to transfers and discharges from long term care facilities.
[159] Centennial Care contract, Section 4.16 – Grievances and Appeals, pp 147-148 (emphasis added).

Measure	Measure Name	Definition	Evaluation Methodology	
		received by the contractor to resolve the appeal."[160] *Expedited appeals – "The contractor shall resolve the expedited appeal in accordance with 42 CFR Section 438.408(b)(3) and (d)(2)."*[161] The CFR section cited in the Centennial Care contract includes the following language: *"For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than three working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section."* Paragraph (c) permits the MCO to extend the timeframe by up to fourteen calendar days if the enrollee requests the extension or the MCO shows (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. HSD requires MCOs to track and report appeal activity, including the date the appeal was filed and the date of resolution. MCOs report appeals filed by providers on behalf of members as a distinct category. Failure to resolve		

[160] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 148.
[161] Centennial Care contract, Section 4.16 – Grievances and Appeals, page 149.

Measure	Measure Name	Definition	Evaluation Methodology	
		these appeals timely could contribute to dissatisfaction with the program and have a negative impact on provider participation and member access to care. The measure examines the percentage of standard appeals resolved timely by the MCO.		
106	Number of eligible providers receiving EHR incentive payments	The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act of 2009, committed the federal government to supporting the development, adoption and meaningful use of EHRs. The EHR offers the potential to improve care coordination and achieve cost savings through consolidation and real time sharing of clinical data across providers and care settings, while also facilitating a patient's access to his or her personal health data. The federal Centers for Medicare and Medicaid Services (CMS) has undertaken a multi-stage EHR incentive payment methodology to encourage adoption and meaningful use of EHRs by Medicare providers. Each state Medicaid program, including New Mexico's, has established a corresponding incentive	2011 to 2016	HSD generated a report with counts of the number of eligible hospitals and professional providers that qualified for an initial incentive payment in 2013 or for a meaningful use incentive payment. Deloitte added the initial payment count to the cumulative count for 2011 – 2012, to arrive at a baseline number for this portion of the measure. (Meaningful use counts are unique to each year and not cumulative.) Deloitte replied on the same reports generated by HSD in DY1 through DY3.

Measure	Measure Name	Definition	Evaluation Methodology	
		methodology for Medicaid providers in accordance with federal regulations. HSD included a definition of EHRs in the Centennial Care MCO contract. Specifically: *"Electronic Health Record (EHR) means a record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information."*[162] HSD also required MCOs to partner with the Department in facilitating adoption of EHRs by New Mexico providers. Specifically: *"The contractor shall participate in, and, as may be directed, implement any Health Information Exchange or Electronic Health Record initiatives undertaken by HSD or other entities."*[163] Under the federally-established rules for EHR incentive payments, Medicaid providers can receive up to six incentive payments. The payments are made on an annual basis and can be earned over non-consecutive years. The eligible		

[162] Centennial Care contract, Section 2 – Definitions, Acronyms and Abbreviations, pp 11-12.
[163] Centennial Care contract, Section 4.20 – Information Systems, page 176.

Measure	Measure Name	Definition	Evaluation Methodology	
		provider types include hospitals and professionals (physicians, dentists, nurse practitioners, certified nurse midwives and physician assistants). Providers qualify for an initial payment upon attesting that they have adopted, implemented or upgraded federally-certified EHR technology. (The federal government has raised the standards for the minimally allowable technology over time). Providers qualify for up to five additional annual payments by attesting that they have met the meaningful use standard in effect for that year. Incentive payment rules differ by provider type. For example, hospitals can receive both Medicare and Medicaid incentive payments in the same year but professionals cannot. Hospitals must meet a 10% Medicaid patient volume threshold; the corresponding threshold for professionals is 30%. There are additional restrictions for individual provider types. For example, physician assistants can qualify for an incentive payment only if they practice at an FQHC. HSD has tracked the number of eligible and participating providers, by provider type, since the program opened to Medicaid providers in 2011. In 2011, 628 eligible professionals and 25 eligible hospitals attested to adopting, implementing or upgrading a certified		

Measure	Measure Name	Definition	Evaluation Methodology	
		EHR and qualified for an initial incentive payment. In 2012, an additional 5 hospitals and 690 professionals made this attestation. At the same time, 5 of the original attesting hospitals from 2011, and 245 of the original attesting professionals met the meaningful use standard and qualified for a second incentive payment. The measure examines the cumulative number and percentage of eligible providers (hospitals and professionals) who have qualified for an initial incentive payment through adoption, implementation or upgrading of certified EHR technology. The measure also examines the number and percentage who have qualified for a meaningful use incentive payment in a calendar year.		
108	Percentage of claims paid accurately	HSD requires MCOs to track and report the percentage of provider claims paid accurately, based on a quarterly MCO audit of a random sample of claims. A high inaccurate percentage can be an indication of claims management issues, including but not limited to: incorrect pricing of claims, payment of duplicate claims and/or payment for non-covered charges. HSD requires separate auditing and reporting of results for ten claim types: • Inpatient hospital	DY1	The MCOs under the Salud! and CoLTS programs did not report on this measure in 2013. Therefore, DY1 data will be utilized as the baseline. For the baseline calculation, HSD furnished Deloitte with quarterly audit reports submitted by the four MCOs. The reports covered the 12 months of CY 2014. Deloitte combined the four plans' total paid claim counts, by claim type, to establish claim type-specific denominators. Deloitte then combined the claims without errors, by claim type, to establish claim type-specific numerators. Deloitte performed the same exercise across all claim types to establish an aggregate denominator and numerator.

Measure	Measure Name	Definition	Evaluation Methodology	
		• Outpatient hospital • Professional • Behavioral health • Nursing Facility • Indian Health Service/Tribal/Urban Indian (I/T/U) • Medicare crossover • Home- and Community-Based Services (HCBS) • Dental • Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) MCOs select at least one hundred paid claims, by claim type, on a quarterly basis. The claims are audited both for dollar accuracy and procedural accuracy. Dollar errors are classified either as overpayments or underpayments. MCOs report the total dollars paid and the total amount of overpayments and underpayments. The overpayment and underpayment amounts are combined to establish a total inaccurate dollar amount by claim type and for all audited claims in aggregate[164]. The measure examines percentage of provider claims paid correctly (no overpayment or underpayment) out of the total audited claims.	DY2	For DY2 HSD supplied Deloitte with claim accuracy rates from each MCO by claim type. These rates did not include underlying claim counts, so the DY2 aggregate rate was calculated as a straight average of MCO rates instead of a weighted average. No aggregate accuracy rate for all types of claims was available. The variations in calculation methodologies should be noted year-to-year when comparing results.

[164] Both values are treated as positive numbers. For example, an underpayment of $100 on a first claim and an overpayment of $50 on a second claim should be combined and reported as a $150 total error amount.

Measure	Measure Name	Definition	Evaluation Methodology	
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	The PCMH Membership and Hospital/ER Utilization measure provides key metrics pertaining to members attributed to a PCMH as well as the impact on key member outcome metrics. This information serves as a proxy for payment reform initiatives as the PCMH model undergoes various levels of credentialing by the NCQA.	DY1 to DY2	HSD provided Deloitte with MCO reports containing membership attributed to a PCMH as well as key ER and hospital admission utilization metrics. The calendar year totals were summed across MCOs and the ER and hospital admission metrics were compared to PCMH membership in each respective year.

B. Data Sources

The following table identifies the data sources used to support measure development and analysis. The table is structured by measure, but some measures were supported by information found in the same data source. Measures with gray shading were retired due to insufficient data.

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
1	Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	MCO HEDIS reports	2013	N/A
2	Mental health services utilization	MCO HEDIS reports	2014	N/A
3	Number of telemedicine providers and telemedicine utilization	Ad hoc MCO report	2013	N/A
4	Number and percentage of people meeting nursing facility level of care (NF LOC) who are in a nursing facility	Ad hoc data provided via email from HSD	2013	N/A
5	Number and percentage who are receiving home- and community-based services (HCBS)	Ad hoc data provided via email from HSD	2013	N/A
6	Number and percentage of people with annual dental visit	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
7	Enrollment in Centennial Care as a percentage of state population	Mercer Data Dashboard and US Census Bureau residency estimates	2014	N/A
8	Number of Native Americans opting-in and opting-out of Centennial Care	Native American Opt In reports	2014	N/A
10	Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support, and recovery)	BH Clients with Respite, Familty Support, Recovery Services MMIS reports	2014	N/A
11	Number and percentage of unduplicated participants with at least one PCP visit	PCP Visits MMIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
12	Number/ratio of enrollees to participating providers	MCO reports (HSD 3)	2014	N/A
13	Percentage of primary care provider with open panels	MCO reports (HSD 3)	2014	N/A
14	Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving Residential Treatment Center (RTC)	MCO reports (HSD 5)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
15	Number and percentage of Behavioral Health (BH) participants with follow-up after hospitalization of mental illness	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
16	Childhood Immunization Status	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
17	Immunization for Adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
18	Well-Child Visits in First Months of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
19	Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
20	Adolescent Well Care Visits	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
21	Prenatal and Postpartum Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
22	Frequency of Ongoing Prenatal Care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
23	Breast Cancer Screening for Women	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
24	Cervical Cancer Screening for Women	MCO HEDIS reports	2013	N/A
25	Flu Vaccinations for Adults	Flu Vaccination MMIS reports	2013	N/A
26	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	MCO HEDIS reports	2014	The NQCA State of Health Quality 2016

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Report (for CY 2015)
27	Geographic Access Measures	MCO reports (HSD 55)	2014	N/A
28	Number and percentage of participants with health risk assessments (HRA) completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
29	Number and percentage of participants who received a care coordination designation and assignment of care coordinator within contract timeframes	MCO reports (HSD 6)	2014	N/A
30	Number and percentage of participants in care coordination Level 2 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
31	Number and percentage of participants in care coordination Level 3 that had comprehensive needs assessments scheduled and completed within contract timeframes	MCO reports (HSD 6)	2014	N/A
32	Number and percentage of participants in care coordination Level 2 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
33	Number and percentage of participants in care coordination Level 3 who received in-person visits and telephone contact within contract timeframes	MCO reports (HSD 6)	2014	N/A
34	Number and percentage of participants the MCO is unable to locate for care coordination	MCO reports (HSD 6)	2014	N/A
35	Number and percentage of participants in Nursing Facility (NF) transitioning to community (HCBS)	MCO reports (HSD 7)	2014	N/A
36	Number and percentage of participants who refuse care coordination	MCO reports (HSD 6)	2014	N/A
37	EPSDT screening ratio	Centers for Medicare & Medicaid (CMS) 416 Report	2013	Federal Fiscal Year (FFY) 2015 National CMS-416 Annual EPSDT Participation Report

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
38	Annual monitoring for patients on persistent medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
39	Medication management for people with asthma	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
40	Asthma medication ratio	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
41	Adult BMI assessment and weight assessment for children/adolescents	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
42	Comprehensive diabetes care	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
43	Ambulatory Care Sensitive (ACS) admission rates: diabetes short and long term complications, uncontrolled admission rates	Centennial Care Diabetes inpatient encounters (PQI) report and MMIS report	2013 (LT diabetes) 2014 (ST diabetes)	N/A
44	ACS admission rates for COPD or asthma in older adults; asthma in younger adults	ACS MMIS reports	2013	N/A
45	ACS admission rates for hypertension	ACS MMIS reports	2013	N/A
46	ACS admission rates for pediatric asthma	ACS MMIS reports	2013	N/A
47	Number and percentage of potentially avoidable ER visits	MCO reports (HSD 40)	2014	N/A
48	Medical assistance with smoking and tobacco use cessation	MCO CAHPS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
49	Number of critical incidents by reporting category	MCO Quarterly Reports (critical incident report)	2014	N/A
50	Antidepressant medication management	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
51	Inpatient admissions to psychiatric hospitals and RTCs	Admissions for Inpatient Psychiatric Hospitals (Claims type A and I) and RTCs MMIS reports	2013	N/A
52	Percentage of nursing facility residents who transitioned from a low nursing facility to a high nursing facility	MCO reports (HSD 8)	2014	N/A
53	Fall risk intervention	HEDIS rates calculated by Mercer	2014 (updated to reflect new data reporting)	N/A
54	Percentage of the population accessing both a behavioral health service and a PCP visit in the same year	BH-PCP Visits MMIS reports	2013	N/A
55	Percentage of population accessing an LTSS service that received a PCP visit in the same year	LTSS-PCP Visits MMIS reports	2013	N/A
56	Percentage of the population accessing an LTSS service and a behavioral health visit in the same year	LTSS and BH MMIS reports	2013	N/A
57	Percentage of the population with behavioral health needs with an ER Visit by type of ER visit	BH Population with ED Visits MMIS reports	2013	N/A
58	Percentage of the population with LTSS needs with an ER visit by type of ER visit	LTSS Population with ED Visits MMIS reports	2013	N/A
59	Percentage of the population at risk for nursing facility placement who remain in the community	MAD SFY Reports	SFY 2013	N/A
60	Number and percentage of members who accessed a behavioral health service that also accessed HCBS in the same year	BH Population with HCBS MMIS reports	2013	N/A
61	Number and percentage of members who maintain their care coordination level, moved to a lower care coordination level, or moved to a higher care coordination level	MCO ad hoc care coordination reports	2014	N/A
62	Percentage of the population accessing a behavioral health service that also received an	BH Clients with Outpatient	2013	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
	outpatient ambulatory visit in the same year	Ambulatory Visits MMIS reports		
63	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
64	Diabetes monitoring for members with diabetes and schizophrenia	MCO HEDIS reports	2013	The NQCA State of Health Quality 2016 Report (for CY 2015)
65	Total program expenditures	CMS-64 Schedule C	STC	N/A
66	Costs per member	CMS-64 Schedule C (Cost and Member Months)	STC	N/A
67	Costs per user of services	CMS-64 Schedule C (Cost and Member Months); Cost per user of service MMIS reports	STC	N/A
68	Utilization by category of service	FIN Reports	2014	N/A
69	Hospital costs	FIN Reports	2014	N/A
70	Use of HCBS	FIN Reports	2014	N/A
71	Use of institutional care (skilled nursing facilities)	FIN Reports	2014	N/A
72	Use of mental health services	FIN Reports	2014	N/A
73	Use of substance abuse services	FIN Reports	2014	N/A
74	Use of pharmacy services	FIN Reports	2014	N/A
75	Inpatient services exceeding $50,000	FIN Reports	2014	N/A
76	Diagnostic imaging costs	FIN Reports	2014	N/A
77	Emergency department use	FIN Reports	2014	N/A
78	All cause readmissions	MMIS reports	2013	N/A
79	Inpatient mental health/substance use services	MMIS reports	2013	N/A
80	Asthma controller medication compliance (children)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
81	Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
82	Prenatal program	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
83	Treatment adherence - schizophrenia	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
84	Treatment adherence - bipolar	Finity member rewards data	2014	N/A
85	Osteoporosis management in elderly women - females aged 65+ years	Osteoporosis MMIS reports; Finity member rewards data	2013/2014	N/A
86	Annual dental visit - adult	MCO HEDIS reports; Finity member rewards data	2014/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
87	Annual dental visit - child	MCO HEDIS reports; Finity member rewards data	2013/2014	The NQCA State of Health Quality 2016 Report (for CY 2015)
88	Number of members spending credits	Finity member rewards data	2014	N/A
88	Percentage of expedited appeals resolved within three business days	MCO reports (HSD 37)	2014	N/A
89	Percentage of grievances resolved within 30 days	MCO reports (HSD 37)	2014	N/A
90	Percentage of appeals by adjudication (upheld)	MCO reports (HSD 37)	2014	N/A
91	Percentage of appeals by adjudication (partially overturned)	MCO reports (HSD 37)	2014	N/A
92	Percentage of appeals by adjudication (overturned in full)	MCO reports (HSD 37)	2014	N/A
93	Number and percentage of calls answered within 30 seconds	MCO HEDIS reports	2013	N/A
94	Number and percentage of participants satisfied with care coordination	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
95	Rating of personal doctor	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
96	Rating of health care	MCO CAHPS reports	2013	SPH and Quality

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
				Compass benchmarks
97	How well doctors communicate	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
98	Customer service satisfaction	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
99	Rating of specialist seen most often	MCO CAHPS reports	2013	SPH and Quality Compass benchmarks
100	Percentage of clean claims adjudicated in 30/90 days	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
101	Percentage of claims denied	Provider Payment Timeliness Report; MCO reports (HSD 47); ad hoc MCO claims payment and activity reports	SFY 2013	N/A
102	Dollar accuracy rate	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
103	Percentage of grievances resolved on time	MCO reports (HSD 37)	2014	N/A
104	Percentage of provider appeals resolved on time	MCO reports (HSD 37)	2014	N/A
105	Provider satisfaction survey results	N/A	2014	N/A
106	Number of eligible providers receiving Electronic Health Record (EHR) incentive payments	Ad hoc EHR program report	2013	N/A
107	Use of different care delivery models, such as number of Health Home participants	N/A	N/A	N/A
108	Percentage of claims paid accurately	MCO reports (HSD 46); ad hoc MCO claims payment and activity reports	2014	N/A
109	PCMH Membership and Hospital/ER Utilization (Use and Outcomes of Payment Reforms)	MCO reports (HSD 48)	2014	N/A

Measure	Measure Name	Data Source	Baseline	National Rate for Comparison
110	Number and percentage of visits in compliance with Electronic Visit Verification (EVV) system requirement	N/A	N/A	N/A
111	Adoption of electronic case management/care coordination system	N/A	2014	N/A

C. Statistical Significance and Hypothesis Testing

As part of the Evaluation process, hypothesis testing was performed on measures where available data was deemed adequate and appropriate for such testing. Hypothesis tests are employed to help indicate if an observed change over time was statistically significant. These tests are often applied to HEDIS data when analyzing changes in rates over time, but can be employed on other data sets as appropriate. Although statistical significance does not prove "meaningful improvement," it does help to indicate whether improvement occurred. Furthermore, tests for statistical significance help to indicate how likely it is that intervention caused the improvement as opposed to chance.

For measures that are rates or proportions, a two-sided, pooled proportion z-test was performed to determine whether the hypothesized difference between rates is significantly different from observed sample differences. A significance level of .05 was used in these tests.

The null hypothesis in a given test was that the rate in one year was equal to the rate in the comparison year, and the null hypothesis was rejected when the calculated test statistic was less than .05.

To perform these tests, an implicit assumption was made that the rates derived from the sample populations were independent between years. In addition for HEDIS measures, rates are only aggregated across MCOs if they were reported under the same methodology (Administrative vs. Hybrid) for statistical significance testing. Refer to Appendix A for detailed calculation methodology for each measure.

Note: Cells with blue font in the below tables indicate a statistically significant change using a two-sided pooled proportion z-test

Access to Preventive/Ambulatory Health Services among Centennial Care Enrollees in Aggregate and in Subgroups (Measure 1)

	Baseline	DY1		DY2		Baseline to DY2
Access to preventive/ambulatory health services among Centennial Care enrollees in aggregate and within subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Access to preventive/ambulatory health services (20-44 Yrs)	84.5%	79.9%	-5.5%	75.8%	-5.2%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	87.3%	85.8%	-1.7%	81.2%	-5.4%	-7.0%
Access to preventive/ambulatory health services (65+ Yrs)	90.0%	88.4%	-1.8%	87.4%	-1.1%	-2.8%
Access to preventive/ambulatory health services (Total)	85.3%	81.9%	-3.9%	77.7%	-5.1%	-8.8%
Molina Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	82.2%	76.3%	-7.2%	73.6%	-3.5%	-10.4%
Access to preventive/ambulatory health services (45-64 Yrs)	86.4%	84.8%	-1.9%	81.9%	-3.4%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	91.4%	86.8%	-5.0%	39.8%	-54.1%	-56.4%
Access to preventive/ambulatory health services (Total)	83.5%	79.5%	-4.8%	76.1%	-4.3%	-8.8%
Blue Cross and Blue Shield of New Mexico						
Access to preventive/ambulatory health services (20-44 Yrs)	81.0%	71.9%	-11.3%	72.4%	0.6%	-10.7%
Access to preventive/ambulatory health services (45-64 Yrs)	86.1%	82.2%	-4.5%	81.6%	-0.7%	-5.2%
Access to preventive/ambulatory health services (65+ Yrs)	NR	85.9%	N/A	89.6%	4.4%	N/A
Access to preventive/ambulatory health services (Total)	82.5%	76.6%	-7.1%	76.4%	-0.3%	-7.4%
United Healthcare of New Mexico, Inc.						
Access to preventive/ambulatory health services (20-44 Yrs)	96.2%	78.7%	-18.1%	75.3%	-4.3%	-21.7%
Access to preventive/ambulatory health services (45-64 Yrs)	99.1%	90.8%	-8.3%	88.0%	-3.1%	-11.1%
Access to preventive/ambulatory health services (65+ Yrs)	97.2%	96.3%	-0.9%	96.9%	0.6%	-0.3%
Access to preventive/ambulatory health services (Total)	98.2%	87.2%	-11.2%	83.5%	-4.3%	-15.0%
Total						
Access to preventive/ambulatory health services (20-44 Yrs)	83.9%	77.3%	-7.8%	74.2%	-4.0%	-11.5%
Access to preventive/ambulatory health services (45-64 Yrs)	89.0%	86.1%	-3.3%	83.0%	-3.6%	-6.8%
Access to preventive/ambulatory health services (65+ Yrs)	93.8%	91.9%	-2.0%	91.4%	-0.6%	-2.6%
Access to preventive/ambulatory health services (Total)	85.5%	81.4%	-4.8%	78.1%	-4.1%	-8.7%

Mental Health Services Utilization (Measure 2)

	DY1	DY2	
Mental health services utilization	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Mental Health Utilization (0-12 Yrs, Male)	12.2%	11.6%	-4.4%
Mental Health Utilization (0-12 Yrs, Female)	8.9%	8.7%	-2.1%
Mental Health Utilization (0-12 Yrs, Total)	10.6%	10.2%	-3.4%
Mental Health Utilization (13-17 Yrs, Male)	18.0%	17.1%	-5.0%
Mental Health Utilization (13-17 Yrs, Female)	19.4%	19.1%	-1.4%
Mental Health Utilization (13-17 Yrs, Total)	18.7%	18.1%	-3.2%
Mental Health Utilization (18-64 Yrs, Male)	16.0%	14.4%	-9.9%
Mental Health Utilization (18-64 Yrs, Female)	16.5%	16.9%	2.0%
Mental Health Utilization (18-64 Yrs, Total)	16.3%	15.9%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	7.9%	8.6%	8.9%
Mental Health Utilization (65+ Yrs, Female)	10.2%	12.0%	17.7%
Mental Health Utilization (65+ Yrs, Total)	9.4%	10.8%	15.0%
Mental Health Utilization (Total, Male)	14.3%	13.5%	-5.4%
Mental Health Utilization (Total, Female)	13.8%	14.1%	2.3%
Mental Health Utilization (Grand Total)	14.0%	13.8%	-1.2%
Molina Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.9%	9.7%	-2.9%
Mental Health Utilization (0-12 Yrs, Female)	7.3%	7.4%	1.6%
Mental Health Utilization (0-12 Yrs, Total)	8.7%	8.6%	-1.0%
Mental Health Utilization (13-17 Yrs, Male)	16.5%	16.5%	0.4%
Mental Health Utilization (13-17 Yrs, Female)	18.1%	17.9%	-1.3%
Mental Health Utilization (13-17 Yrs, Total)	17.3%	17.2%	-0.5%
Mental Health Utilization (18-64 Yrs, Male)	14.6%	14.2%	-3.0%
Mental Health Utilization (18-64 Yrs, Female)	15.1%	16.2%	7.4%
Mental Health Utilization (18-64 Yrs, Total)	14.9%	15.4%	3.1%
Mental Health Utilization (65+ Yrs, Male)	8.8%	8.9%	0.9%
Mental Health Utilization (65+ Yrs, Female)	11.3%	10.1%	-10.5%
Mental Health Utilization (65+ Yrs, Total)	10.4%	9.6%	-7.1%
Mental Health Utilization (Total, Male)	12.5%	12.5%	-0.6%
Mental Health Utilization (Total, Female)	12.4%	13.1%	5.7%
Mental Health Utilization (Grand Total)	12.5%	12.8%	2.8%
Blue Cross and Blue Shield of New Mexico			
Mental Health Utilization (0-12 Yrs, Male)	10.9%	8.9%	-18.3%
Mental Health Utilization (0-12 Yrs, Female)	7.8%	6.6%	-15.7%
Mental Health Utilization (0-12 Yrs, Total)	9.4%	7.8%	-17.2%
Mental Health Utilization (13-17 Yrs, Male)	18.2%	15.5%	-15.2%
Mental Health Utilization (13-17 Yrs, Female)	20.9%	17.6%	-16.0%
Mental Health Utilization (13-17 Yrs, Total)	19.5%	16.5%	-15.5%
Mental Health Utilization (18-64 Yrs, Male)	18.1%	15.4%	-14.9%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	17.5%	-9.2%
Mental Health Utilization (18-64 Yrs, Total)	18.7%	16.5%	-11.9%
Mental Health Utilization (65+ Yrs, Male)	15.3%	12.8%	-16.2%
Mental Health Utilization (65+ Yrs, Female)	18.4%	15.4%	-16.3%
Mental Health Utilization (65+ Yrs, Total)	17.2%	14.4%	-16.2%
Mental Health Utilization (Total, Male)	15.6%	13.3%	-14.6%
Mental Health Utilization (Total, Female)	16.0%	14.4%	-10.1%
Mental Health Utilization (Grand Total)	15.8%	13.9%	-12.3%

Mental Health Services Utilization (Continued)

Mental health services utilization	DY1 Rate, p_1	DY2 Rate, p_2	DY2 Change (p_2/p_1-1)
United Healthcare of New Mexico, Inc.			
Mental Health Utilization (0-12 Yrs, Male)	9.6%	8.2%	-14.1%
Mental Health Utilization (0-12 Yrs, Female)	6.9%	5.6%	-17.8%
Mental Health Utilization (0-12 Yrs, Total)	8.3%	7.0%	-15.4%
Mental Health Utilization (13-17 Yrs, Male)	17.6%	15.6%	-11.7%
Mental Health Utilization (13-17 Yrs, Female)	18.4%	17.0%	-7.5%
Mental Health Utilization (13-17 Yrs, Total)	18.0%	16.3%	-9.5%
Mental Health Utilization (18-64 Yrs, Male)	17.5%	16.8%	-3.8%
Mental Health Utilization (18-64 Yrs, Female)	19.3%	19.1%	-1.0%
Mental Health Utilization (18-64 Yrs, Total)	18.5%	18.0%	-2.5%
Mental Health Utilization (65+ Yrs, Male)	10.3%	9.4%	-9.1%
Mental Health Utilization (65+ Yrs, Female)	11.6%	11.0%	-5.0%
Mental Health Utilization (65+ Yrs, Total)	11.2%	10.5%	-6.2%
Mental Health Utilization (Total, Male)	15.6%	14.7%	-5.8%
Mental Health Utilization (Total, Female)	16.4%	15.9%	-3.2%
Mental Health Utilization (Grand Total)	16.0%	15.3%	-4.5%

Total			
Mental Health Utilization (0-12 Yrs, Male)	11.0%	10.2%	-6.9%
Mental Health Utilization (0-12 Yrs, Female)	8.0%	7.7%	-4.1%
Mental Health Utilization (0-12 Yrs, Total)	9.5%	9.0%	-5.7%
Mental Health Utilization (13-17 Yrs, Male)	17.4%	16.6%	-4.8%
Mental Health Utilization (13-17 Yrs, Female)	19.0%	18.3%	-3.6%
Mental Health Utilization (13-17 Yrs, Total)	18.2%	17.5%	-4.1%
Mental Health Utilization (18-64 Yrs, Male)	16.3%	15.1%	-7.5%
Mental Health Utilization (18-64 Yrs, Female)	16.9%	17.2%	1.4%
Mental Health Utilization (18-64 Yrs, Total)	16.7%	16.3%	-2.4%
Mental Health Utilization (65+ Yrs, Male)	10.4%	10.0%	-3.6%
Mental Health Utilization (65+ Yrs, Female)	12.3%	12.1%	-1.5%
Mental Health Utilization (65+ Yrs, Total)	11.7%	11.4%	-2.1%
Mental Health Utilization (Total, Male)	14.0%	13.3%	-5.2%
Mental Health Utilization (Total, Female)	13.9%	14.1%	1.1%
Mental Health Utilization (Grand Total)	13.9%	13.7%	-1.8%

Number and percentage of people with an annual dental visit (Measure 6)[165]

	Baseline	DY1		DY2		Baseline to DY2
Annual dental visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Annual Dental Visit (Total)	71.0%	68.1%	-4.1%	66.4%	-2.5%	-6.5%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Annual Dental Visit (Total)	70.9%	62.7%	-11.5%	70.1%	11.7%	-1.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
Annual Dental Visit (Total)	66.8%	57.5%	-14.0%	59.6%	3.8%	-10.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Annual Dental Visit (Total)	51.5%	41.5%	-19.4%	49.9%	20.1%	-3.2%
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%
Annual Dental Visit (Total)	70.6%	64.0%	-9.3%	66.0%	3.1%	-6.5%

Enrollment in Centennial Care as a Percentage of State Population (Measure 7)

	DY1	DY2		DY3		DY1 to DY3
Enrollment in Centennial Care as a Percentage of State Population	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Enrollment in Centennial Care as a Percentage of State Population	27.3%	31.0%	13.3%	32.7%	5.6%	19.6%

[165] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Number and percentage of participants with BH conditions who accessed any of the three new BH services (BH respite, family support and recovery) (Measure 10)

	DY1		DY2		DY1 to DY3
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_3/p_1-1)**
Total					
Number and percentage of participants with BH conditions who accessed any of the three new BH services (respite, family support and recovery)	1.02%	N/A	1.10%	7.82%	16.90%

Number and percentage of Unduplicated Participants with at Least One PCP Visit (Measure 11)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_2/p_0-1)**
Total								
Number and percentage of unduplicated participants with at least one PCP visit, in aggregate and among subgroups	65.5%	57.6%	-12.1%	50.4%	-12.6%	47.4%	-5.8%	-27.7%

Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC (Measure 14)

	DY1		DY2	
Number and percentage of substance use disorder participants with follow-up 7 and 30 days after leaving RTC	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	43.0%	N/A	27.1%	-37.0%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	64.7%	N/A	47.7%	-26.3%
Molina Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.6%	N/A	24.9%	82.8%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	22.0%	N/A	41.0%	86.3%
Blue Cross and Blue Shield of New Mexico				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	13.8%	N/A	11.5%	-16.7%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	30.3%	N/A	28.7%	-5.3%
United Healthcare of New Mexico, Inc.				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	NR	N/A	58.1%	N/A
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	NR	N/A	74.2%	N/A
Total				
Percent of Members Seen for Follow-Up within 7 Days of Discharge from RTC	26.5%	N/A	25.7%	-3.1%
Percent of Members Seen for Follow-Up within 30 Days of Discharge from RTC	43.2%	N/A	44.0%	1.9%

Follow-up after Hospitalization of Mental Illness (Measure 15)[166]

	DY1	DY2	
Number and percentage of BH participants with follow-up after hospitalization of mental illness	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Presbyterian Health Plan			
Follow-Up After Hospitalization for Mental Illness (30-day)	67.9%	59.7%	-12.0%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.1%	32.6%	-24.5%
Molina Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	64.8%	59.8%	-7.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	41.8%	34.6%	-17.1%
Blue Cross and Blue Shield of New Mexico			
Follow-Up After Hospitalization for Mental Illness (30-day)	58.5%	55.1%	-5.8%
Follow-Up After Hospitalization for Mental Illness (7-day)	39.0%	34.3%	-12.1%
United Healthcare of New Mexico, Inc.			
Follow-Up After Hospitalization for Mental Illness (30-day)	71.0%	73.1%	2.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	55.2%	55.0%	-0.4%
Total			
Follow-Up After Hospitalization for Mental Illness (30-day)	65.3%	60.9%	-6.9%
Follow-Up After Hospitalization for Mental Illness (7-day)	43.8%	37.6%	-14.2%

[166] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Childhood Immunization Status (Measure 16)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Childhood Immunization Status (DTaP)	77.3%	79.2%	2.4%	75.9%	-4.1%	-1.8%
Childhood Immunization Status (IPV)	88.0%	88.0%	0.0%	87.3%	-0.8%	-0.8%
Childhood Immunization Status (MMR)	87.5%	91.2%	4.2%	85.2%	-6.6%	-2.6%
Childhood Immunization Status (HiB)	90.0%	90.3%	0.3%	87.3%	-3.3%	-3.1%
Childhood Immunization Status (Hepatitis B)	79.2%	81.3%	2.6%	83.8%	3.1%	5.8%
Childhood Immunization Status (VZV)	88.0%	90.5%	2.9%	85.0%	-6.1%	-3.4%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.6%	78.0%	-3.2%	76.4%	-2.1%	-5.2%
Childhood Immunization Status (Hepatitis A)	86.1%	87.3%	1.3%	84.5%	-3.2%	-1.9%
Childhood Immunization Status (Rotavirus)	73.1%	75.5%	3.2%	75.9%	0.6%	3.8%
Childhood Immunization Status (Influenza)	57.2%	53.9%	-5.7%	52.1%	-3.4%	-8.9%
Childhood Immunization Status (Combination 2)	67.4%	69.4%	3.1%	69.7%	0.3%	3.4%
Childhood Immunization Status (Combination 3)	66.0%	64.6%	-2.1%	66.4%	2.9%	0.7%
Childhood Immunization Status (Combination 4)	63.0%	61.8%	-1.8%	65.0%	5.2%	3.3%
Childhood Immunization Status (Combination 5)	57.6%	56.5%	-2.0%	59.7%	5.7%	3.6%
Childhood Immunization Status (Combination 6)	44.4%	39.1%	-12.0%	44.0%	12.4%	-1.0%
Childhood Immunization Status (Combination 7)	55.8%	54.4%	-2.5%	58.3%	7.2%	4.6%
Childhood Immunization Status (Combination 8)	43.1%	38.2%	-11.3%	43.5%	13.9%	1.1%
Childhood Immunization Status (Combination 9)	39.4%	35.2%	-10.6%	39.4%	11.8%	0.0%
Childhood Immunization Status (Combination 10)	38.7%	34.5%	-10.8%	38.9%	12.8%	0.6%
Molina Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	81.9%	83.0%	1.3%	70.6%	-14.9%	-13.7%
Childhood Immunization Status (IPV)	92.5%	93.2%	0.7%	84.8%	-9.0%	-8.4%
Childhood Immunization Status (MMR)	92.1%	93.4%	1.4%	87.2%	-6.6%	-5.3%
Childhood Immunization Status (HiB)	92.3%	93.2%	1.0%	83.9%	-10.0%	-9.1%
Childhood Immunization Status (Hepatitis B)	92.1%	92.9%	1.0%	84.8%	-8.8%	-7.9%
Childhood Immunization Status (VZV)	92.3%	92.9%	0.7%	86.3%	-7.1%	-6.5%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.1%	82.6%	3.0%	71.5%	-13.4%	-10.7%
Childhood Immunization Status (Hepatitis A)	87.9%	89.6%	2.0%	83.4%	-6.9%	-5.0%
Childhood Immunization Status (Rotavirus)	72.6%	76.4%	5.2%	67.8%	-11.3%	-6.7%
Childhood Immunization Status (Influenza)	53.6%	54.5%	1.6%	41.9%	-23.1%	-21.8%
Childhood Immunization Status (Combination 2)	78.6%	80.8%	2.8%	67.1%	-16.9%	-14.6%
Childhood Immunization Status (Combination 3)	73.3%	77.7%	6.0%	64.7%	-16.8%	-11.7%
Childhood Immunization Status (Combination 4)	71.1%	75.1%	5.6%	62.0%	-17.4%	-12.7%
Childhood Immunization Status (Combination 5)	59.6%	66.4%	11.5%	57.8%	-13.0%	-3.0%
Childhood Immunization Status (Combination 6)	46.1%	50.3%	9.1%	35.3%	-29.8%	-23.4%
Childhood Immunization Status (Combination 7)	57.8%	64.2%	11.1%	55.4%	-13.7%	-4.2%
Childhood Immunization Status (Combination 8)	45.5%	49.4%	8.7%	34.7%	-29.9%	-23.8%
Childhood Immunization Status (Combination 9)	40.4%	45.7%	13.1%	32.7%	-28.5%	-19.1%
Childhood Immunization Status (Combination 10)	39.7%	44.8%	12.8%	32.0%	-28.6%	-19.4%

Childhood Immunization Status (Continued)

	Baseline	DY1		DY2		Baseline to DY2
Childhood Immunization Status	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Blue Cross and Blue Shield of New Mexico						
Childhood Immunization Status (DTaP)	81.8%	80.6%	-1.5%	72.6%	-9.9%	-11.2%
Childhood Immunization Status (IPV)	92.2%	92.7%	0.5%	86.3%	-6.9%	-6.4%
Childhood Immunization Status (MMR)	91.8%	90.5%	-1.4%	87.0%	-3.9%	-5.3%
Childhood Immunization Status (HiB)	92.0%	92.9%	1.0%	85.0%	-8.6%	-7.6%
Childhood Immunization Status (Hepatitis B)	91.4%	92.7%	1.5%	87.2%	-6.0%	-4.5%
Childhood Immunization Status (VZV)	92.7%	90.1%	-2.8%	87.0%	-3.4%	-6.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.0%	80.8%	0.9%	74.0%	-8.5%	-7.6%
Childhood Immunization Status (Hepatitis A)	87.1%	88.5%	1.6%	83.9%	-5.2%	-3.7%
Childhood Immunization Status (Rotavirus)	74.1%	74.8%	1.0%	68.7%	-8.3%	-7.3%
Childhood Immunization Status (Influenza)	52.8%	51.4%	-2.5%	52.8%	2.6%	0.0%
Childhood Immunization Status (Combination 2)	78.3%	76.8%	-1.9%	70.9%	-7.8%	-9.5%
Childhood Immunization Status (Combination 3)	73.8%	74.4%	0.8%	67.8%	-8.9%	-8.2%
Childhood Immunization Status (Combination 4)	71.8%	73.1%	1.7%	65.8%	-10.0%	-8.4%
Childhood Immunization Status (Combination 5)	62.3%	63.4%	1.7%	57.4%	-9.4%	-7.9%
Childhood Immunization Status (Combination 6)	45.9%	45.7%	-0.4%	45.9%	0.5%	0.0%
Childhood Immunization Status (Combination 7)	61.4%	62.7%	2.1%	55.6%	-11.3%	-9.4%
Childhood Immunization Status (Combination 8)	45.0%	45.7%	1.5%	44.4%	-2.9%	-1.4%
Childhood Immunization Status (Combination 9)	39.9%	40.4%	1.2%	39.1%	-3.3%	-2.1%
Childhood Immunization Status (Combination 10)	39.2%	40.4%	2.9%	37.7%	-6.6%	-3.8%
United Healthcare of New Mexico, Inc.						
Childhood Immunization Status (DTaP)	NR	65.7%	N/A	51.3%	-21.9%	N/A
Childhood Immunization Status (IPV)	NR	74.3%	N/A	62.5%	-15.8%	N/A
Childhood Immunization Status (MMR)	NR	80.0%	N/A	71.8%	-10.3%	N/A
Childhood Immunization Status (HiB)	NR	75.7%	N/A	64.7%	-14.5%	N/A
Childhood Immunization Status (Hepatitis B)	NR	74.3%	N/A	60.8%	-18.1%	N/A
Childhood Immunization Status (VZV)	NR	80.0%	N/A	71.3%	-10.9%	N/A
Childhood Immunization Status (Pneumo- coccal Conjugate)	NR	67.1%	N/A	50.1%	-25.4%	N/A
Childhood Immunization Status (Hepatitis A)	NR	75.7%	N/A	72.5%	-4.2%	N/A
Childhood Immunization Status (Rotavirus)	NR	64.3%	N/A	44.3%	-31.1%	N/A
Childhood Immunization Status (Influenza)	NR	41.4%	N/A	34.8%	-16.0%	N/A
Childhood Immunization Status (Combination 2)	NR	60.0%	N/A	47.0%	-21.7%	N/A
Childhood Immunization Status (Combination 3)	NR	58.6%	N/A	43.6%	-25.6%	N/A
Childhood Immunization Status (Combination 4)	NR	55.7%	N/A	43.1%	-22.7%	N/A
Childhood Immunization Status (Combination 5)	NR	51.4%	N/A	34.3%	-33.3%	N/A
Childhood Immunization Status (Combination 6)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 7)	NR	48.6%	N/A	33.8%	-30.4%	N/A
Childhood Immunization Status (Combination 8)	NR	31.4%	N/A	26.0%	-17.2%	N/A
Childhood Immunization Status (Combination 9)	NR	25.7%	N/A	22.4%	-12.9%	N/A
Childhood Immunization Status (Combination 10)	NR	25.7%	N/A	22.4%	-12.9%	N/A

Childhood Immunization Status (Continued)

Childhood Immunization Status	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Childhood Immunization Status (DTaP)	80.4%	80.2%	-0.3%	67.9%	-15.3%	-15.5%
Childhood Immunization Status (IPV)	90.9%	90.5%	-0.5%	80.6%	-11.0%	-11.4%
Childhood Immunization Status (MMR)	90.5%	91.1%	0.7%	83.0%	-8.9%	-8.3%
Childhood Immunization Status (HiB)	91.5%	91.3%	-0.1%	80.5%	-11.9%	-12.0%
Childhood Immunization Status (Hepatitis B)	87.6%	88.4%	0.8%	79.5%	-10.0%	-9.3%
Childhood Immunization Status (VZV)	91.0%	90.6%	-0.4%	82.6%	-8.8%	-9.2%
Childhood Immunization Status (Pneumo- coccal Conjugate)	80.2%	79.8%	-0.5%	68.3%	-14.4%	-14.8%
Childhood Immunization Status (Hepatitis A)	87.1%	87.9%	0.9%	81.2%	-7.5%	-6.7%
Childhood Immunization Status (Rotavirus)	73.3%	75.0%	2.3%	64.5%	-14.0%	-12.0%
Childhood Immunization Status (Influenza)	54.5%	52.7%	-3.3%	45.6%	-13.5%	-16.4%
Childhood Immunization Status (Combination 2)	74.9%	75.0%	0.2%	64.0%	-14.7%	-14.5%
Childhood Immunization Status (Combination 3)	71.1%	71.7%	0.8%	60.9%	-14.9%	-14.3%
Childhood Immunization Status (Combination 4)	68.7%	69.4%	1.0%	59.3%	-14.6%	-13.7%
Childhood Immunization Status (Combination 5)	59.9%	61.6%	3.0%	52.7%	-14.6%	-12.1%
Childhood Immunization Status (Combination 6)	45.5%	44.5%	-2.3%	38.0%	-14.5%	-16.5%
Childhood Immunization Status (Combination 7)	58.4%	59.9%	2.7%	51.1%	-14.7%	-12.4%
Childhood Immunization Status (Combination 8)	44.5%	43.9%	-1.4%	37.3%	-14.9%	-16.2%
Childhood Immunization Status (Combination 9)	39.9%	39.8%	-0.3%	33.6%	-15.6%	-15.9%
Childhood Immunization Status (Combination 10)	39.2%	39.3%	0.1%	32.9%	-16.1%	-16.0%

Immunizations for Adolescents (Measure 17)[167]

Immunizations for Adolescents	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Immunizations for Adolescents (Meningococcal)	67.8%	67.1%	-1.1%	60.4%	-10.0%	-10.9%
Immunizations for Adolescents (Tdap/Td)	78.9%	78.7%	-0.3%	73.9%	-6.1%	-6.3%
Immunizations for Adolescents (Combination 1)	63.4%	64.9%	2.2%	58.9%	-9.2%	-7.1%
Molina Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	62.3%	63.9%	2.6%	76.2%	19.2%	22.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	75.9%	-3.3%	85.4%	12.6%	8.9%
Immunizations for Adolescents (Combination 1)	60.2%	61.1%	1.6%	73.8%	20.8%	22.7%
Blue Cross and Blue Shield of New Mexico						
Immunizations for Adolescents (Meningococcal)	NR	39.1%	N/A	39.2%	0.2%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	42.2%	N/A	43.5%	3.2%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.9%	N/A	34.6%	2.0%	N/A
United Healthcare of New Mexico, Inc.						
Immunizations for Adolescents (Meningococcal)	NR	33.3%	N/A	43.6%	30.7%	N/A
Immunizations for Adolescents (Tdap/Td)	NR	53.3%	N/A	49.4%	-7.4%	N/A
Immunizations for Adolescents (Combination 1)	NR	33.3%	N/A	40.6%	21.9%	N/A
Total						
Immunizations for Adolescents (Meningococcal)	65.1%	64.3%	-1.2%	60.3%	-6.3%	-7.3%
Immunizations for Adolescents (Tdap/Td)	78.5%	76.4%	-2.7%	69.8%	-8.6%	-11.1%
Immunizations for Adolescents (Combination 1)	61.6%	61.9%	0.5%	58.1%	-6.2%	-5.8%

[167] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in the First 15 Months of Life (Measure 18)[168]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in first 15 months of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	63.4%	46.5%	-26.6%	48.3%	3.7%	-23.9%
Molina Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.5%	51.8%	-17.2%	55.4%	7.1%	-11.3%
Blue Cross and Blue Shield of New Mexico						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.3%	44.3%	-28.8%	47.9%	8.0%	-23.0%
United Healthcare of New Mexico, Inc.						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	NR	NR	N/A	56.9%	N/A	N/A
Total						
Well-Child Visits in the First 15 Months of Life (6+ Visits)	62.7%	46.1%	-26.5%	56.1%	21.7%	-10.5%

[168] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life (Measure 19)[169]

	Baseline	DY1		DY2		Baseline to DY2
Well-child visits in third, fourth, fifth and sixth years of life	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Well-child visits in third, fourth, fifth and sixth years of life	66.7%	54.9%	-17.6%	54.8%	-0.2%	-17.8%
Molina Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	66.5%	63.6%	-4.4%	68.8%	8.2%	3.5%
Blue Cross and Blue Shield of New Mexico						
Well-child visits in third, fourth, fifth and sixth years of life	60.2%	56.6%	-5.9%	57.6%	1.7%	-4.3%
United Healthcare of New Mexico, Inc.						
Well-child visits in third, fourth, fifth and sixth years of life	NR	65.9%	N/A	52.6%	-20.3%	N/A
Total						
Well-child visits in third, fourth, fifth and sixth years of life	64.3%	64.8%	0.7%	60.8%	-6.1%	-5.5%

Adolescent Well Care Visits (Measure 20)[170]

	Baseline	DY1		DY2		Baseline to DY2
Adolescent well care visits	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adolescent well care visits	48.1%	36.4%	-24.5%	32.3%	-11.3%	-33.0%
Molina Healthcare of New Mexico, Inc.						
Adolescent well care visits	50.8%	51.7%	1.7%	45.9%	-11.1%	-9.6%
Blue Cross and Blue Shield of New Mexico						
Adolescent well care visits	39.0%	36.3%	-6.8%	33.1%	-8.9%	-15.2%
United Healthcare of New Mexico, Inc.						
Adolescent well care visits	NR	31.1%	N/A	37.2%	19.5%	N/A
Total						
Adolescent well care visits	49.7%	41.9%	-15.6%	41.8%	-0.3%	-15.9%

[169] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[170] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Prenatal and Postpartum Care (Measure 21)[171]

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[171] UHC baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.

Frequency of Ongoing Prenatal Care (Measure 22)[172]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

[172] UHC baseline numerators and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Breast Cancer Screening for Women (Measure 23)[173]

	Baseline	DY1		DY2		Baseline to DY2
Breast cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Breast cancer screening	54.6%	49.7%	-9.0%	44.4%	-10.7%	-18.7%
Molina Healthcare of New Mexico, Inc.						
Breast cancer screening	67.0%	71.4%	6.6%	63.5%	-11.1%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Breast cancer screening	51.4%	51.2%	-0.4%	54.6%	6.5%	6.1%
United Healthcare of New Mexico, Inc.						
Breast cancer screening	44.4%	36.7%	-17.3%	38.9%	6.0%	-12.4%
Total						
Breast cancer screening	54.5%	52.5%	-3.7%	50.7%	-3.3%	-6.9%

Cervical Cancer Screening for Women (Measure 24)[174]

	Baseline	DY1		DY2		Baseline to DY2
Cervical cancer screening for women	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Cervical cancer screening	65.0%	57.3%	-12.0%	56.4%	-1.5%	-13.3%
Molina Healthcare of New Mexico, Inc.						
Cervical cancer screening	66.7%	45.8%	-31.3%	52.7%	15.1%	-20.9%
Blue Cross and Blue Shield of New Mexico						
Cervical cancer screening	48.0%	28.4%	-41.0%	45.8%	61.5%	-4.7%
United Healthcare of New Mexico, Inc.						
Cervical cancer screening	43.1%	27.3%	-36.7%	39.7%	45.5%	-7.9%
Total						
Cervical cancer screening	58.4%	43.2%	-26.0%	48.7%	12.7%	-16.6%

Flu Vaccinations for Adults (Measure 25)

	Baseline	DY1		DY2		DY3		Baseline to DY3
Flu Vaccinations for Adults	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Rate, p_3**	**Change (p_3/p_2-1)**	**Change (p_3/p_0-1)**
Total								
Flu Vaccinations for Adults	4.5%	5.0%	10.7%	10.3%	106.2%	10.3%	0.2%	128.7%

[173] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.
[174] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 26)

	DY1	DY2	
Initiation and engagement of alcohol and other drug dependence treatment	**Rate, p_1**	**Rate, p_2**	**Change (p_2/p_1-1)**
Initiation of AOD Treatment (13-17 Yrs)	36.6%	46.1%	25.9%
Initiation of AOD Treatment (18+ Yrs)	36.7%	39.6%	8.0%
Initiation of AOD Treatment (Total)	36.7%	40.2%	9.7%
Engagement of AOD Treatment (13-17 Yrs)	15.0%	21.5%	43.2%
Engagement of AOD Treatment (18+ Yrs)	14.0%	14.7%	5.0%
Engagement of AOD Treatment (Total)	14.1%	15.3%	8.5%
Molina Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	46.6%	44.8%	-3.9%
Initiation of AOD Treatment (18+ Yrs)	38.9%	34.9%	-10.2%
Initiation of AOD Treatment (Total)	39.5%	35.6%	-9.9%
Engagement of AOD Treatment (13-17 Yrs)	17.6%	16.8%	-4.6%
Engagement of AOD Treatment (18+ Yrs)	13.1%	11.7%	-10.7%
Engagement of AOD Treatment (Total)	13.5%	12.0%	-10.5%
Blue Cross and Blue Shield of New Mexico			
Initiation of AOD Treatment (13-17 Yrs)	51.6%	46.6%	-9.7%
Initiation of AOD Treatment (18+ Yrs)	39.0%	37.0%	-4.9%
Initiation of AOD Treatment (Total)	39.5%	37.3%	-5.4%
Engagement of AOD Treatment (13-17 Yrs)	25.0%	16.2%	-35.3%
Engagement of AOD Treatment (18+ Yrs)	14.2%	14.2%	0.0%
Engagement of AOD Treatment (Total)	14.7%	14.3%	-2.4%
United Healthcare of New Mexico, Inc.			
Initiation of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Initiation of AOD Treatment (18+ Yrs)	NR	NR	N/A
Initiation of AOD Treatment (Total)	NR	NR	N/A
Engagement of AOD Treatment (13-17 Yrs)	NR	NR	N/A
Engagement of AOD Treatment (18+ Yrs)	NR	NR	N/A
Engagement of AOD Treatment (Total)	NR	NR	N/A
Total			
Initiation of AOD Treatment (13-17 Yrs)	42.3%	45.6%	7.7%
Initiation of AOD Treatment (18+ Yrs)	38.2%	37.1%	-2.9%
Initiation of AOD Treatment (Total)	38.6%	37.7%	-2.4%
Engagement of AOD Treatment (13-17 Yrs)	17.2%	18.9%	9.8%
Engagement of AOD Treatment (18+ Yrs)	13.7%	13.5%	-1.6%
Engagement of AOD Treatment (Total)	14.0%	13.8%	-1.2%

Annual Monitoring Persistent Medications (Measure 38)[175]

	Baseline	DY1		DY2		Baseline to DY2
Annual monitoring for patients on persistent medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Annual monitoring for patients on ACE Inhibitors or ARBs	84.7%	83.9%	-0.9%	83.5%	-0.5%	-1.4%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	87.8%	84.8%	-3.4%	85.8%	1.2%	-2.3%
Annual monitoring for patients: Total	85.9%	84.0%	-2.2%	84.1%	0.1%	-2.1%
Molina Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	87.2%	83.1%	-4.7%	82.7%	-0.6%	-5.2%
Annual monitoring for patients on persistent Digoxin	NR	60.0%	N/A	42.9%	-28.6%	N/A
Annual monitoring for patients on Diuretics	88.9%	83.2%	-6.4%	83.5%	0.3%	-6.1%
Annual monitoring for patients: Total	87.8%	83.1%	-5.4%	82.8%	-0.3%	-5.7%
Blue Cross and Blue Shield of New Mexico						
Annual monitoring for patients on ACE Inhibitors or ARBs	89.7%	85.1%	-5.2%	82.7%	-2.8%	-7.8%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	89.8%	85.2%	-5.1%	83.3%	-2.2%	-7.2%
Annual monitoring for patients: Total	89.6%	85.0%	-5.2%	82.8%	-2.5%	-7.6%
United Healthcare of New Mexico, Inc.						
Annual monitoring for patients on ACE Inhibitors or ARBs	88.6%	84.7%	-4.4%	83.0%	-1.9%	-6.3%
Annual monitoring for patients on persistent Digoxin	NR	NR	N/A	NR	N/A	N/A
Annual monitoring for patients on Diuretics	91.5%	86.4%	-5.5%	84.9%	-1.8%	-7.2%
Annual monitoring for patients: Total	89.9%	85.3%	-5.1%	83.5%	-2.1%	-7.1%
Total						
Annual monitoring for patients on ACE Inhibitors or ARBs	86.6%	83.9%	-3.0%	82.9%	-1.2%	-4.2%
Annual monitoring for patients on persistent Digoxin	85.4%	54.3%	-36.4%	42.0%	-22.8%	-50.9%
Annual monitoring for patients on Diuretics	89.0%	84.5%	-5.1%	84.3%	-0.2%	-5.3%
Annual monitoring for patients: Total	87.5%	84.0%	-4.0%	83.3%	-0.9%	-4.9%

[175] All MCOs Digoxin subcomponent numerators and denominators were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Medication Management for People with Asthma (Measure 39)[176]

	Baseline	DY1		DY2		Baseline to DY2
Medication Management for People With Asthma	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
5-11 Years - Medication Compliance 50%	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
12-18 Years - Medication Compliance 50%	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
19-50 Years - Medication Compliance 50%	47.4%	51.2%	8.1%	59.8%	16.8%	26.3%
51-64 Years - Medication Compliance 50%	71.4%	56.8%	-20.5%	72.5%	27.7%	1.5%
Total - Medication Compliance 50%	46.4%	44.7%	-3.6%	54.6%	22.0%	17.6%
Molina Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
12-18 Years - Medication Compliance 50%	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
19-50 Years - Medication Compliance 50%	48.5%	47.9%	-1.3%	56.2%	17.3%	15.8%
51-64 Years - Medication Compliance 50%	NR	56.6%	N/A	71.0%	25.6%	N/A
Total - Medication Compliance 50%	44.8%	47.0%	5.0%	49.4%	5.0%	10.3%
Blue Cross and Blue Shield of New Mexico						
5-11 Years - Medication Compliance 50%	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
12-18 Years - Medication Compliance 50%	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
19-50 Years - Medication Compliance 50%	62.5%	55.3%	-11.6%	59.6%	7.8%	-4.7%
51-64 Years - Medication Compliance 50%	NR	NR	N/A	66.7%	N/A	N/A
Total - Medication Compliance 50%	48.5%	49.5%	2.1%	51.1%	3.2%	5.3%
United Healthcare of New Mexico, Inc.						
5-11 Years - Medication Compliance 50%	NR	NR	N/A	31.6%	N/A	N/A
12-18 Years - Medication Compliance 50%	NR	NR	N/A	36.7%	N/A	N/A
19-50 Years - Medication Compliance 50%	NR	NR	N/A	56.7%	N/A	N/A
51-64 Years - Medication Compliance 50%	NR	63.3%	N/A	67.7%	6.9%	N/A
Total - Medication Compliance 50%	64.9%	67.2%	3.7%	56.3%	-16.3%	-13.2%
Total						
5-11 Years - Medication Compliance 50%	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
12-18 Years - Medication Compliance 50%	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
19-50 Years - Medication Compliance 50%	50.0%	51.0%	2.0%	58.2%	14.1%	16.3%
51-64 Years - Medication Compliance 50%	69.7%	59.4%	-14.7%	69.6%	17.2%	0.0%
Total - Medication Compliance 50%	46.3%	46.3%	-0.1%	52.2%	12.8%	12.7%

[176] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Asthma Medication Ratio (Measure 40)[177]

	Baseline	DY1		DY2		Baseline to DY2
Asthma Medication Ratio	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Asthma Medication Ratio (5-11)	71.7%	62.3%	-13.1%	67.3%	8.1%	-6.1%
Asthma Medication Ratio (12-18)	54.0%	47.7%	-11.6%	50.9%	6.7%	-5.7%
Asthma Medication Ratio (19-50)	36.4%	34.1%	-6.2%	43.6%	27.8%	19.9%
Asthma Medication Ratio (51-64)	34.5%	34.8%	0.9%	50.6%	45.4%	46.6%
Asthma Medication Ratio: Total	59.3%	51.5%	-13.2%	54.2%	5.2%	-8.6%
Molina Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	69.2%	60.9%	-12.0%	74.7%	22.5%	7.9%
Asthma Medication Ratio (12-18)	58.5%	51.7%	-11.7%	57.1%	10.5%	-2.4%
Asthma Medication Ratio (19-50)	43.6%	44.4%	1.8%	49.9%	12.4%	14.5%
Asthma Medication Ratio (51-64)	31.0%	49.6%	60.4%	51.4%	3.6%	66.2%
Asthma Medication Ratio: Total	60.1%	53.0%	-11.8%	61.2%	15.5%	1.8%
Blue Cross and Blue Shield of New Mexico						
Asthma Medication Ratio (5-11)	85.6%	62.5%	-27.0%	66.3%	6.1%	-22.5%
Asthma Medication Ratio (12-18)	65.2%	47.0%	-28.0%	53.6%	14.1%	-17.8%
Asthma Medication Ratio (19-50)	70.2%	55.6%	-20.9%	50.1%	-9.8%	-28.6%
Asthma Medication Ratio (51-64)	NR	NR	N/A	60.5%	N/A	N/A
Asthma Medication Ratio: Total	74.8%	55.0%	-26.4%	56.8%	3.3%	-24.0%
United Healthcare of New Mexico, Inc.						
Asthma Medication Ratio (5-11)	NR	NR	N/A	70.0%	N/A	N/A
Asthma Medication Ratio (12-18)	NR	NR	N/A	55.9%	N/A	N/A
Asthma Medication Ratio (19-50)	36.7%	46.7%	27.3%	42.4%	-9.2%	15.6%
Asthma Medication Ratio (51-64)	42.4%	51.2%	20.7%	48.2%	-6.0%	13.5%
Asthma Medication Ratio: Total	40.0%	49.4%	23.6%	47.7%	-3.5%	19.2%
Total						
Asthma Medication Ratio (5-11)	71.9%	61.9%	-13.9%	70.2%	13.5%	-2.3%
Asthma Medication Ratio (12-18)	55.9%	48.9%	-12.5%	53.8%	9.9%	-3.8%
Asthma Medication Ratio (19-50)	41.8%	40.6%	-3.0%	46.8%	15.4%	11.9%
Asthma Medication Ratio (51-64)	36.6%	45.6%	24.6%	52.4%	14.8%	43.0%
Asthma Medication Ratio: Total	60.2%	52.2%	-13.3%	56.8%	8.7%	-5.7%

[177] BCBS and UHC baseline and DY1 numerators and denominators (except for UHCs 5-11 years of age cohort) were included in the calculation of aggregate rates in each year; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Adult BMI Assessment and Weight Assessment for Children/Adolescents (Measure 41)[178]

	Baseline	DY1		DY2		Baseline to DY2
Adult Body Mass Index (BMI) assessment; weight assessment for children/adolescents	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Adult BMI assessment	73.4%	84.3%	14.9%	83.9%	-0.5%	14.4%
BMI Percentile (3-11 Yrs)	34.6%	44.7%	29.3%	61.7%	38.0%	78.5%
BMI Percentile (12-17 Yrs)	40.6%	40.8%	0.3%	64.8%	59.0%	59.6%
BMI Percentile (Total)	36.8%	43.3%	17.5%	62.8%	45.1%	70.5%
Counseling for Nutrition (3-11 Yrs)	48.9%	55.7%	13.9%	51.8%	-6.9%	6.0%
Counseling for Nutrition (12-17 Yrs)	43.1%	47.8%	10.8%	50.3%	5.4%	16.7%
Counseling for Nutrition (Total)	46.8%	52.8%	12.9%	51.3%	-2.8%	9.7%
Counseling for Physical Activity (3-11 Yrs)	38.2%	44.7%	16.9%	37.2%	-16.7%	-2.6%
Counseling for Physical Activity (12-17 Yrs)	40.0%	42.0%	5.1%	51.7%	23.0%	29.3%
Counseling for Physical Activity (Total)	38.9%	43.7%	12.4%	42.2%	-3.4%	8.6%
Molina Healthcare of New Mexico, Inc.						
Adult BMI assessment	81.0%	74.5%	-8.1%	79.7%	7.0%	-1.7%
BMI Percentile (3-11 Yrs)	57.8%	32.3%	-44.1%	53.7%	66.1%	-7.2%
BMI Percentile (12-17 Yrs)	56.4%	40.0%	-29.1%	51.6%	29.1%	-8.5%
BMI Percentile (Total)	57.4%	35.0%	-39.1%	53.0%	51.6%	-7.7%
Counseling for Nutrition (3-11 Yrs)	51.1%	55.2%	8.0%	54.0%	-2.2%	5.7%
Counseling for Nutrition (12-17 Yrs)	49.3%	49.7%	0.8%	50.3%	1.3%	2.1%
Counseling for Nutrition (Total)	50.6%	53.3%	5.5%	52.8%	-1.0%	4.4%
Counseling for Physical Activity (3-11 Yrs)	41.5%	50.2%	20.8%	49.3%	-1.7%	18.8%
Counseling for Physical Activity (12-17 Yrs)	45.7%	47.7%	4.4%	49.7%	4.0%	8.7%
Counseling for Physical Activity (Total)	42.8%	49.3%	15.2%	49.4%	0.2%	15.5%
Blue Cross and Blue Shield of New Mexico						
Adult BMI assessment	71.7%	79.2%	10.6%	72.1%	-9.0%	0.6%
BMI Percentile (3-11 Yrs)	52.9%	55.2%	4.3%	52.7%	-4.5%	-0.4%
BMI Percentile (12-17 Yrs)	46.2%	55.8%	20.9%	53.2%	-4.7%	15.2%
BMI Percentile (Total)	51.0%	55.4%	8.7%	52.9%	-4.6%	3.7%
Counseling for Nutrition (3-11 Yrs)	41.5%	57.1%	37.7%	43.4%	-24.0%	4.6%
Counseling for Nutrition (12-17 Yrs)	36.2%	52.2%	44.3%	41.8%	-19.8%	15.7%
Counseling for Nutrition (Total)	40.0%	55.6%	39.2%	42.9%	-22.8%	7.4%
Counseling for Physical Activity (3-11 Yrs)	34.4%	48.9%	42.3%	38.6%	-21.1%	12.3%
Counseling for Physical Activity (12-17 Yrs)	37.7%	52.9%	40.3%	40.4%	-23.6%	7.3%
Counseling for Physical Activity (Total)	35.3%	50.1%	41.9%	39.2%	-21.9%	10.9%
United Healthcare of New Mexico, Inc.						
Adult BMI assessment	71.5%	74.5%	4.1%	71.7%	-3.8%	0.2%
BMI Percentile (3-11 Yrs)	NR	43.8%	N/A	48.1%	9.9%	N/A
BMI Percentile (12-17 Yrs)	NR	43.8%	N/A	42.6%	-2.7%	N/A
BMI Percentile (Total)	NR	43.8%	N/A	46.2%	5.6%	N/A
Counseling for Nutrition (3-11 Yrs)	NR	53.4%	N/A	54.8%	2.7%	N/A
Counseling for Nutrition (12-17 Yrs)	NR	43.1%	N/A	52.5%	21.7%	N/A
Counseling for Nutrition (Total)	NR	49.4%	N/A	54.0%	9.4%	N/A
Counseling for Physical Activity (3-11 Yrs)	NR	31.5%	N/A	43.3%	37.7%	N/A
Counseling for Physical Activity (12-17 Yrs)	NR	40.6%	N/A	50.4%	23.9%	N/A
Counseling for Physical Activity (Total)	NR	35.0%	N/A	45.7%	30.6%	N/A
Total						
Adult BMI assessment	74.2%	78.2%	5.4%	76.0%	-2.8%	2.4%
BMI Percentile (3-11 Yrs)	49.2%	44.2%	-10.1%	54.0%	22.3%	9.9%
BMI Percentile (12-17 Yrs)	47.4%	44.8%	-5.5%	53.1%	18.7%	12.1%
BMI Percentile (Total)	48.6%	44.4%	-8.7%	53.7%	21.0%	10.5%
Counseling for Nutrition (3-11 Yrs)	47.4%	55.5%	16.9%	50.8%	-8.4%	7.1%
Counseling for Nutrition (12-17 Yrs)	43.5%	48.0%	10.4%	48.8%	1.6%	12.1%
Counseling for Nutrition (Total)	46.2%	52.9%	14.5%	50.1%	-5.1%	8.6%
Counseling for Physical Activity (3-11 Yrs)	38.3%	44.4%	15.9%	42.2%	-5.0%	10.1%
Counseling for Physical Activity (12-17 Yrs)	41.2%	45.6%	10.5%	48.1%	5.6%	16.7%
Counseling for Physical Activity (Total)	39.2%	44.8%	14.2%	44.1%	-1.4%	12.5%

[178] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual Rate Data for Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam (Measure 42 & 81)[179]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
HbA1c Testing	81.4%	86.5%	6.3%	84.6%	-2.2%	3.9%
HbA1c Poor Control (>9.0%)	47.9%	43.9%	-8.3%	48.3%	10.1%	0.9%
HbA1c Control (<8.0%)	42.8%	47.9%	12.0%	44.9%	-6.4%	4.8%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	48.3%	47.8%	-1.0%	46.1%	-3.5%	-4.5%
Medical Attention for Nephropathy	71.6%	79.5%	11.0%	86.9%	9.3%	21.3%
Blood Pressure Controlled <140/90 mm Hg	63.7%	64.2%	0.9%	62.7%	-2.5%	-1.6%
Molina Healthcare of New Mexico, Inc.						
HbA1c Testing	85.1%	85.7%	0.6%	88.1%	2.8%	3.5%
HbA1c Poor Control (>9.0%)	41.8%	49.9%	19.5%	45.0%	-9.7%	7.8%
HbA1c Control (<8.0%)	48.5%	37.7%	-22.2%	45.0%	19.3%	-7.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	58.2%	56.5%	-3.0%	54.5%	-3.5%	-6.4%
Medical Attention for Nephropathy	78.1%	74.8%	-4.2%	88.1%	17.7%	12.8%
Blood Pressure Controlled <140/90 mm Hg	64.3%	59.4%	-7.7%	62.0%	4.5%	-3.6%
Blue Cross and Blue Shield of New Mexico						
HbA1c Testing	82.2%	83.4%	1.4%	80.4%	-3.6%	-2.2%
HbA1c Poor Control (>9.0%)	53.6%	47.3%	-11.7%	52.9%	11.9%	-1.2%
HbA1c Control (<8.0%)	36.3%	43.1%	18.7%	39.3%	-8.8%	8.2%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	51.9%	54.2%	4.5%	47.8%	-11.9%	-8.0%
Medical Attention for Nephropathy	75.4%	78.6%	4.2%	85.1%	8.2%	12.8%
Blood Pressure Controlled <140/90 mm Hg	55.7%	57.4%	2.9%	55.9%	-2.6%	0.3%
United Healthcare of New Mexico, Inc.						
HbA1c Testing	85.9%	84.4%	-1.7%	84.4%	0.0%	-1.7%
HbA1c Poor Control (>9.0%)	49.5%	49.1%	-0.8%	52.6%	6.9%	6.1%
HbA1c Control (<8.0%)	41.9%	43.3%	3.4%	37.5%	-13.5%	-10.6%
HbA1c Control (<7.0%) for a Selected Population	NR	NR	N/A	NR	N/A	N/A
Eye Exam	44.0%	65.2%	48.3%	62.5%	-4.1%	42.2%
Medical Attention for Nephropathy	82.9%	83.7%	1.0%	90.3%	7.8%	8.9%
Blood Pressure Controlled <140/90 mm Hg	62.5%	54.7%	-12.4%	52.3%	-4.4%	-16.3%
Total						
HbA1c Testing	83.5%	85.0%	1.8%	84.1%	-1.0%	0.7%
HbA1c Poor Control (>9.0%)	47.9%	47.2%	-1.5%	49.8%	5.4%	3.9%
HbA1c Control (<8.0%)	42.7%	43.4%	1.6%	41.8%	-3.7%	-2.1%
HbA1c Control (<7.0%) for a Selected Population	33.3%	35.2%	5.7%	31.9%	-9.5%	-4.4%
Eye Exam	50.4%	55.0%	9.2%	51.8%	-5.9%	2.7%
Medical Attention for Nephropathy	76.6%	79.1%	3.3%	87.3%	10.4%	14.0%
Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	-4.4%	58.4%	-1.4%	-5.7%

[179] DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Antidepressant Medication Management (Measure 50)

Antidepressant medication management	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Effective Acute Phase Treatment	NR	53.9%	N/A	53.4%	-1.1%	N/A
Effective Continuation Phase Treatment	NR	39.0%	N/A	36.2%	-7.0%	N/A
Molina Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	40.8%	53.5%	31.2%	49.5%	-7.4%	21.5%
Effective Continuation Phase Treatment	25.1%	38.6%	54.2%	34.7%	-10.2%	38.4%
Blue Cross and Blue Shield of New Mexico						
Effective Acute Phase Treatment	42.8%	60.0%	40.2%	54.8%	-8.6%	28.1%
Effective Continuation Phase Treatment	29.9%	47.8%	59.8%	39.4%	-17.5%	31.8%
United Healthcare of New Mexico, Inc.						
Effective Acute Phase Treatment	51.0%	62.5%	22.6%	56.6%	-9.4%	11.0%
Effective Continuation Phase Treatment	37.1%	48.3%	30.4%	42.9%	-11.3%	15.7%
Total						
Effective Acute Phase Treatment	43.2%	55.6%	28.6%	53.1%	-4.4%	22.9%
Effective Continuation Phase Treatment	28.6%	41.1%	43.9%	37.8%	-8.1%	32.2%

Percentage of the Population Accessing a Behavioral Health Service that Received a PCP Visit in the Same Year (Measure 54)

Percentage of population accessing a behavioral health service that received a PCP visit in the same year	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Total						
Percentage of population accessing a behavioral health service that received a PCP visit in the same year	13.6%	12.6%	-7.6%	12.2%	-3.2%	-10.6%

Percentage of the Population Accessing an LTSS Service that Received a PCP Visit in the Same Year (Measure 55)

Percentage of LTSS population accessing a PCP visit during the year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_3/p_0-1)
Total								
Percentage of LTSS population accessing a PCP visit during the year	76.5%	73.5%	-3.8%	70.7%	-3.8%	69.4%	-1.9%	-9.3%

Percentage of the Population Accessing an LTSS Service that also accessed a BH Service in the Same Year (Measure 56)

Percentage of population accessing an LTSS service that also accessed a BH service in the same year	Baseline	DY1		DY2		DY3		Baseline to DY3
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Rate, p_3	Change (p_3/p_2-1)	Change (p_2/p_0-1)
Total								
Percentage of population accessing an LTSS service that also accessed a BH service in the same year	1.12%	1.06%	-5.38%	1.32%	25.14%	1.39%	4.89%	24.20%

Percentage of the Population with LTSS Needs with an ED Visit by Type of ED Visit (Measure 57)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with BH needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	18.7%	11.0%	-41.0%	7.0%	-36.49%	-62.51%
BH Population with EMTALA ER Visit Type	0.2%	0.1%	-58.9%	0.1%	-13.01%	-64.27%
BH Population with Urgent Care ER Visit Type	0.0%	0.0%	-100.0%	0.0%	N/A	-95.53%
BH Population with Limited or Minor ER Visit Type	0.6%	0.3%	-45.2%	0.4%	15.09%	-36.91%
BH Population with Low to Moderate ER Visit Type	1.8%	0.6%	-66.7%	0.7%	23.54%	-58.85%
BH Population with Moderate ER Visit Type	6.4%	2.5%	-61.2%	2.2%	-11.30%	-65.59%
BH Population with High Severity ER Visit Type	7.0%	2.2%	-68.0%	2.5%	12.59%	-63.96%
BH Population with Life Threatening ER Visit Type	5.4%	2.5%	-54.1%	2.3%	-7.48%	-57.55%
BH Population with Admitted Through ER Visit Type	3.6%	5.1%	44.1%	0.9%	-82.76%	-75.16%

Percentage of the Population with BH Needs with an ED Visit by Type of ED Visit (Measure 58)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population with LTSS needs with an ED visit by type of ED visit	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
BH Population with ER Visits	35.71%	37.56%	5.18%	44.22%	17.71%	23.82%
BH Population with EMTALA ER Visit Type	0.30%	0.25%	-14.62%	0.29%	14.99%	-1.82%
BH Population with Urgent Care ER Visit Type	0.02%	0.02%	-15.91%	0.01%	-32.54%	-43.27%
BH Population with Limited or Minor ER Visit Type	1.50%	1.76%	16.96%	2.68%	52.12%	77.92%
BH Population with Low to Moderate ER Visit Type	3.91%	3.73%	-4.59%	4.88%	30.78%	24.78%
BH Population with Moderate ER Visit Type	13.33%	13.78%	3.38%	16.06%	16.60%	20.53%
BH Population with High Severity ER Visit Type	15.18%	15.46%	1.84%	19.67%	27.28%	29.61%
BH Population with Life Threatening ER Visit Type	13.19%	14.07%	6.68%	17.22%	22.39%	30.57%
BH Population with Admitted Through ER Visit Type	8.66%	12.78%	47.62%	14.47%	13.16%	67.05%

Percentage of Participants Who Accessed a BH Service that also Accessed HCBS (Measure 60)

	Baseline	DY1		DY2		Baseline to DY3
Number and percentage of participants who accessed a BH service that also accessed HCBS	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Number and percentage of participants who accessed a BH service that also accessed HCBS	0.19%	0.21%	13.21%	0.23%	10.22%	15.37%

Percentage of the Population Accessing a BH Service that Received an Outpatient Ambulatory Visit in the Same Year (Measure 62)

	Baseline	DY1		DY2		Baseline to DY2
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Total						
Percentage of population accessing a BH service that received an outpatient ambulatory visit in the same year	14.5%	13.9%	-4.4%	15.6%	12.7%	7.7%

Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Measure 63)[180]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	85.3%	79.8%	-6.4%	79.7%	-0.1%	-6.6%
Molina Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	79.5%	77.0%	-3.2%	78.5%	1.9%	-1.3%
Blue Cross and Blue Shield of New Mexico						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	NR	79.7%	N/A	76.3%	-4.2%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	80.7%	74.2%	-8.0%	76.5%	3.0%	-5.2%
Total						
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	83.7%	77.6%	-7.2%	77.9%	0.3%	-7.0%

[180] BCBS baseline numerator and denominator were included in the calculation of aggregate rates; "NR" is shown since the denominator was less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Diabetes Monitoring for People with Diabetes and Schizophrenia (Measure 64)[181]

	Baseline	DY1		DY2		Baseline to DY2
Diabetes monitoring for people with diabetes and schizophrenia	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Diabetes monitoring for people with diabetes and schizophrenia	76.7%	75.0%	-2.2%	54.9%	-26.8%	-28.4%
Molina Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	NR	57.9%	N/A	55.0%	-4.9%	N/A
Blue Cross and Blue Shield of New Mexico						
Diabetes monitoring for people with diabetes and schizophrenia	NR	44.6%	N/A	44.9%	0.7%	N/A
United Healthcare of New Mexico, Inc.						
Diabetes monitoring for people with diabetes and schizophrenia	55.8%	49.8%	-10.9%	47.4%	-4.7%	-15.0%
Total						
Diabetes monitoring for people with diabetes and schizophrenia	62.4%	56.6%	-9.2%	49.9%	-11.8%	-20.0%

[181] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Statistical Significance Testing of Annual Rate Data for Asthma controller medication compliance (Measure 80)[182]

	Baseline	DY1		DY2		Baseline to DY2
Asthma controller medication compliance (children)	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Medication Compliance - 50% (5-11)	47.9%	45.5%	-5.0%	53.4%	17.4%	11.5%
Medication Compliance - 75% (5-11)	20.9%	21.3%	2.0%	26.5%	24.1%	26.6%
Medication Compliance - 50% (12-18)	42.7%	40.6%	-4.9%	48.9%	20.4%	14.5%
Medication Compliance - 75% (12-18)	19.5%	18.9%	-3.4%	25.4%	34.8%	30.2%
Molina Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	44.1%	46.2%	4.8%	46.2%	0.0%	4.8%
Medication Compliance - 75% (5-11)	22.2%	23.1%	4.2%	21.7%	-6.0%	-2.1%
Medication Compliance - 50% (12-18)	42.7%	44.2%	3.7%	41.5%	-6.1%	-2.7%
Medication Compliance - 75% (12-18)	18.8%	19.1%	2.0%	18.9%	-1.2%	0.7%
Blue Cross and Blue Shield of New Mexico						
Medication Compliance - 50% (5-11)	43.6%	43.9%	0.6%	45.1%	2.8%	3.5%
Medication Compliance - 75% (5-11)	18.1%	20.4%	12.8%	22.0%	7.6%	21.4%
Medication Compliance - 50% (12-18)	43.3%	48.2%	11.3%	35.8%	-25.8%	-17.5%
Medication Compliance - 75% (12-18)	16.7%	25.0%	50.0%	15.1%	-39.7%	-9.5%
United Healthcare of New Mexico, Inc.						
Medication Compliance - 50% (5-11)	NR	NR	N/A	31.6%	N/A	N/A
Medication Compliance - 75% (5-11)	NR	NR	N/A	NR	N/A	N/A
Medication Compliance - 50% (12-18)	NR	NR	N/A	36.7%	N/A	N/A
Medication Compliance - 75% (12-18)	NR	NR	N/A	13.3%	N/A	N/A
Total						
Medication Compliance - 50% (5-11)	46.5%	45.6%	-2.0%	49.1%	7.7%	5.6%
Medication Compliance - 75% (5-11)	21.1%	21.8%	3.4%	24.3%	11.5%	15.2%
Medication Compliance - 50% (12-18)	42.7%	42.2%	-1.1%	44.1%	4.4%	3.2%
Medication Compliance - 75% (12-18)	19.2%	19.4%	1.0%	21.3%	9.9%	11.0%

[182] UHC baseline and DY1 numerators and denominators for the 12-18 age cohort were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Prenatal program (Measure 82)[183]

	Baseline	DY1		DY2		Baseline to DY2
Frequency of Prenatal Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Frequency of Ongoing Prenatal Care (<21%)	9.3%	13.6%	47.4%	21.3%	56.4%	130.5%
Frequency of Ongoing Prenatal Care (21-40%)	10.6%	12.5%	17.1%	10.9%	-12.6%	2.4%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	12.7%	37.2%	10.7%	-16.0%	15.3%
Frequency of Ongoing Prenatal Care (61-80%)	13.9%	12.5%	-10.2%	14.2%	13.5%	1.9%
Frequency of Ongoing Prenatal Care (>= 81%)	56.9%	48.7%	-14.5%	42.9%	-11.9%	-24.6%
Molina Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	4.0%	9.0%	124.2%	7.6%	-16.2%	87.9%
Frequency of Ongoing Prenatal Care (21-40%)	3.5%	7.7%	115.9%	7.8%	1.6%	119.4%
Frequency of Ongoing Prenatal Care (41-60%)	5.7%	8.3%	46.9%	10.3%	23.6%	81.5%
Frequency of Ongoing Prenatal Care (61-80%)	13.5%	14.0%	3.6%	19.0%	36.0%	40.9%
Frequency of Ongoing Prenatal Care (>= 81%)	73.3%	61.0%	-16.7%	55.4%	-9.3%	-24.4%
Blue Cross and Blue Shield of New Mexico						
Frequency of Ongoing Prenatal Care (<21%)	7.7%	16.1%	107.4%	11.6%	-27.9%	49.6%
Frequency of Ongoing Prenatal Care (21-40%)	6.0%	7.7%	28.8%	10.7%	39.0%	79.0%
Frequency of Ongoing Prenatal Care (41-60%)	9.3%	6.6%	-29.4%	11.1%	69.7%	19.8%
Frequency of Ongoing Prenatal Care (61-80%)	16.2%	14.5%	-10.3%	16.0%	10.7%	-0.7%
Frequency of Ongoing Prenatal Care (>= 81%)	60.8%	55.2%	-9.3%	50.6%	-8.4%	-16.9%
United Healthcare of New Mexico, Inc.						
Frequency of Ongoing Prenatal Care (<21%)	NR	20.7%	N/A	20.4%	-1.2%	N/A
Frequency of Ongoing Prenatal Care (21-40%)	NR	12.2%	N/A	23.1%	90.0%	N/A
Frequency of Ongoing Prenatal Care (41-60%)	NR	11.2%	N/A	10.5%	-6.5%	N/A
Frequency of Ongoing Prenatal Care (61-80%)	NR	13.4%	N/A	11.9%	-10.9%	N/A
Frequency of Ongoing Prenatal Care (>= 81%)	NR	42.6%	N/A	34.1%	-20.0%	N/A
Total						
Frequency of Ongoing Prenatal Care (<21%)	7.4%	14.8%	100.1%	15.1%	2.4%	104.9%
Frequency of Ongoing Prenatal Care (21-40%)	6.8%	9.9%	45.2%	13.0%	30.5%	89.5%
Frequency of Ongoing Prenatal Care (41-60%)	8.1%	9.6%	19.7%	10.6%	10.5%	32.2%
Frequency of Ongoing Prenatal Care (61-80%)	14.5%	13.6%	-6.4%	15.3%	12.9%	5.7%
Frequency of Ongoing Prenatal Care (>= 81%)	63.2%	52.1%	-17.6%	45.9%	-11.8%	-27.3%

	Baseline	DY1		DY2		Baseline to DY2
Prenatal and Postpartum Care	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Postpartum Care	57.9%	61.9%	6.9%	53.1%	-14.1%	-8.2%
Timeliness of Prenatal Care	80.0%	77.9%	-2.7%	66.4%	-14.8%	-17.1%
Molina Healthcare of New Mexico, Inc.						
Postpartum Care	62.9%	54.5%	-13.4%	51.5%	-5.5%	-18.1%
Timeliness of Prenatal Care	89.2%	76.8%	-13.9%	76.0%	-1.1%	-14.8%
Blue Cross and Blue Shield of New Mexico						
Postpartum Care	63.1%	54.5%	-13.5%	57.9%	6.2%	-8.2%
Timeliness of Prenatal Care	86.1%	73.1%	-15.1%	72.6%	-0.6%	-15.6%
United Healthcare of New Mexico, Inc.						
Postpartum Care	NR	48.2%	N/A	41.4%	-14.1%	N/A
Timeliness of Prenatal Care	NR	63.7%	N/A	67.4%	5.7%	N/A
Total						
Postpartum Care	61.3%	54.8%	-10.5%	51.2%	-6.7%	-16.5%
Timeliness of Prenatal Care	84.8%	73.0%	-13.9%	70.7%	-3.2%	-16.6%

[183] UHC baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 Prenatal and Postpartum Care rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Treatment adherence – schizophrenia (Measure 83)[184]

Treatment adherence - schizophrenia	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	24.0%	58.1%	141.9%	56.5%	-2.7%	135.4%
Molina Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	58.7%	N/A	52.8%	-10.0%	N/A
Blue Cross and Blue Shield of New Mexico						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	60.0%	N/A	44.6%	-25.6%	N/A
United Healthcare of New Mexico, Inc.						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.0%	61.1%	22.2%	54.6%	-10.6%	9.2%
Total						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.7%	59.3%	70.8%	52.2%	-12.0%	50.3%

Annual dental visit – adult (Measure 86)

Annual dental visit – adult	Baseline	DY1		DY2		Baseline to DY2
	Rate, p_0	Rate, p_1	Change (p_1/p_0-1)	Rate, p_2	Change (p_2/p_1-1)	Change (p_2/p_0-1)
Presbyterian Health Plan						
Annual Dental Visit (19-21 Yrs)	44.2%	39.3%	-11.1%	41.2%	4.8%	-6.9%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	45.9%	35.5%	-22.8%	43.6%	22.9%	-5.2%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (19-21 Yrs)	41.0%	29.6%	-27.8%	37.1%	25.2%	-9.7%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (19-21 Yrs)	NR	25.9%	N/A	28.6%	10.4%	N/A
Total						
Annual Dental Visit (19-21 Yrs)	44.4%	34.9%	-21.5%	40.4%	15.9%	-9.0%

[184] MHC and BCBS baseline numerators and denominators were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.
DY2 rates included supplemental data for calculating numerator events, which was not explicitly included for the baseline or DY1.

Annual dental visit – child (Measure 87)[185]

	Baseline	DY1		DY2		Baseline to DY2
Annual dental visit – child	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Annual Dental Visit (2-3 Yrs)	55.6%	54.4%	-2.3%	52.9%	-2.6%	-4.8%
Annual Dental Visit (4-6 Yrs)	75.0%	73.2%	-2.5%	71.7%	-2.1%	-4.5%
Annual Dental Visit (7-10 Yrs)	79.1%	76.7%	-3.0%	75.0%	-2.3%	-5.3%
Annual Dental Visit (11-14 Yrs)	74.1%	72.6%	-2.0%	70.6%	-2.8%	-4.8%
Annual Dental Visit (15-18 Yrs)	64.3%	61.9%	-3.7%	61.5%	-0.7%	-4.3%
Molina Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	55.6%	51.1%	-8.1%	57.8%	13.2%	4.1%
Annual Dental Visit (4-6 Yrs)	74.3%	67.8%	-8.6%	74.8%	10.2%	0.7%
Annual Dental Visit (7-10 Yrs)	78.9%	71.0%	-10.0%	78.3%	10.2%	-0.8%
Annual Dental Visit (11-14 Yrs)	74.2%	66.2%	-10.9%	74.7%	12.9%	0.6%
Annual Dental Visit (15-18 Yrs)	64.0%	57.1%	-10.9%	65.1%	14.1%	1.7%
Blue Cross and Blue Shield of New Mexico						
Annual Dental Visit (2-3 Yrs)	56.5%	47.8%	-15.4%	48.8%	2.0%	-13.6%
Annual Dental Visit (4-6 Yrs)	73.3%	63.3%	-13.7%	65.2%	3.1%	-11.1%
Annual Dental Visit (7-10 Yrs)	75.5%	66.9%	-11.3%	68.1%	1.7%	-9.8%
Annual Dental Visit (11-14 Yrs)	68.1%	61.4%	-9.9%	63.5%	3.4%	-6.8%
Annual Dental Visit (15-18 Yrs)	59.1%	51.4%	-13.0%	55.2%	7.3%	-6.6%
United Healthcare of New Mexico, Inc.						
Annual Dental Visit (2-3 Yrs)	NR	36.4%	N/A	41.8%	14.6%	N/A
Annual Dental Visit (4-6 Yrs)	NR	51.3%	N/A	58.4%	13.9%	N/A
Annual Dental Visit (7-10 Yrs)	NR	54.8%	N/A	59.2%	8.0%	N/A
Annual Dental Visit (11-14 Yrs)	NR	48.8%	N/A	54.6%	12.0%	N/A
Annual Dental Visit (15-18 Yrs)	NR	39.9%	N/A	42.3%	6.2%	N/A
Total						
Annual Dental Visit (2-3 Yrs)	55.7%	51.6%	-7.5%	53.5%	3.8%	-4.0%
Annual Dental Visit (4-6 Yrs)	74.6%	69.3%	-7.1%	71.1%	2.7%	-4.7%
Annual Dental Visit (7-10 Yrs)	78.7%	72.9%	-7.4%	74.6%	2.3%	-5.2%
Annual Dental Visit (11-14 Yrs)	73.6%	68.4%	-7.1%	70.4%	3.0%	-4.3%
Annual Dental Visit (15-18 Yrs)	63.8%	58.5%	-8.3%	61.0%	4.4%	-4.3%

Calls answered within 30 seconds (Measure 93)

	Baseline	DY1		DY2		Baseline to DY2
Calls answered within 30 seconds	**Rate, p_0**	**Rate, p_1**	**Change (p_1/p_0-1)**	**Rate, p_2**	**Change (p_2/p_1-1)**	**Change (p_2/p_0-1)**
Presbyterian Health Plan						
Call Answer Timeliness	86.8%	87.8%	1.1%	88.0%	0.3%	1.4%
Molina Healthcare of New Mexico, Inc.						
Call Answer Timeliness	95.6%	93.7%	-2.0%	NR	N/A	N/A
Blue Cross and Blue Shield of New Mexico						
Call Answer Timeliness	NR	89.7%	N/A	NR	N/A	N/A
United Healthcare of New Mexico, Inc.						
Call Answer Timeliness	93.4%	92.9%	-0.5%	95.2%	2.4%	1.9%
Total						
Call Answer Timeliness	90.6%	90.7%	0.1%	90.4%	-0.3%	-0.2%

[185] UHC baseline numerators and denominators for the 11-14 and 15-18 age cohorts were included in the calculation of aggregate rates; "NR" is shown since the denominators were less than 30.

D. Additional DY3 Data for HEDIS Measures

In the below table, we have included the DY3 measure values for measures supported by HEDIS data. The DY3 information was not incorporated into the narrative of the report due to the timing that the data was received, but it is provided here for the reader's consideration.

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
1	Access to preventive/ambulatory health services among CC enrollees in aggregate and within subgroups		85.5%	81.4%	78.1%	76.0%
2	Mental Health Services Utilization		N/A	13.9%	13.7%	14.0%
6	Number and percentage of people with annual dental visit		111,798 (70.6%)	148,066 (64.0%)	171,663 (66.0%)	184,458 (67.6%)
17	Childhood Immunization Status	DTaP	80.4%	80.2%	67.9%	74.1%
		IPV	90.9%	90.5%	80.6%	86.0%
		MMR	90.5%	91.1%	83.0%	87.0%
		HiB	91.5%	91.3%	80.5%	85.3%
		Hepatitis B	87.6%	88.4%	79.5%	84.3%
		VZV	91.0%	90.6%	82.6%	86.6%
		PCV	80.2%	79.8%	68.3%	75.2%
		Hepatitis A	87.1%	87.9%	81.2%	85.0%
		Rotavirus	73.3%	75.0%	64.5%	71.2%
		Influenza	54.5%	52.7%	45.6%	45.3%
		Combo 2	74.9%	75.0%	64.0%	69.4%
		Combo 3	71.1%	71.7%	60.9%	66.7%
		Combo 4	68.7%	69.4%	59.3%	65.4%
		Combo 5	59.9%	61.6%	52.7%	59.0%
		Combo 6	45.5%	44.5%	38.0%	38.4%
		Combo 7	58.4%	59.9%	51.1%	57.9%
		Combo 8	44.5%	43.9%	37.3%	38.1%
		Combo 9	39.9%	39.8%	33.6%	35.0%
		Combo 10	39.2%	39.3%	32.9%	34.9%
18	Immunizations for Adolescents	MCV4	65.1%	64.3%	60.3%	71.1%
		Tdap/TD	78.5%	76.4%	69.8%	84.4%
		Combo 1	61.6%	61.9%	58.1%	69.9%
19	Well-child visits in first 15 months of life	PHP	63.4%	46.5%	48.3%	52.2%
		MHC	62.5%	51.8%	55.4%	59.2%
		BCBS	62.3%	44.3%	47.9%	58.4%
		UHC	0.0%	0.0%	56.9%	68.9%
20	Well-child visits in third, fourth, fifth and sixth years of life	PHP	66.7%	54.9%	54.8%	55.6%
		MHC	66.5%	63.6%	68.8%	64.4%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
		BCBS	60.2%	56.6%	57.6%	55.8%
		UHC	0.0%	65.9%	52.6%	53.5%
21	Adolescent well care visits	PHP	48.1%	36.4%	32.3%	33.1%
		MHC	50.8%	51.7%	45.9%	47.7%
		BCBS	39.0%	36.3%	33.1%	32.3%
		UHC	N/A	31.1%	37.2%	32.1%
22	Prenatal and Postpartum care: timeliness of prenatal care and percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Prenatal	84.8%	73.0%	70.7%	76.8%
		Postpartum	61.3%	54.8%	51.2%	57.8%
23	Frequency of ongoing prenatal care		63.2%	52.1%	45.9%	55.8%
24	Breast cancer screening for women		54.5%	52.5%	50.7%	47.2%
25	Cervical cancer screening for women		54.8%	43.2%	48.7%	53.5%
27	Initiation and engagement of alcohol and other drug dependence treatment	Initiation of AOD	N/A	38.6%	37.7%	36.8%
		Engagement of AOD	N/A	14.0%	13.8%	13.5%
40	EPSDT screening ratio		0.82	0.82	0.84	N/A
41	Monitoring for patients on persistent medications		87.5%	84.0%	83.3%	83.6%
45	Medication Management for people with asthma		46.3%	46.3%	52.2%	53.5%
47	Asthma medication ratio		60.2%	52.2%	56.8%	57.1%
48	Adult BMI assessment; weight assessment for children/adolescents		74.2%	78.2%	76.0%	78.6%
49	Comprehensive Diabetes care	HbA1c Testing	83.5%	85.0%	84.1%	N/A
		HbA1c Poor Control (>9.0%)	47.9%	47.2%	49.8%	N/A
		HbA1c Control (<8.0%)	42.7%	43.4%	41.8%	N/A
		Eye Exam	50.4%	55.0%	51.8%	N/A
		Medical Attention for Nephropathy	76.6%	79.1%	87.3%	N/A
		Blood Pressure Controlled <140/90 mm Hg	62.0%	59.3%	58.4%	N/A
58	Antidepressant medication management	Effective Acute Phase Treatment	43.2%	55.6%	53.1%	50.4%
		Effective Continuation Phase Treatment	28.6%	41.1%	37.8%	34.9%

Measure Number and Name		Description (as applicable)	2013 Baseline Value	DY1 Value	DY2 Value	DY3 Value
74	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications		83.7%	77.6%	77.9%	78.1%
75	Diabetes monitoring for people with diabetes and schizophrenia		62.4%	56.6%	49.9%	57.6%
106	Number and percentage of calls answered; answered within 30 seconds; call abandonment rate		90.6%	90.7%	90.4%	NR by MCOs

Public Notice

1. HSD Website

Public Information and Communications Overview

Opportunity for Public Comment

Bench Warrant Program

Centennial Care 2.0 (Current & 2019 Proposed Updates)

Centennial Care 2.0 2019 Waiver Application

2017 Centennial Care 2.0 MCO RFP & Procurement Library

2017-2018 Centennial Care 2.0 Procurement Schedule

Centennial Care 2.0 Wavier Application (Archive)

Centennial Care

HSD Presentations

IPRA Requests

Legislative Session

Medicaid Eligibility Reports

Newsroom

Monthly Statistical Reports

Waiver Documents

Centennial Care 2.0

2019 Centennial Care Waiver Application

Amendment to 1115 Demonstration Waiver

- Draft Waiver Application
- Public Hearing Presentation

Request for Comments

The Human Services Department (HSD), Medical Assistance Division (MAD), invites comments from the public about changes to the Centennial Care 2.0 program that are being considered as part of an amendment that is proposed to be effective July 1, 2019. Comments will be accepted until **5:00pm MST on Monday, April 15, 2019.** Read below to learn more about the Centennial Care 2.0 waiver amendment.

HSD will hold two public hearings in different regions of the state to receive comments about the draft amendment to the waiver. Please see below for the locations and times of the hearings.

All comments will be reviewed and evaluated to inform additional modifications prior to submission of the final waiver amendment application to CMS.

Public Hearings

Las Cruces – Wednesday, April 10, 2019

Thomas Branigan Library
200 East Picacho Avenue
Las Cruces, NM 88001
5:00 p.m. – 7:00 p.m.

Santa Fe – Monday, April 15, 2019

Medicaid Advisory Committee Meeting
New Mexico Department of Health
Harold L. Runnels Building - Auditorium
1190 S. St. Francis Dr.
Santa Fe, NM 87501
1:00 p.m. -4:00 p.m.

A phone line will be available for the Santa Fe event on April 15th for call-in participants to listen to or provide comments via telephone.
Call (toll-free) 1-800-747-5150; Participant Code: 0139586.

About Centennial Care 2.0

The New Mexico Human Services Department (HSD) is proposing improvements to the Centennial Care 2.0 program and is seeking input from stakeholders throughout New Mexico for consideration before submitting a final waiver amendment to the federal Centers for Medicare and Medicaid Services (CMS).

HSD has released a draft Section 1115 Demonstration Waiver amendment application for Centennial Care 2.0. The draft amendment outlines HSD's modifications to improve the program. The draft amendment can be reviewed by clicking here. HSD is seeking federal authority to amend the 1115 Centennial Care 2.0 Waiver (Project Number 11W-00285/6) to make the following changes:

1. **Removal of Co-payments for Centennial Care Members**

   As currently approved, the Centennial Care 2.0 waiver would allow co-payments of $8 for non-emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care members. HSD does not intend to implement these co-payments and seeks to remove this authority from the waiver.

2. **Removal of Premiums for Members of the Adult Expansion Group**

   The current Centennial Care 2.0 waiver requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% of the Federal Poverty Level (FPL), effective July 1, 2019. HSD does not intend to implement premiums and seeks to remove the requirement to implement them from the waiver.

3. **Reinstatement of Retroactive Eligibility**

   The current Centennial Care 2.0 waiver includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the waiver requires the HSD to eliminate retroactive coverage for this population completely.

   HSD does not intend to proceed with eliminating retroactive coverage in 2020 and seeks federal approval to reinstate the full retroactive coverage period for all affected individuals as quickly as possible. HSD's proposed effective date for reinstating retroactive coverage is July 1, 2019.

4. **Community Benefit Services**

   Centennial Care expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care waiver. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase. HSD is proposing to increase the number of slots by 1,500 through the waiver amendment.

5. **Home Visiting Pilot**

   The Centennial Care 2.0 home visiting pilot program focuses on pre-natal care, post-partum care, and early childhood development in state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by HSD throughout the term of the waiver.

The public will have opportunities to provide feedback to HSD about the changes outlined in the draft application during two public hearings in April 2019, or by submitting written comments. After the hearings, HSD will develop its final waiver amendment application for submission to CMS in April 2019.

http://www.hsd.state.nm.us/approvals.aspx.

The requested changes will impact the currently approved waiver authorities, expenditure authorities and Special Terms and Conditions (STCs) for the period between January 1, 2019 and December 31, 2023. Please note that the STCs for Centennial Care 2.0 are currently being modified by CMS for technical corrections identified by HSD. Due to the status of the technical corrections, actual references to STC language are not reflected in this document; however, STC language will be made available upon request.

I. Program Description, Goals, and Objectives

The state's goals for the Centennial Care 2.0 demonstration include providing the most effective and efficient health care possible for eligible New Mexicans, as well as continuing the healthcare delivery reforms of Centennial Care. Specifically, the state will further the following goals:

- 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.

Today, Centennial Care 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and community-based services (HCBS).

The waiver amendment provides the opportunity for the state to continue advancing successful initiatives under the demonstration while continuing to implement new, targeted initiatives to address specific gaps in care and improve healthcare outcomes for Centennial Care members. Key initiatives under the Centennial Care 2.0 program include:

- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through value-based purchasing arrangements to achieve improved quality and better health outcomes;
- Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

As part of the demonstration extension, the state will continue to expand access to LTSS through the Community Benefit (CB) that includes both the personal care and HCBS benefits, and by allowing eligible members who meet a NF LOC to access the CB without the need for a waiver slot. Individuals who are not otherwise Medicaid eligible and meet the criteria for the 217-like group will be able to access the CB if a slot is available. As is the case today, managed care enrollment will be required for all members who meet NF level of care or who are dually eligible.

II. Proposed Health Care Delivery System and Eligibility Requirements, Benefit Coverage, and Cost-Sharing

A. Delivery System & Eligibility Requirements

Centennial Care 2.0 provides a comprehensive benefit package to eligible populations through an integrated managed care model that includes a number of innovations. The following are descriptions of the current eligible populations and covered benefits:

Table 1: Eligibility Groups Covered in Centennial Care

Population Group	Populations
TANF and Related	Newborns, infants, and children
	Children's Health Insurance Program (CHIP)
	Foster children
	Adopted children
	Pregnant women
	Low-income parent(s)/caretaker(s) and families
	Breast and Cervical Cancer
	Refugees
	Transitional Medical Assistance

Supplemental Security Income (SSI) Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years-old up to 133% of Modified Adjusted Gross Income (MAGI)

The following populations are excluded from Centennial Care:

- Qualified Medicare Beneficiaries;
- Specified Low-Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with an Intellectual Disability;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only; and
- Mi Via 1915(c) waiver participants for HCBS.

B. *Benefit Coverage*

Centennial Care 2.0 provides a comprehensive package of services that includes behavioral health, physical health, and long-term care services and supports (LTSS). Members meeting a Nursing Facility Level of Care (NF LOC) are able to access LTSS through Community Benefit (CB) services (i.e., home- and community-based services) without a waiver slot. The CB is available through Agency-Based Community Benefit (ABCB) services (services provided by a provider agency) and Self-Directed Community Benefit (SDCB) services (services that a participant can control and direct).

As outlined in the draft amendment waiver application, the state has proposed some additional refinements to benefits and eligibility, including:

- Reinstatement of three-month retroactive eligibility period for most Centennial Care 2.0 members;
- Expanding the Centennial Home Visiting (CHV) program that focuses on prenatal care, post-partum care and early childhood development in collaboration with CYFD and the New Mexico Department of Health; and
- Expanding the availability of Community Benefit (CB) services for certain members who do not meet standard Medicaid financial eligibility by establishing an additional 1,500 slots through the waiver amendment.

C. Cost-Sharing – Co-Payments & Premiums

The Centennial Care 2.0 waiver amendment proposal removes premium requirements (monthly payments) for individuals in the Adult Expansion Group who have income above 100% of the federal poverty level (FPL). The waiver amendment also removes all co-payments for Centennial Care members.

Additional details may be found in the proposed waiver amendment application.

III. Budget Neutrality

A. Budget Neutrality Overview

The proposed waiver amendment proposals will have a minimal impact to the budget neutrality.

B. CHIP Allotment Neutrality

The amendment proposals will not impact allotment neutrality.

C. Budget Neutrality Summary

The federal share of the combined Medicaid expenditures for the populations included in this demonstration, excluding those covered under the Title XXI Allotment Neutrality, will not exceed what the federal share of Medicaid expenditures would have been without the demonstration.

The federal share of the combined Medicaid expenditures for the populations included in this demonstration, excluding those covered under the Title XXI Allotment Neutrality, will not exceed what the federal share of Medicaid expenditures would have been without the demonstration.

HSD makes the following assumptions regarding budget neutrality:

- HSD proposes a per capita budget neutrality model for the populations covered under the demonstration, outlines the per capita limit by Medicaid Eligibility Group (MEG) and proposes an aggregate cap, trended annually for uncompensated care and Hospital Quality Improvement Incentive expenditures;
- State administrative costs are not subject to the budget neutrality calculations;
- The projected savings is the difference between the without and with waiver projections;
- Nothing in this demonstration application precludes HSD from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that HSD is adversely affected by future changes to federal medical assistance percentages.

Current Approved Without Waiver and With Waiver Projected Medicaid Expenditures (Toal Computable)

IV. Hypothesis and Evaluation Parameters of the Demonstration

HSD will maintain the original hypotheses and evaluation design plan of Centennial Care 2.0 but will remove metrics associated with the implementation and administration of premiums and co-payments. The table below describes the hypotheses of Centennial Care 2.0 and how HSD will evaluate the impact.

Table 4 – Quality Goals and Evaluation

	Hypothesis	Methodology	Data Sources
Goal 1: Improve Member outcomes with refinements to care coordination			
1.1	Enhancements to care coordination will result in decreases for avoidable emergency room visits and hospital readmissions.	Track and trend member utilization of avoidable emergency room visits and hospital readmissions and monitor MCO adherence to common chronic disease management and other social support services requirements for care coordination.	Claims data HEDIS reports MCO reporting
1.2	Birthing outcomes will improve with pregnant women participating in the home visiting pilot.	Track and trend low birthweight, pre-term birth, prenatal/post-partum visits and well child visits for members in pilot.	Claims data HEDIS reports MCO reporting
Goal 2: Increase Behavioral Health Integration			
2.1	Member's utilization of Health Homes will increase.	Track and trend the number of members participating in Health Homes.	Claims data MCO reporting
2.2	Treatment outcomes of members participating	Track and trend Health Homes' treatment outcomes of common	Claims data HEDIS reports

	Hypothesis	Methodology	Data Sources
	in Health Homes will improve.	behavioral/physical health conditions and care coordination outcomes such as avoidable emergency room visits, hospital readmissions and follow up after hospitalization for mental illness.	MCO reporting
Goal 3: Expand member access to Long Term Services and Supports			
3.1	Allowing all Medicaid-eligible members who meet a nursing facility level of care to access the Community Benefit will maintain New Mexico's accomplishments in rebalancing efforts.	Track and trend members accessing community benefits.	Claims data
3.2	Increasing caregiver respite hours will improve member outcomes and utilization.	Track and trend member utilization and member outcomes.	Claims data HEDIS reports
3.3	Automatic Nursing Facility Level of Care (NFLOC) approvals will achieve administrative simplification for HSD, the MCOs and members.	Track and trend automatic NFLOC approvals.	MCO reporting
Goal 4: Increase quality of care with Value Based Payment (VBP) arrangements.			
4.1	Healthcare outcomes will improve for members served by providers that have VBP arrangements for the full delegation of care coordination.	Track and trend member utilization and common chronic disease management outcomes of providers with VBP arrangements that include full delegation of care coordination.	Claims data HEDIS reports MCO reporting
4.2	Implementing incremental minimum VBP requirements will support bending the cost curve of Medicaid program costs through alignment with Centennial Care 2.0 program goals of improving care coordination, focus on transitions of care.	Track and trend program expenditure.	Claims data HEDIS reports MCO reporting
Goal 5: Promoting Member Engagement and Responsibility			
5.1	Members participating in the Centennial Rewards program will continue to have improved healthcare	Track and trend member utilization of preventive services and rewards credits.	Claims data HEDIS reports MCO/Reward Program Contractor reporting

	Hypothesis	Methodology	Data Sources
	outcomes with decreases in higher-cost services, such as inpatient stays.		
Goal 6: Improve administrative effectiveness and simplicity.			
6.1	Members will have increased access to inpatient services at an Institution for Mental Disease (IMD).	Track and trend member utilization of IMDs.	Claims data
Goal 7: Improve Delivery System and Access to Services			
7.1	Members will have increased access to CHWs and CHRs.	Track and trend member utilization.	MCO reporting
7.2	Members will have increased access to telehealth.	Track and trend member utilization.	Claims data
7.2	Members will have increased access to Patient Centers Medical Homes.	Track and trend member utilization.	MCO reporting

V. Waiver and Expenditure Authorities

A. Title XIX Waiver Amendment Language/Removal/Elimination

1.	**Reasonable Promptness and Medical Assistance**	**Section 1902(a)(8) and (10)**
To the extent necessary to enable the state to begin benefit coverage on the first day of the month following receipt of the required premium by the premium due date for individuals in a Medicaid category of eligibility that requires premiums. To the extent necessary to enable the state to prohibit initial enrollment for individuals who fail to pay required premiums. To the extent necessary to enable the state to suspend coverage for individuals detailed in STC 60(a) who fail to pay required premiums until such time the premiums are paid in full or a hardship waiver, as detailed in STC 60(a)(1), is granted.		
2.	**Retroactive Eligibility**	**Sections 1902(a)(10) and (34) 42 CFR 435.915**
To the extent necessary to enable the state to reduce, and then eliminate in demonstration year 7, coverage for the three-month period prior to the date that an application for medical assistance (and treatment as eligible for medical assistance) is made for specified eligibility groups, as described in STC 23. This waiver does not apply with respect to individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, or individuals under age 19.		
3.	**Premiums**	**Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).		
3.	**Comparability**	**Sections 1902(a)(17) and 1902(a)(10)(B)**

To the extent necessary to enable the state to charge monthly premiums, as described in the STC 60(a).

B. Expenditure Authority Requests

No language changes are required as part of the waiver amendment proposals.

Submit a comment:

HSD continues to welcome input from New Mexicans regarding the Centennial Care program. To submit a comment, please fill out the online form below. You may also email it directly to HSD-PublicComment@state.nm.us or send it by mail to:

Human Services Department
ATTN: HSD Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

What are your ideas? Type here or upload a file using the button below.

File Upload: Upload a file

Name:

Email:

Address 1:

Address 2:

City/Town:

Zip Code:

* State: New Mexico

Submit

Public Notice

2. Public Notice (abbreviated notice) in the state's newspaper

ALBUQUERQUE JOURNAL THE SUNDAY JOURNAL
Albuquerque Publishing Company
7777 Jefferson N.E. Albuquerque, New Mexico 87109
P.O. Drawer J-T Albuquerque, New Mexico 87103
(505) 823-7777

Account Number
1009565

Ad Proof/Order Confirmation

Ad Order Number
0001440172

N M DEPT OF HUMAN SERVICES
MEDICAL ASSISTANCE DIV
ATTENTION: PPIB
PO BOX 2348
SANTA FE, NM 875042348 USA

Ordered By	Bernice	**Customer Phone**	5752576165	**Joint Ad #**
Customer EMail		**PO Number**	63000-0000031788	
Ad Cost	$390.31	**Sales Rep**	cwhite	
Tax Amount	$30.74	**Order Taker**	cwhite	
Total Amount	$421.05	**Payment Method**	Credit Card	
Amount Due	$421.05	**Payment Amount**	$0.00	

Affidavits 0

Pick Up #

Product	Albuquerque Journal	**Placement**	0Legal Notices
Ad Number	0001440172-01	**Classification**	0Government
Ad Type	0 Legals Multi Col	**Sort Text**	NEWSPAPERNOTICEAMENDMENTTO 1115DEMONSTRATIONWAIVERTHEN EWMEXICOHUMANSERVICESDEPAR TMENTHSDTHROUGHTHEMEDICALA SSISTANCEDIVISIONMADWILLH
Ad Size	3 X 10.40"		
Color			

Run Date
03/01/2019
03/01/2019

WYSIWYG Content

HUMAN SERVICES DEPARTMENT

Newspaper Notice
Amendment to 1115 Demonstration Waiver

The New Mexico Human Services Department (HSD), through the Medical Assistance Division (MAD), will hold public hearings and accept public comments on the Medicaid health care program known as Centennial Care 2.0. regarding changes to the program as part of the amendment to the Centennial Care federal waiver proposed to be effective July 1, 2019.

HSD is seeking federal authority to amend the 1115 Centennial Care 2.0 Waiver (Project Number 11W-00285/6) to make the following changes:

1) Removal of Co-payments for Centennial Care Members
As currently approved, the Centennial Care 2.0 waiver would allow co-payments of $8 for non--emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care members. HSD does not intend to implement these co--payments and seeks to remove this authority from the waiver.

Removal of Premiums for Members of the Adult Expansion Group
The current Centennial Care 2.0 waiver requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% of the Federal Poverty Level (FPL), effective July 1, 2019. HSD does not intend to implement premiums and seeks to remove the requirement to implement them from the waiver.

3) Reinstatement of Retroactive Eligibility
The current Centennial Care 2.0 waiver includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the waiver requires the HSD to eliminate retroactive coverage for this population completely.

HSD does not intend to proceed with eliminating retroactive coverage in 2020 and seeks federal approval to reinstate the full retroactive coverage period for all affected individuals as quickly as possible. HSD's proposed effective date for reinstating retroactive coverage is July 1, 2019.

4) Community Benefit Services
Centennial Care expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care waiver. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase. HSD is proposing to increase the number of slots by 1,500 through the waiver amendment.

5) Home Visiting Pilot
The Centennial Care 2.0 home visiting pilot program focuses on pre-natal care, post-partum care, and early childhood development in state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by HSD throughout the term of the waiver.

The requested amendment will impact the currently approved waiver authorities, expenditure authorities, and Special Terms and Conditions (STCs) for the period between July 1, 2019 and December 31, 2023. Please note that the STCs for Centennial Care 2.0 are being modified by CMS to make technical corrections identified by HSD. Due to the status of the technical corrections, actual references to STC language are not reflected in this document; however, STC language can be made available by request.

http://www.hsd.state.nm.us/approvals.aspx.

The public hearings will take place:

Las Cruces, NM:
Wednesday, April 10, 2019, 5–7:00 p.m. at Thomas Branigan Library
(200 East Picacho Avenue, Las Cruces, NM 88001)

Santa Fe, NM
Monday, April 15, 2019, 1:00–4 p.m. at the Medicaid Advisory Committee
Meeting, to be held at the New Mexico Department of Health,
Harold L. Runnels Building - Auditorium (1190 S. St. Francis Dr., Santa Fe, NM 87501)

Participate in a Public Hearing Event By Phone:

Monday, April 15, 2019, 1:00–4 p.m. A phone line will be available for any member of the public join the Santa Fe public hearing to hear or provide comments via telephone. Call (toll-free) 1-800-747-5150; Participant Code: 0139586.

Recorded comments may be left by calling (505) 827-1337. Electronic comments may be submitted to HSD-PublicComment@state.nm.us. Written, electronic, and recorded comments will be given the same consideration as oral testimony made at the public hearing. All comments must be received no later than **5 p.m. Mountain Time (MT) on Monday, April 15, 2019** .

The public may view the draft waiver application that outlines changes being considered on HSD's website: **http://www.hsd.state.nm.us/2017-comment-period-open.aspx and http://www.hsd.state.nm.us/centennial-care-2-0.aspx.**

If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at 505-827-1337. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-1337. HSD requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

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Journal: March 1, 2019

Journal: March 1, 2019

LAS CRUCES SUN-NEWS

AFFIDAVIT OF PUBLICATION

Ad No.
0001278711

PPIB
HUMAN SVCS DEPT - MED ASSIST DIV
PO BOX 2348

SANTA FE NM 87504

I, a legal clerk of the **Las Cruces Sun-News**, a newspaper published daily at the county of Dona Ana, state of New Mexico and of general paid circulation in said county; that the same is a duly qualified newspaper under the laws of the State wherein legal notices and advertisements may be published; that the printed notice attached hereto was published in the regular and entire edition of said newspaper and not in supplement thereof on the date as follows, to wit:

03/01/19

Despondent further states this newspaper is duly qualified to publish legal notice or advertisements within the meaning of Sec. Chapter 167, Laws of 1937.

Nancy Heyman

Legal Clerk

STATE OF WISCONSIN **SS.**
County of Brown

Subscribed and sworn before me this 1st of March 2019.

Vicky Felty

NOTARY PUBLIC in and for
Brown County, Wisconsin

4-19-21

My Commission Expires

VICKY FELTY NOTARY PUBLIC STATE OF WISCONSIN

Ad#:0001278711
P O :
# of Affidavits :0.00

Newspaper Notice
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The public hearings will take place:
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Wednesday, April 10, 2019, 5-7:00 p.m. at Thomas Branigan Library (200 East Picacho Avenue, Las Cruces, NM 88001)
Santa Fe, NM

Monday, April 15, 2019, 1:00-4 p.m. at the Medicaid Advisory Committee Meeting, to be held at the New Mexico Department of Health, Harold L. Runnels Building - Auditorium (1190 S. St. Francis Dr., Santa Fe, NM 87501)
Participate in a Public Hearing Event By Phone: Monday, April 15, 2019, 1:00-4 p.m. A phone line will be available for any member of the public join the Santa Fe public hearing to hear or provide comments via telephone. Call (toll-free) 1-800-747-5150; Participant Code: 0139586.
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Copies of all comments will be made available by the MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.
Publish: Mar. 1, 2019
Ad No.: 1278711

Public Notice

3. Proposal posting (abbreviated notice) via the State's electronic mail lists

Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary
Nicole Comeaux, J.D., M.P.H, Director

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1) Removal of Co-payments for Centennial Care Members
2) Removal of Premiums for Members of the Adult Expansion Group
3) Reinstatement of Retroactive Eligibility
4) Community Benefit Services
5) Home Visiting Pilot

The public hearings will be held to receive comments about the draft amendment waiver in different regions of the state as follows:

Las Cruces – Wednesday, April 10, 2019
Thomas Branigan Library
200 East Picacho Avenue
Las Cruces, NM 88001
5:00 p.m. – 7:00 p.m.

Santa Fe – Monday, April 15, 2019
Medicaid Advisory Committee Meeting
New Mexico Department of Health
Harold L. Runnels Building - Auditorium
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Santa Fe, NM 87501
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If you do not have Internet access, a copy of the Centennial Care draft waiver application may be requested by contacting MAD at 505-827-1337. If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-1337.

HUMAN SERVICES
DEPARTMENT

Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary
Nicole Comeaux, J.D., M.P.H, Director

February 28, 2019

RE: Tribal Notification to Request Advice and Comments Letter 19-05: Draft Section 1115 Demonstration Waiver Amendment Application

Dear Tribal Leadership, Indian Health Service, Tribal Health Providers, and Other Interested Parties:

Seeking advice and comments from New Mexico's Indian Nations, Tribes, Pueblos and their health care providers is an important component of the government-to-government relationship with the State of New Mexico. In accordance with the New Mexico Human Services Department's (HSD's) Tribal Notification to Request Advice and Comments process, this letter is to inform you that HSD, through the Medical Assistance Division (MAD), is accepting written comments until **5:00 p.m. Mountain Time (MT) on Tuesday, April 30, 2019**. regarding the Medicaid health care program known as Centennial Care 2.0 and changes to the program that are being considered as part of the amendment to the Centennial Care federal waiver that will be effective on July 1, 2019.

1) Removal of Co-payments for Centennial Care Members

   As currently approved, the Centennial Care 2.0 waiver would allow co-payments of $8 for non-emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care members. HSD does not intend to implement these co-payments and seeks to remove this authority from the waiver.

   Tribal Impact: ***HSD does not anticipate a service or financial impact to individual, tribes or their healthcare providers.***

2) Removal of Premiums for Members of the Adult Expansion Group

   The current Centennial Care 2.0 waiver requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% of the Federal Poverty Level (FPL), effective July 1, 2019. HSD does not intend to implement premiums and seeks to remove the requirement to implement them from the waiver.

   Tribal Impact: ***HSD does not anticipate a service or financial impact to individual, tribes or their healthcare providers.***

3) Reinstatement of Retroactive Eligibility

The current Centennial Care 2.0 waiver includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the waiver requires the HSD to eliminate retroactive coverage for this population completely.

Tribal Impact: ***HSD does not anticipate a service or financial impact to individual, tribes or their healthcare providers.***

4) Community Benefit Services

Centennial Care expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care waiver. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase. HSD is proposing to increase the number of slots by 1,500 through the waiver amendment.

Tribal Impact: ***HSD does not anticipate a service or financial impact to individual, tribes or their healthcare providers.***

5) Home Visiting Pilot

The Centennial Care 2.0 home visiting pilot program focuses on pre-natal care, post-partum care, and early childhood development in state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the home visiting project can be implemented, as well as the number of potential members who can be served by home visiting services. Additional counties providing home visiting services will be designated by HSD throughout the term of the waiver.

Tribal Impact: ***HSD does not anticipate a service or financial impact to individual, tribes or their healthcare providers.***

Tribal Advice and Comments

Tribes and tribal healthcare providers may view the draft waiver application on the HSD webpage at: http://www.hsd.state.nm.us/providers/written-tribal-consultations.aspx ***Notification Letter*** *19-05.*

A written copy of these documents may be requested by contacting the HSD Medical Assistance Division (HSD/MAD) in Santa Fe at (505) 827-1337.

Important Dates
A public hearing on Monday, April 15, 2019 is scheduled at the Medicaid Advisory Committee Meeting, be held at the Harold L. Runnels Building - Auditorium, 1190 S. St. Francis Dr., Santa Fe, NM 87501, 1:00 p.m. to 4:00 p.m. MT.

Written advice and comments must be received no later than 5:00pm Mountain Time (MT) on Monday, April 15, 2019. Please send your advice, comments or questions to the MAD Native American Liaison, Theresa Belanger, at (505) 827-3122 or by email to Theresa.Belanger@state.nm.us.

Comments and responses will be compiled and made available upon request.

Sincerely,

Nicole Comeaux, J.D., M.P.H
Director

cc:

Public Hearings

1. Public Hearing Materials
    a. Las Cruces, April 10, 2019
    b. Santa Fe, April 15, 2019

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Amendment Application
Public Hearings
April 2019
Las Cruces and Santa Fe

Opportunity to Provide Comments

- The Department is accepting comments from the public about the Medicaid program known as Centennial Care 2.0 and changes to the program being considered as part of the amendment to the Centennial Care federal 1115 waiver proposed to be effective on July 1, 2019.
- Comments will be accepted until **5:00 pm MST on Monday, April 15, 2019.**
- Two public hearings in different regions of the state:

Las Cruces – Wednesday, April 10, 2019
Thomas Branigan Library
200 East Picacho Avenue
Las Cruces, NM 88001
5:00 p.m. – 7:00 p.m.

Santa Fe – Monday, April 15, 2019
New Mexico Department of Health
Harold L. Runnels Building – Auditorium
1190 S. St. Francis Dr.
Santa Fe, NM 87501
Participants can also join the Santa Fe hearing by phone at 1-800-747-5150; access code: 0139586#

Opportunity to Provide Comments

- Comments are also being accepted through email at HSD-PublicComment@state.nm.us or by mail at:

  Human Services Department
  ATTN: HSD Public Comments
  PO Box 2348
  Santa Fe, NM 87504-2348

- More information about the amendment to the waiver and public comment process may be found on the Department's website at:

  http://www.hsd.state.nm.us/centennial-care-2-0.aspx

- The Public Hearing process is a process to obtain public feedback about the waiver amendment before the Department submits a final waiver proposal to the federal Centers for Medicare & Medicaid Services (CMS).

Opportunity to Provide Comments

- We appreciate your attendance today and look forward to your comments after the presentation.
- Today's presentation is a summary of the proposed changes to amend the 1115 demonstration waiver, which are also outlined in the draft amendment application that was released on February 28, 2019, and which is available to review on the HSD website.
- As part of the formal hearing process, we will accept and record all of your comments.
- Our responses to the comments received will be documented in a section of the final waiver amendment application that is submitted to CMS in late April 2019.

Proposed Timeline of the Waiver Amendment Process

February	March	April	May	June	July
Release of Draft Application					
	Public & Tribal Comment Period				
		Public Hearings			
			Submit Application to CMS		
					Effective 7/1/19

The state's goals for amending the demonstration for New Mexico's Medicaid managed care program, known as Centennial Care 2.0, include providing the most effective, efficient health care possible for covered New Mexicans and to continue the healthcare delivery reforms that were initiated during the previous demonstration period.

Areas of Focus in the Waiver Amendment:

- Member engagement and personal responsibility
- Administrative simplification through refinements to eligibility
- Benefit and service delivery modifications

Proposed Changes to Member Engagement & Personal Responsibility

Proposed Waiver Amendment Areas:

#1: Remove all co-payments from Centennial Care

As currently approved, the Centennial Care 2.0 waiver would allow co-payments of $8 for non-emergency use of the hospital Emergency Department (ED) and $8 for non-preferred prescription drugs for most Centennial Care members. HSD does not intend to implement these co-payments and seeks to remove this authority from the waiver.

#2: Remove premiums for members of the Adult Expansion Group

The current Centennial Care 2.0 waiver requires HSD to implement monthly premiums of $10 for members of the Adult Expansion Group who have income above 100% of the federal poverty level (FPL), effective July 1, 2019. HSD does not intend to implement premiums and seeks to remove the requirement to implement them from the waiver.

Proposed Changes Through Refinements to Eligibility

Proposed Waiver Amendment Area:

#3: Reinstate Retroactive Eligibility

The current Centennial Care 2.0 waiver includes a phase-out of the three-month retroactive Medicaid coverage period for non-pregnant adults covered under Centennial Care. In calendar year 2019, the retroactive period is limited to one month. In calendar year 2020, the waiver requires HSD to eliminate retroactive coverage for this population entirely.

HSD does not intend to proceed with eliminating retroactive coverage in 2020 and seeks federal approval to reinstate the full retroactive coverage period for all affected individuals as quickly as possible. HSD's proposed effective date for reinstating retroactive coverage is July 1, 2019.

Proposed Benefit & Service Delivery Modifications

Proposed Waiver Amendment Area:

#4: Community Benefit Services

Centennial Care expanded the availability of Community Benefit (CB) services to individuals who qualify for full Medicaid coverage and meet a Nursing Facility Level of Care (NF LOC) by eliminating the requirement for a waiver allocation in order to access the full suite of CB services. HSD has continued to provide access to CB for certain members who do not meet the standard Medicaid financial eligibility by establishing 4,289 slots in the Centennial Care waiver. Current allocation efforts by HSD are keeping up with attrition; however, HSD anticipates that the need for additional slots will increase.

HSD is proposing to increase the number of slots by 1,500 through the waiver amendment.

Proposed Benefit & Service Delivery Modifications

Proposed Waiver Amendment Area:

#5: Home Visiting Pilot

The Centennial Care 2.0 Home Visiting Pilot program focuses on prenatal care, postpartum care, and early childhood development in state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the Home Visiting Pilot can be implemented, as well as the number of **potential members who can be served by home visiting services.**

Additional counties providing home visiting services will be designated by HSD throughout the term of the waiver.

Thank you for attending and your participation in the public hearing process.

We will now receive and record your feedback related to the information presented.

An electronic version of this presentation can be downloaded at:

http://www.hsd.state.nm.us/centennial-care-2-0.aspx

Or may be requested via e-mail at:

CCInfo@state.nm.us

Public Hearings

2. MAC Meeting – Santa Fe, April 15, 2019

Medicaid Advisory Committee Meeting
Monday, April 15, 2019
AGENDA

Time: 1:00 PM – 4:00 PM Location: Harold L. Runnels Building, O.A. Larrazolo Auditorium, 1190 S. St. Francis Dr., Santa Fe, NM 87501

MAC Chair: Larry A. Martinez, Presbyterian Medical Services

Committee Support: Alysia Beltran, Medical Assistance Division

Committee Members:

Sylvia Barela, Santa Fe Recovery Center
Michael Batte, Public Member
Meggin Lorino, NM Association for Home and Hospice Care
Ramona Dillard, Pueblo of Laguna
Jeff Dye, NM Hospital Association
Mary Eden, Presbyterian Healthcare Services
Michael Hely, NM Legislative Council Service
Mark Freeland, Navajo Nation
Ruth Hoffman, Lutheran Advocacy Ministry NM
Gary Housepian, Disability Rights
Carol Luna-Anderson, The Life Link/Behavioral Health Planning Council
Kim Jevertson, Public Member
Natalyn Begay, Ohkay Owingeh
Jim Copeland, NM Department of Health
Richard Madden, NM Chapter of the American Academy of Family Physicians
Rodney McNease, UNM Hospital
Carolyn Montoya, UNM College of Nursing
Eileen Goode, NM Primary Care Association
Jason Espinoza, NM Health Care Association
Laurence Shandler, Pediatrician
Dale Tinker, NM Pharmacists Association

HSD Representatives:

Nicole Comeaux, JD, MPH, Director, HSD/MAD
Kari Armijo, Deputy Director, HSD/MAD
Jason Sanchez, Deputy Director, HSD/MAD
Linda Gonzales, Deputy Director, HSD/MAD
David R. Scrase, M.D., HSD Secretary
Angela Medrano, HSD Deputy Secretary
Russel Toal, HSD Deputy Secretary
Megan Pfeffer, Acting Deputy Director, HSD/MAD

DISCUSSION ITEM		DISCUSSION LEADER	DESCRIPTION	TIME
I.	Introductions	Larry Martinez, MAD Chairperson	Introduction of all committee members, staff and guests.	1:00
II.	Approval of Agenda	Larry Martinez, MAC Chairperson	Approval of agenda	1:05
III.	Approval of Minutes	Larry Martinez, MAC Chairperson	Committee approval of minutes from previous meeting held January 28, 2018	1:10
IV.	Legislative Update	Nicole Comeaux, JD, MPH, Director Jason Sanchez, Deputy Director Human Services Department Medical Assistance Division	2019 Legislative Session Update	1:15
V.	Director's Update	Nicole Comeaux, JD, MPH, Director Human Services Department Medical Assistance Division	MCO Centennial Care 2.0 Update	1:45
VI.	Amendment Presentation	Nicole Comeaux, JD, MPH, Director Jason Sanchez, Deputy Director Human Services Department Medical Assistance Division	Centennial Care 2.0 Waiver Amendment Presentation	2:15
VII.	Public Comment		Public comments on CC 2.0 Waiver Amendment	3:00
VIII.	Adjournment	Larry Martinez, MAC Chairperson		4:00

New Mexico Human Services Department
Medical Assistance Division

Centennial Care 2.0 Updates

April 11, 2019

Centennial Care 2.0 Updates

- On December 14, 2018, CMS approved HSD's request to extend New Mexico's Medicaid 1115 Demonstration Waiver
  - Approval effective January 1, 2019 through December 23, 2023

- HSD and CMS continue to have ongoing discussions regarding the Special Terms and Conditions (STCs) to clarify the state's obligations to CMS during the life of the waiver

Centennial Care 2.0 Updates - Continued

- On March 1, 2019, HSD sent CMS an amendment to New Mexico's 1115 Demonstration Waiver requesting the following changes:
  - Removal of $8 co-payments for non-preferred prescription medications and non-emergency use of Emergency Departments
  - Removal of premium requirements
  - Reinstate the 3 month retroactive eligibility/coverage
  - Increase the number of allocations for members who do not meet standard Medicaid financial eligibility, but do meet clinical criteria for long term care services in the community
  - Expand the number of counties for the home visiting pilot, allowing HSD to expand the program based on member outcomes

Centennial Care 2.0 Updates - Continued

- On March 1, 2019, Notice of Public Comment was issued and comments will be accepted until 5:00 p.m. MST on Monday, April 15, 2019

- Public Hearing occurred on Wednesday, April 10, 2019 in Las Cruces and another hearing is scheduled to occur Monday, April 15, 2019 in Santa Fe at the following location:

  Thomas Branigan Library
  200 East Picacho Avenue
  Las Cruces, NM 88001
  5:00 p.m. – 7:00 p.m.

Centennial Care 2.0 Updates - Continued

- If members were auto-enrolled with a Managed Care Organization (MCO) in December 2018, they had until March 31, 2019 to switch their enrollment to a different MCO.

HUMAN SERVICES
DEPARTMENT

Centennial Care 2.0
1115 Demonstration Waiver Amendment Application
Public Hearings
April 2019
Las Cruces and Santa Fe

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- The Public Hearing process is a process to obtain public feedback about the waiver amendment before the Department submits a final waiver proposal to the federal Centers for Medicare & Medicaid Services (CMS).

Opportunity to Provide Comments

- We appreciate your attendance today and look forward to your comments after the presentation.
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Proposed Waiver Amendment Area:

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The Centennial Care 2.0 Home Visiting Pilot program focuses on prenatal care, postpartum care, and early childhood development in state-designated counties. HSD is proposing to remove the restriction on the number of counties in which the Home Visiting Pilot can be implemented, as well as the number of **potential members who can be served by home visiting services.**

Additional counties providing home visiting services will be designated by HSD throughout the term of the waiver.

Thank you for attending and your participation in the public hearing process.

We will now receive and record your feedback related to the information presented.

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Or may be requested via e-mail at:

CCInfo@state.nm.us

Public Comment Summary for the 1115 Demonstration Amendment

Comment Overview

The Human Services Department (HSD) received comments from 26 entities related to its Draft 1115 Demonstration Amendment (released on February 28, 2019) through multiple public comment opportunities that included two public hearings, email submissions, and voicemail comments. Comments were submitted from Centennial Care members and providers, members of the general public, tribal representatives, provider organizations, legal advocates, advocacy groups, non-profit organizations, and health care management entities. All commenters expressed support for the proposals in the demonstration amendment.

There were 11 letters with comments submitted on behalf of organizations expressing strong support to proposals in the demonstration. The letters submitted were from tribal representatives, provider organizations, legal advocates, advocacy groups, non-profit organizations, and health care management entities.

HSD Response: Many dedicated organizations, advocates, stakeholders and community members have contributed to the review and comment process for the draft amendment application. HSD appreciates and acknowledges those efforts and the valuable input of these entities. In addition, HSD appreciates the commenters' support for the policy initiatives set forth in the demonstration amendment. Feedback will continue to be incorporated throughout the demonstration amendment process.

Summary of Comments by Proposal

The summary of comments that follows is organized by subject area. Throughout the public input process, HSD presented the full scope of proposed demonstration modifications, including the removal of co-payments and premiums, reinstatement of retroactive eligibility, increasing the number of community benefit slots, and expanding the number of areas that can be served by the Centennial Home Visiting (CHV) Pilot Program.

1. **Removal of co-payment requirements** (21 comments received)

All commenters expressed support for the removal of co-payments. Commenters speaking in support of the removal of co-payments expressed concern that these changes raise barriers to coverage and care, and would financially burden Medicaid enrollees. One commenter mentioned that additional financial hardship does not accomplish stated purpose of the Medicaid program to provide coverage in the best interest of recipients. Another commenter mentioned that co-payments are not cost-effective and would harm health outcomes in New Mexico.

Comments from tribal organizations were also supportive of the removal of co-payments.

HSD Response: HSD appreciates the commenters' strong support of this demonstration proposal. The language stands as proposed.

2. Removal of premium requirements (21 comments)

All commenters expressed support for the removal of premiums. Commenters speaking in support of the removal of premiums expressed concern that any imposition of even modest premium amounts for patients at low income levels will likely cause increased churn in the Medicaid population, resulting in patients accessing services more episodically, at risk to their own health and at higher more expensive levels of care. Another commenter mentioned that when financial barriers are put between Medicaid beneficiaries and the services and medications they need, it can lead to foregoing needed care and financial insecurity.

Comments from tribal organizations were also supportive of the removal of premiums.

HSD Response: HSD appreciates the commenters' strong support of this demonstration proposal. The language stands as proposed.

3. Reinstate Retroactive Eligibility (17 comments)

All commenters expressed support for the reinstatement of retroactive eligibility. Commenters speaking in support of this proposal expressed concern that Medicaid is a vital safety net for families in poverty and on the brink of poverty. Many commenters mentioned that retroactive eligibility protects people and providers from financial harm by ensuring that medical bills are paid, even while an application for Medicaid is pending.

Comments from tribal organizations were also supportive of reinstating retroactive eligibility.

HSD Response: HSD appreciates the commenters' strong support of this demonstration proposal. The language stands as proposed.

4. Increase the number of Community Benefit slots by 1,500 (14 comments)

All commenters expressed support for increasing the number of community benefit slots by 1,500. Many commenters noted that these slots will allow HSD to continue providing Community Benefit services to individuals who lose Medicaid due to age or other factors, to assist in transitioning members to nursing facilities if it becomes necessary to do so, and to add new members receiving long-term supports in their communities.

Comments from tribal organizations were also supportive of this increase.

HSD Response: HSD appreciates the commenters' strong support of this demonstration proposal. The language stands as proposed.

5. Expand to Centennial Home Visiting (CHV) Pilot Program (12 comments)

All commenters expressed support for proposed expansion of the CHV Pilot Program. Commenters expressed the importance of expanding the reach of these important services by removing restrictions on the number of sites and the number of people served. One commenter asked that HSD focus the CHV pilot program in communities with the greatest need, including those facing the highest rate of Adverse Childhood Experiences. One commenter asked HSD to provide more culturally and linguistically responsive home visiting guided by strengthening integrational relationships and incorporating teachings on traditional stories, beliefs, and practices that help promote healing and community wellness. Additionally, commenters expressed that home visiting is an effective way to improve the health and well-being of young children and their parents.

Comments from tribal organizations were also supportive of the expansion of the CHV pilot program.

Response: HSD appreciates the commenters' support of this demonstration proposal. HSD recognizes the importance of culturally and linguistically responsive home visiting. NM Stat § 32A-23B-1 (2016), the Home Visiting Accountability Act, provides definitions for standards-based home visiting programs. HSD has adopted this definition to align the CHV pilot program with the existing programs governed by the Home Visiting Accountability Act with an adaptation to reflect more stringent requirement of evidence-based program that is recognized by the federal MIECHV project. The service agencies are expected to deliver the program curriculum with fidelity and with an oversight from the program-founding organizations and MCOs to assure adherence to program standards.

6. Miscellaneous Comments (3 comments)

Additional comments were received from stakeholders for the state to consider. One commenter asked that the state remove limits on certain services in the Self-Directed Community Benefit (SDCB). One commenter asked the state to add new service benefits that harness caregiver support to achieve better quality of life and longer lengths of stay in the community, while providing savings to the state. One commenter asked the state to develop technology-enabled coaching supports and evidence-based protocols specifically designed for lay caregivers who are not living with, but who are heavily engaged in, supporting a loved one.

Response: HSD appreciates these comments; however, the comments are best addressed through review of contractual requirements with and monitoring of MCOs and review of the agency's internal procedures and processes. HSD did not amend the final application to incorporate these recommendations at this time.

Comments on Centennial Care 2.0 1115 Demonstration Amendment
(Comments March 1, 2019 through April 15, 2019)

Comments are received from emails and public hearings are included below.
Content from letters and attachments are not included here.

Comments (all via HSD website unless noted otherwise)	Date Submitted	Submitter name, location, and email
I am a mother, student, advocate and social worker who lives and works in the state of New Mexico. I am an advocate for families and children, particularly those living in poverty or in impoverished conditions. It is unethical to create medical premiums and/or co-pays for families who are struggling to provide for their children or other family members and for individuals who are struggling to make ends meet. I recognize the importance of access and availability to community health and benefit services. It is of great importance for the state of New Mexico to help individuals and families thrive and improve their overall health and living conditions. In recognition of this, I am in support of the following amendments: I am in support of these amendments proposed to the federal government for Centennial Care 2.0 Medicaid waiver: I support the removal of co-pays of $8.00 for non-emergency use of the Emergency room and $8.00 for non-preferred prescription drugs for individuals and families who use Centennial Care. I support the removal of monthly premiums for adults and medicaid recipients who are living just above the poverty line. I support reinstating retroactive medical coverage back to three months for eligible Medicaid recipients. I support the expansion of the HSD Community Benefit and for HSD to continue to increase the number of slots for members to access community benefit services by 1500. I am in support of these amendments. Please consider the health and wellness of New Mexico communities.	3/22/19	Grace Olivas olivas.grace@ymail.com

Letter from NMAHHC	4/1/19	Meggin Lorino meggin@nmahc.org
Letter from NMHA	4/5/19	Andrea Lohse alohse@nmhsc.com
Pegasus Legal Services for Children whole heartedly supports HSD's proposal to not implement co-payments, premiums, the phase out of retroactive coverage. Pegasus also supports HSD's proposal to expand home visiting and community benefits services. The previous Centennial Care 2.0 proposed the addition of premiums and co-pays for our state's poorest residents. If prior changes were implemented they would have a significant negative impact on New Mexico's most vulnerable citizens. Medicaid is designed to cover health insurance for families and individuals who would otherwise not be able to afford health insurance. Any additional burdens on these families and individuals would only drive them deeper into poverty. Forcing New Mexico's most vulnerable citizens to choose between medical care, putting food on the table, and a roof over their children's heads. The increase in home visiting and community benefit services will assist New Mexico families in raising their children.	4/11/19	Mariel Willow Mwillow@pegasuslaw.org
Letter from Taos Pueblo	4/12/19	Ezra Bayles EBayles@taospueblo.com
Letter from DRNM	4/15/19	Tim Gardner tgardner@drnm.org
Letter from National Multiple Sclerosis Society	4/15/19	Simone Nichols – Segers Simone.Nichols-Segers@nmss.org
Letter from Health Action New Mexico	4/15/19	Colin Baillio colin@healthactionnm.org
Letter from Disability Collation	4/15/19	Ellen Pines EPinnes@msn.com
Letter from Office of Attorney General	4/15/19	Jennie Lusk JLusk@nmag.gov
Letter from Senior Link	4/15/19	Jennifer P. Crosbie jcrosbie@seniorlink.com
Letter from New Mexico Center for Law and Poverty	4/15/19	William Townley william@nmpovertylaw.org

Letter from Cochiti Pueblo	4/15/19	Antoinette Bird antoinette.bird@cochiti.org
Comments from April 15, 2019 MAC Meeting		
Supports all amendments set forth. Copayments and premiums: we stand and support the provisions that would be considered detrimental to low income families. As well as anything that would cause the lose of thousands of New Mexicans. Retro active eligibility: it protects families as a vital safety net as well as insures that providers are compensated for services provided. Home Visiting: we are in support of expansion of this pilot. we would love to see that is it done in areas of high need in the state of NM. Many counties that are not currently selected have demonstrated need of early childhood intervention now being set forth. This is an opponent for a pilot to really study the infrastructure and staffing needs in those areas to ensure those families are receiving services that are known to provide an outcome for the health and education. Every home is provided a comfortable home visiting service is something this state should look to do. This program is overseeing through the oversight of home visiting providers as well as stake holders and early childhood.	4/15/19	William Toweny NM Center Law and Poverty
Thank you for implementing these changes. A firm believer that copays are designed to be a … of very good care, so getting rid of those is a really good move. Charging a ten dollar premium or so for folks that are almost poverty level, doesn't make any sense in terms of administration. The changes are very positive.	4/15/19	Dale Tinker NM Pharmacy Association
Submitted letter via email 4/15 in support of all March 1st, 2019 amendments and we thank you for those. Waiver slot expansion: people with MS are diagnosed in-between ages 20-50 and women are diagnosed more often then men. 60% of MS clients leave the work force within 10 years and that is due to disability and disease progression. MS impacts in cognition and also the physical aspects. Nursing homes are not appropriate for people between the ages 20-50. Because of the really long wait list, we have families living in these homes to get on Medicaid quicker, which allows them to get the waiver at home. Some individuals with MS are living at home without any home care support without any personal care. Their caregivers are children of the individual, or the parents, which puts everyone at risk. Its also impacts the employment of the spouse and	4/15/19	Vickie Knowal National MS Society

their ability to work while caring for this individual. Opening up more slots allows more access to life changing and lifesaving services. Cost share and premiums: Copays really add up. So if you are living with MS you are not only getting prescriptions, you are going to PT, OT, multiple doctor visits. Any payment of any kind per month for the low moderate income individuals makes it so these individuals don't go to their appointments.		
Applaud HSD and GOV office for not only these waiver amendments but also to rescind the harmful provisions including the premiums, copays and changes to retro active coverage and also using it as an opportunity to improve upon the waiver with the changes to the home visiting as well as the community benefits. it is great to look at the evidence in all these programs and the changes that were proposed, and adopted and moved towards the ones that were supported by the evidence. Appreciate, HSD was fighting for the Medicaid budget and advocating for the beneficiaries for the program. Question: Folks that did incur medical costs in results of the MCO changes, that have been put into effect retro active coverage since January 1, if they would be held harmless if the amendment gets accepted.	4/15/19	Colin Baillio Health Action NM
Stand in support of all amendment changes. The dept really has the health and the best interest of kids and families in mind. Feels very different. The legislative session shows it is very different and the proposed changes also show a new direction. Very excited and very grateful for that.	4/15/19	Bill Jordan Voices for Jordan
Commend the dept in terms of what they are doing in child health. Home visiting: Was an article in 2016 called Home Visiting and use of Infant Health Care.	4/15/19	Carolyn Montoya College of Nursing
Supports and shows gratitude of all the amendments. 65 % of of SBHC are run by federally qualified health centers and are often in the position to absorb the cost of health care for confidential visits in the BH and reproductive health. If these centers would have been in the position to absorb the cost of these copays for these visits, it could have killed the SBHC in the state. Very excited for these amendments. Excited for the new expansion.	4/15/19	Nancy Rodriguez NM Alliance for School Based Health Care
While the waiver was being developed there were sub-committees of the MAC committee on different topics. Cost share: The committee voted not to have any cost sharing in the waiver and that advice of by the sub-committee was ignored. Thank you for reversing that decision.	4/15/19	Ruth Hoffman LAM-NM

Supports all five amendments for the CC Waiver. Thanks Gov. for singing bills into law that will increase access into Medicaid and other insurance coverage for members with disabilities example HB 323 HB436. Wants to encourage the department to review and address the steady decline in the average utilization of personal care services and some other long term benefits under CC. Encourage the dept on an on-going basis post it, publicize the data about utilization with the long term services. Encourage the dept to solicited advice from the committee.	4/15/19	Jim Jackson Disability Rights NM
Written comments submitted. Copays and retro active eligibility: These put a particular administrative burden and a cost on hospitals that are sometimes standing in a situation that are having to not have the copays paid and having to eat that cost. As well as being able to provide the retroactive care.	4/15/19	Jeff Dye Disability Rights NM
Supports all amendments. Care Coordination at the NFLOC level care in the home. There seems to be difficulty for participants outside of MCOs that the interaction with the CC and the subscribers. Not enough training on the MCO side and lack of follow ups. Echo Jim Jacksons comment about MAC members.	4/15/19	Nat Dean Disability Advocate
Echo comments that have been made. Supports the amendments.	4/15/19	Eileen Goode
Support the elimination of premiums.	4/15/19	Hyde & Associations

NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

QUALITY STRATEGY

September 2017 Update

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Section I: Introduction:

CMS requirement CFR §438.340(a)

General rule. Each State contracting with a MCO must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO.

Program History

CMS requirement CFR §438.340

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

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

On July 1, 1997, New Mexico implemented the Salud! program, a managed care program for physical health services. The program was designed to improve quality of care and access to care while making cost-effective use of state and federal funds. During that period, approximately 65% of Medicaid eligible members were participants in Salud!.
In addition, the Medicaid safety net programs for children, including the Children's Health Insurance Program (CHIP) were combined into one program known as New Mexikids.

In 1999, HSD/MAD implemented the Personal Care Option (PCO) as a state plan service to meet the needs of Medicaid members in need of long-term services and who met a Nursing Facility Level of Care (NF LOC). PCO was developed to allow members to receive care in their home rather than being placed in a Nursing Facility.

In August 2002, A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver program utilized unspent CHIP funds to provide basic health benefits for New Mexicans with incomes up to 200 percent of the federal poverty level through an employer based buy-in insurance plan.

In 2004, the Interagency Behavioral Health Purchasing Collaborative (The Collaborative) was established as a pioneering effort in the behavioral health system transformation. The Collaborative had the authority to contract for behavioral health services and make decisions regarding the administration, direction and management of state-funded behavioral healthcare services in New Mexico. Optum Health, was selected as the Statewide Entity charged with the oversight of behavioral healthcare services for Medicaid recipients in Salud!.

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

In 2008, the Coordination of Long-Term Services (CoLTS) program was implemented as the state's first managed long-term care program for Medicaid members who met a NF LOC. This 1915 (b) (c) concurrent program covered members residing in nursing facilities, participants of the Disabled & Elderly (D&E) waiver, Personal Care Option (PCO) members, dual eligible members and members with a qualified brain injury (BI). The program was an interagency collaboration between HSD/MAD and the New Mexico Aging and Long-Term Services Department (ALTSD). All acute, preventative and long-term care services were provided through contracted MCOs. The primary goal of the program was to mitigate the array of problems resulting from the fragmentation of services provided to Medicare and Medicaid dual eligibles.

Centennial Care

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

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

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

- Developing a comprehensive service delivery system;
- Increasing personal responsibility;
- Encouraging active engagement of members in their health care;

- Emphasizing payment reforms to incentivize quality versus quantity of services; and
- Maximizing opportunities to achieve administrative simplification.

Today, four MCOs administer the full array of services in an integrated model of care. The care coordination infrastructure is an integral focus of Centennial Care and promotes a person-centered approach to care with more than 900 care coordinators ensuring members receive services in the right place when they need them. Centennial Care increased access to LTSS for people who previously needed a waiver allocation to receive such services by allowing any Medicaid member who meets a NF LOC to access home and community based services (HCBS). As a result, New Mexico experienced an increase of 11.4% individuals receiving HCBS between 2014 and 2016.

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

In 2016, New Mexico launched two Health Homes sites targeting individuals with serious mental illness or severe emotional disturbance. The Medicaid program continues to see an increase in members participating in a patient centered medical home (PCMH) with over 300,000 members to date.

In November 2017, HSD/MAD will submit the Centennial Care 1115 Waiver renewal. In the renewal application, New Mexico has identified opportunities for continued progress in transforming its Medicaid program into an integrated, person-centered, value-based delivery system through the implementation of Centennial Care 2.0; therefore, building on the many successes and accomplishments achieved since implementation of the program.

Quality Management Structure

Include an overview of the quality management structure that is in place at the state level.

The Quality Bureau (QB) within HSD/MAD currently consists of 14 positions plus a bureau chief. The QB is structured with three units: Care Coordination Unit (CCU); Performance Measure Unit (PMU); and the Critical Incident Unit (CIU). The CCU conducts oversight and monitoring activities related to MCO care coordination requirements. The PMU conducts oversight of MCO quality performance and improvement initiatives and manages both the External Quality Review Organization and the 1115 Demonstration evaluation activities. The CIU conducts oversight of the reporting of critical incidents by MCOs and provider monitoring to ensure the health and welfare of members for 14 categories of eligibility (COE). All units operate in accordance within applicable state and federal regulations as well as MCO contract and policy requirements.

The QB is responsible for directing the Division's Quality Program and coordinating existing quality improvement and future health reform initiatives with contracted MCOs. The bureau

oversees all aspects of performance measurement for Centennial Care including quality improvement projects, performance measures and performance evaluation and reporting. The State retains ultimate authority and accountability for ensuring the quality initiatives of Centennial Care are accomplished, although several internal and external collaborations/partnerships are utilized to address specific initiatives and/or issues. Administrative authority for the Quality Strategy lies within the HSD/MAD Director's Office and is delegated to the QB for development, revision, evaluation, and reporting.

Section II: State Standards:

Quality and Appropriateness of Care Standards

CMS requirement CFR §438.340(b)

Summarize the procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO contracts, and to individuals with special health care needs.

Quality Management and Quality Improvement Standards:

MCOs are required to comply with state and federal standards for quality management and quality improvement (QM/QI) and shall adhere to the following:

- Establish a QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;
- Recognize the opportunities for improvement are continual;
- Ensure the QM/QI process is data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements;
- Require re-measurement of effectiveness and continuing development and implementation of improvements as appropriate;
- Reflect member and Contract Provider input;
- Develop a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that result in continuous quality improvement;
- Review outcome data at least quarterly for performance improvement, recommendations and interventions;
- Establish a mechanism to detect under and over utilization of services;
- Have access to, and the ability to collect, manage and report to the State data necessary to support the QM/QI activities;
- Establish a committee to oversee and implement all policies and procedures;
- Ensure that the ultimate responsibility for QM/QI is with the MCO and shall not be delegated to subcontractors;

- Develop an annual QM/QI work plan to be submitted at the beginning of each year and include, at a minimum, immediate objectives for each year and long-term objectives for the entire term of the contract;
- Implement Performance Improvement Projects (PIPs) identified internally by the MCO and as directed by HSD;
- Design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and
- Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:
    - A description of ongoing and completed QM/QI activities;
    - Inclusion of measures that are trended to assess performance;
    - Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;
    - Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;
    - Demonstration that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention's effectiveness;
    - Demonstration that the results of QM/QI projects and reviews are incorporated in the QM/QI program;
    - Incorporation of annual HEDIS results in the following year's plan as applicable to HSD specific programs;
    - Communication with appropriate Contract Providers about the results of QM/QI activities and opportunities for provider to review and use this information to improve their performance, including technical assistance, corrective action plans, and follow-up activities as necessary; and
    - Upon request, present about Behavioral Health aspects of the MCOs' annual QM/QI work plan during a quarterly meeting of the Collaborative.

Utilization Management Standards:

HSD/MAD requires that the MCOs establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and

promotes quality of care, adherence to standards of care, and efficient use of resources, member choice, and the identification of service gaps within the service system. The MCO UM system must:

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

MCO Accreditation Standards:

The MCO shall be either (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the MCO provided Medicaid services and achieved New Mexico NCQA accreditation by 1/01/16.

Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with the State. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

CMS requirement CFR §438.340(b)(9)
Describe the mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs. (This must include the state's definition of special health care needs.)

Care Coordination Standards:

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

HSD/MAD requires the MCOs to conduct a standardized health risk assessment (HRA) on each member to determine if he or she requires a comprehensive needs assessment (CNA) and/or a higher level of care coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a Comprehensive Care Plan (CCP), which establishes the necessary services based on needs identified in the CNA. Members assigned to

care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their total care. MCOs are required to routinely monitor claims and utilization data for all members (including members who are not assigned to care coordination levels 2 or 3) to identify changes in health status and high-risk members in need of a higher level of care coordination.

Additional components of care coordination includes:

- Assessing each member's physical, behavioral, functional and psychosocial needs;
- Identifying the specific medical, behavioral, LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet the member's needs;
- Assessing members for LTSS. This applies to members of all ages who have functional limitations and/or chronic illnesses. The primary purpose is to support the ability of the beneficiary to receive services in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or institutional setting;
- Identifying members with special health care needs. The state defines members with special health care needs as those who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who also require health and related services of a type or amount beyond that required by individuals generally;
- Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member's health, safety, and welfare.

Access and Network Adequacy Standards

CMS requirement CFR §438.340(b)(1)

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

New Mexico must ensure the delivery of all covered benefits to all Medicaid beneficiaries. Services must be delivered in a culturally competent manner and require that the MCO coordinate health care services and maintain a provider network sufficient to provide timely access to covered services for all of its members.

The MCO must have written policies and procedures that align with the Network Adequacy Standards detailed in the MCO contract and the Centennial Care policy manual. The policies and procedures must describe how access to services will be available including prior authorization and referral requirements for medical and surgical services; emergency room services; behavioral health services; and long-term care services.

The MCO must establish a mechanism to monitor adherence with Network Adequacy Standards and shall submit a Network Adequacy Report as directed by HSD/MAD to ensure compliance with the following:

- Access Standards
    - Member caseload of any PCP should not exceed two-thousand (2,000)
    - Members have adequate access to specialty providers
- Distance Requirements for PCPs (including internal medicine, general practice, and family practice types), and pharmacies
    - Ninety percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety percent (90%) of Rural members shall travel no farther than forty-five (45) miles
    - Ninety percent (90%) of Frontier members shall travel no farther than sixty (60) miles
- Distance Requirements for Behavioral Health Providers practitioners and Specialty
    - Ninety Percent (90%) of Urban members shall travel no farther than thirty (30) miles
    - Ninety Percent (90%) of Rural members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by the State
    - Ninety Percent (90 %) of Frontier members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved ty the State
- Timeliness requirements
    - No more than thirty (30) Calendar Days, for routine, asymptomatic, member-initiated, outpatient appointments for primary medical care
    - No more than sixty (60) Calendar Days, for routine, asymptomatic member-initiated dental appointments.
    - No more than fourteen (14) calendar Days for routine, symptomatic member-initiated, outpatient appointments for non-urgent primary medical, behavioral health and dental care
    - Within twenty four (24) hours for Primary medical, behavioral health and dental care outpatient appointments for urgent conditions
    - Consistent with clinical urgency but no more than twenty-one (21) calendar days for specialty outpatient referral and consultation appointments, excluding behavioral health
    - Consistent with clinical urgency but no more than fourteen (14) calendar days for routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments
    - Consistent with the severity of the clinical need, walk-in rather than an appointment, for outpatient diagnostic laboratory, diagnostic imaging and other testing

- Consistent with clinical urgency, but no longer than forty-eight (48) hours for urgent outpatient diagnostic laboratory, diagnostic imaging and other testing
- No longer than forty (40) minutes for the in-person prescription fill time (ready for pickup). A prescription called in by a practitioner shall be filled within ninety (90) minutes
- Consistent with clinical needs for scheduled follow-up outpatient visits with practitioners
- Within two (2) hours for face-to-face Behavioral Health crisis services

Provider Standards:
The MCO must have the appropriate licenses in the State to do risk-based contracting through a managed care network of health care providers. The MCO is required by the state to employ a full-time staff person responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education.

The MCO must develop written policies and procedures that meet NCQA standards and State and federal regulations for credentialing and re-credentialing of contracted providers. The document should include but not be limited to: defining the scope of providers covered; the criteria and the primary source verification of information used to meet the criteria; the process used to make decisions that shall not be discriminatory; and the extent of delegated credentialing and re-credentialing arrangements.

MCO network providers are obligated to abide by all federal, state and local laws, rules and regulations, including but not limited to those laws, regulation, and rules applicable to providers of services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by the State.

All health care providers rendering services to Medicaid beneficiaries must render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief or source of payment.

Evidenced-Based Clinical Practice Guideline (CPGs) from the MCOs include examples from their QM/QI plan such as Asthma, Diabetes, ADHD (Attention Deficit Hyperactive Disorder)/ADD (Attention Deficit Disorder), Depression, and Obesity. CPGs are updated every two years and analyzed for relevant member population and practitioner/specialists and disseminated to providers. Typically, measurements (i.e. Healthcare Effectiveness Data and Information Set [HEDIS]) are established and evaluated through MCO Quality Committees, NCQA, and HSD/MAD.

CMS requirement CFR §438.340(b)(6)

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

Health Disparities

In New Mexico many factors contribute to health disparities, including access to health care, behavioral choices, genetic predisposition, geographic location, poverty, environmental and occupational conditions, language barriers and social and cultural factors.

HSD/MAD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for the State's Medicaid beneficiaries. Resources include, but are not limited to:

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

Transition of Care Standards:

CMS requirement CFR §438.340(b)(5)

Must include a description of the State's transition of care policy.

The State is committed to providing the necessary supports to assist Medicaid beneficiaries and requires the MCOs to establish policies and procedures that adhere to the standards defined by the State in the Managed Care Policy Manual and MCO contract.

The MCOs shall facilitate and ensure a timely and seamless transition for all Medicaid members transitioning to new services or service providers without any disruptions in services.

The MCOs must identify and facilitate coordination of care for all members during various transitions including, but not limited to:

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

Monitoring and Compliance Standards:

CMS requirement CFR §438.340(b)(2)

Detail the State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.

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

Centennial Care is driven by the following goals:

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

Centennial Care objectives include:

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

HSD/MAD, through the QM/QM standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement in the health status of the population served by the MCOs. The State conducts an annual review of each MCO's QM/QI program that includes a Work Plan and Evaluation by an integrated team from the QB, the Behavioral Health Services Division (BHSD) and the Centennial Care Contracts Bureau.

HSD/MAD monitors provider access and network adequacy in a variety of ways and through various reports submitted by the MCOs. The following outlines the various methods utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey
- Member Satisfaction Survey
- Secret Shopper Survey
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
- External Quality Review Organization (EQRO) Reviews
- MCO Call Center Reports
- Grievance & Appeals Reports
- PCP Report
- Geo Access Report
- Network Adequacy Report
- Ad Hoc Reports
- Primary Care Physician to member ratio report

In addition, the State evaluates achievement through analysis of the quality and appropriateness of care and services delivered to members by the MCOs based on member needs and the level of contract compliance of MCOs by comprehensively monitoring MCO activities on an on-going basis. The State requires monthly, quarterly, and annual reports, including Ad Hoc reports reflective of all MCO service delivery activities. Various reports evaluate structure, process, and outcome measures.

Sanctions

CMS requirement CFR §438.340(b)(7)

Detail the appropriate use of the intermediate sanctions for MCOs.

HSD/MAD has established sanctions for the failure to meet certain contract requirements by the MCO, affiliate, parent or subcontractor, and if a party fails to comply with the contract, HSD/MAD may impose sanctions.

HSD/MAD has the option to apply Corrective Action Plans (CAPs) if HSD /MAD determines that the MCO is not in compliance with one or more requirements. HSD/MAD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a CAP or an HSD/MAD Directed Corrective Action Plan (DCAP). A notice from HSD/MAD of noncompliance that directs a CAP or DCAP may also serve as a notice of sanction in the event HSD/MAD determines that sanctions are also necessary.

HSD/MAD may impose any or all of the non-monetary sanctions and monetary penalties to the

extent authorized by federal and state law. Non-monetary intermediate sanctions may include:

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

The State has established monetary penalties that may include:

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

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

Failure to comply with Encounter submission as described in Section 4.19 of the contract	Monetary penalties up to two percent (2%) of the MCO's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3	$1,000 per member where the MCO fails to comply with the timeframes for that member.
Failure to complete or comply with CAPs/DCAPs	.12% of the monthly capitation payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
Failure to obtain approval of member Materials as required by Section 4.14.1 of the contract	$5,000 per day for each Calendar Day that HSD determines the MCO has provided member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to comply with the timeframe for responding to Grievances and Appeals required in Section 4.16 of the contract	$1,000 per occurrence where the MCO fails to comply with the timeframes.
For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of the contract	$5,000 per report, per occurrence With the exception of the cure period: $1,000 per report, per Calendar Day. The $1,000 per day damage amounts will double every ten (10) Calendar days.
Failure to submit timely Summary of Evidence in accordance with Section 4.16 of the contract	$1,000 per occurrence.
Failure to have legal counsel appear in accordance with Section 4.16 of the contract	$10,000 per occurrence.
Failure to meet targets for the performance measures described in Section 4.12.8 of the contract	A monetary penalty based on 2% of the total capitation paid to the MCO for the contract/ agreement year, divided by the number of performance measures specified in the contract/agreement year.

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

Below is a total by year of HSD imposed monetary penalties:

- 2014: $3,212,744.66
- 2015: $3,271,585.54
- 2016: $0

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

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

Development

CMS requirement CFR §438.340(c)

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

CMS requirement CFR §438.340(c)(1)

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

CMS requirement CFR §438.340(c)(1)(i)

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

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

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

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

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

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

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

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

HSD/MAD developed the Quality Strategy with input from the Medicaid Advisory Committee (MAC), a diverse and comprehensive group of stakeholders and providers, including Native American Advisory Boards (NAAB) and the Native American Technical Advisory Committee (NATAC). The MAC serves as an advisory body to the Secretary of the Human Services

Department and the Medical Assistance Division Director on policy development and program administration for the Medicaid services provided to New Mexicans. The MAC encourages participation of health professionals, consumers and consumer groups, advocates, and public health entities concerned or involved with the NM Medicaid program. Additionally, quality review committees representing the various populations meet periodically to discuss quality of care issues and performance measure outcomes with the intention of improving health outcomes and safety.

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

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

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

Evaluation

CMS requirement CFR §438.340(c)(2)

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

CMS requirement CFR §438.340(c)(2)(i)

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

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

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

Updates to the quality strategy must take into consideration the recommendations for improving the quality of health care service furnished by the MCO including how the State can target goals

and objectives in the quality strategy to better support improvement in the quality timeliness and access to health care services furnished to Medicaid beneficiaries. Include a timeline for modifying or updating the Quality Strategy. (If this is based on an assessment of "significant changes")

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

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

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

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

HSD/MAD received approval for the Quality Strategy from CMS in May 2014. The Quality Strategy was reassessed in September 2017 and revised to address the program outcomes through calendar year 2016. New Mexico will continue to assess quality outcomes to determine the need for modifications to the Quality Strategy. Upon approval of the 1115 Demonstration Waiver renewal in 2018, HSD/MAD will revise the Quality Strategy to include additional goals, objectives, and outcome measures.

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

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

Section IV: Assessment

CMS requirement CFR §438.340(b)(8)

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

Quality Metrics

CMS requirement CFR §438.340(b)(3)

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

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

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

HSD/MAD selects PMs and PIPS utilizing data that identifies the strengths and opportunities for improvement specific to the Medicaid population. PMs, PIPs and performance targets are reasonable and based on industry standards and consistent with CMS EQR Protocols. An annual review of PMs and PIPs is conducted by the EQRO and the final technical report with findings and recommendations are posted on the HSD website.

Performance Measures (PMs)

PMs and performance targets are based on HEDIS technical specification for the current reporting year. The MCO is required to follow relevant and current NCQA HEDIS standards for reporting. HSD/MAD requires the MCOs to meet the established performance targets. HSD/MAD considered calendar year 2014 and calendar year 2015 to be noncompetitive baseline years for PM thresholds and for setting PM targets.

The performance targets listed in the MCO contracts requires: 1) a two (2) percentage point improvement above the MCO's NCQA audited HEDIS rates; or 2) achievement of the Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass, or the State's determined target.

Failure to meet the established performance targets will result in monetary penalties as detailed in the MCO Medicaid contract.

HSD/MAD directed the MCOs to focus on eight (8) clinical initiatives to drive improved quality outcomes. The table below reflects the aggregate percentage by calendar year of the annual HEDIS results reported to HSD by the four (4) contracted MCOs.

Performance Measures	**2014**	**2015**	**2016**
PM#1 Annual Dental Visits	57.50%	61.50%	63.75%

PM#2 **Use of Appropriate Medication for People with Asthma**	51.75%	55.75%	56%
PM#3 **Controlling High Blood Pressure**	52.75%	53.5%	54.5%
PM#4 **Comprehensive Diabetes Care**			
HbA1C testing	85%	84.25%	83.5%
HbA1C >9%	47.5%	50%	47.5%
Retinal Eye Exam	56%	53%	56%
Nephropathy Screening	80.75%	87.5%	88.75%
PM#5 **Prenatal/Postpartum Visits**			
Prenatal visits within first trimester or within 42 days of enrollment	73%	70.5%	76.5%
Postpartum visit on or before 21 & 56 days after delivery	55%	50.75%	57.75%
PM#6 **Frequency of on-going prenatal care**	52%	44.75%	55.75%
PM#7 **Antidepressant Medication Management**			
Acute Phase 84 days	52%	53.75%	50.75%
Continuous Phase 180 days	43.5%	38.25%	35.5%
PM#8 **Follow up after hospitalization for Mental illness**			
7 days	65.75%	62%	64.75%
30 days	44.74%	39.25%	42.75%

Performance Improvement Projects (PIPs)

HSD/MAD directed the MCOs to implement PIPs designed to meet the unique needs of its members. The PIPs were developed to ensure sustainable improvements and interventions with a focus on quality improvement. The 2014 Centennial Care Managed Care Contract directed the MCOs to implement PIPs in the following areas: one (1) on Long-Term Care Services, one (1) on services to children, one (1) on Behavioral Health, and one (1) on women's health.

In January 2013, New Mexico was awarded the Adult Medicaid Quality Grant (AMQG) by CMS. The grant was designed to support the development of staff capacity to collect, report, and analyze data for adults enrolled in Medicaid. HSD/MAD developed Quality Improvement Projects (QIPs) in accordance with the Initial Adult Core Set Technical Specification and selected Diabetes: Prevention and Enhanced Disease Management, and Behavioral Health: Screening and Management for Clinical Depression. The AMQG ended in December of 2015, and in an effort to promote sustainability of the projects associated with the AMQG, the MCO contract was amended in 2015 directing the MCOs to incorporate the ongoing QIPs as PIPs.

The MCO contract continues to direct the MCOs to, at a minimum, implement the following PIPs:

- One (1) on Long-Term Care
- One (1) on Services to Children
- One (1) on Diabetes Prevention and Management
- One (1) on Screening and Management for Clinical Depression

Tracking Measures

HSD/MAD directed the MCOs to report on tracking measures (TMs) that focus on a specific target populations. TMs are areas for the MCOs to evaluate and make improvements, if necessary. The MCOs are required to submit quarterly reports to HSD/MAD using the QB developed reporting template which applies HEDIS, CMS Adult Core Set, or HSD defined technical specifications. The report is analyzed by the QB to identify performance trends, best practices, gaps and interventions reported by the MCOs.

Currently, these measures do not have associated sanctions. Feedback is shared and discussed with the MCOs during the quarterly quality workgroup meetings. Below is a timeline, description and measure of the TMs implemented:

Date of Direction	Tracking Measure	Description of Target Population or Topic	2014	2015	2016
March 2014	Fall Risk Management	The Percentage of Medicaid members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 Months and who received fall risk intervention from their current practitioner.	12%	8%	12%
August 2015	Diabetes, Short-Term Complications Admission Rate	The number of inpatient discharges with a principal diagnosis code for diabetes short-term complications for Medicaid enrollees.			
		18 to 64 years of age	22%	17%	19%
		65 + years of age	88%	95%	60%

August 2015	Screening for Clinical Depression and Follow-Up Plan	The percentage of Medicaid enrollees screened for clinical depression using a standardized depression screening tool and if positive a follow-up plan is documented on the date of the positive screen.	NR		
		18 to 64 years of age	0.02%	0.07%	0.12%
		65+ years of age	0.04%	0.24%	0.26%
May 2016	Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a PCP during their first 15 months of life	NR	NR	58%
May 2016	Children and Adolescents' Access to Primary Care Practitioners (PCP)	The percentage of members 12 months – 19 years of age who had a visit with a PCP.	NR	NR	61%
October 2016	Long Acting Reversible Contraceptive (LARC)	The use of LARC among members age 15 -19 years of age.	NR	NR	3106
October 2016	Smoking Cessation	The monitoring of smoking cessations products: Cost utilization	NR	NR	$1,146,190
		The monitoring of counseling: Products and Services (Total Units) utilization			7609

Child and Adult Core Set Quality Measures

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

HSD/MAD incorporates the CAHPS 5.0H Survey required by NCQA for accreditation as part of the required MCO annual report submissions. CAHPS 5.0H allows for inclusion of state specific questions and provides information on New Mexico's Medicaid beneficiaries and their experiences with the services provided. Below is a table with the Supplemental questions and results for 2015 and 2016.

CAHPS Supplemental Questions *CCC-Children with Chronic Conditions *N/A- Not Reported	Year	BCBS		MHC		PHP		UHC	
Child Care Coordination									
1. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (% answering Yes)	2015	27%	43% CCC	64%	71% CCC	52%	60% CCC	N/A	
	2016	28%	28% CCC	27%	44% CCC	14%	29% CCC	56%	51% CCC
2. In the last 6 months, who helped to coordinate your child's care?									
Someone from your child's health plan	2015	4%	8% CCC	13%	14% CCC	4%	9% CCC	N/A	
	2016	6%	6% CCC	5%	6% CCC	13%	20% CCC	5%	10% CCC
Someone from your child's doctor's office or clinic	2015	19%	22% CCC	55%	48% CCC	48%	50% CCC	N/A	
	2016	22%	22% CCC	24%	31% CCC	63%	57% CCC	29%	35% CCC
Someone from another organization	2015	1%	4% CCC	6%	10% CCC	6%	7% CCC	N/A	
	2016	3%	3% CCC	2%	4% CCC	0%	6% CCC	2%	6% CCC
A friend or family member	2015	5%	6% CCC	1%	1% CCC	3%	3% CCC	N/A	
	2016	4%	4% CCC	5%	3% CCC	9%	3% CCC	6%	3% CCC
You	2015	71%	60% CCC	25%	27% CCC	39%	31% CCC	N/A	
	2016	65%	65% CCC	64%	56% CCC	16%	14% CCC	59%	46% CCC
3. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?									
Satisfied or Very Satisfied	2015	81%	74% CCC	86%	87% CCC	91%	88% CCC	N/A	
	2016	77%	77% CCC	90%	86% CCC	86%	87% CCC	84%	77% CCC
Adult Care Coordination									
4. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (% answering Yes)	2015	33%		24%		27%		N/A	
	2016	38%		30%		29%		37%	
5. In the last 6 months, who helped to coordinate your care?									
Someone from your health plan	2015	9%		19%		17%		N/A	
	2016	14%		12%		34%		12%	
Someone from your doctor's office or clinic	2015	25%		48%		47%		N/A	
	2016	26%		23%		48%		21%	
Someone from another organization	2015	2%		3%		4%		N/A	
	2016	4%		1%		1%		5%	
A friend or family member	2015	14%		16%		13%		N/A	

	2016	14%	11%	8%	23%
You	2015	50%	16%	19%	N/A
	2016	43%	53%	9%	39%
6. How satisfied are you with the help you received to coordinate your care in the last 6 months?					
Satisfied or Very Satisfied	2015	80%	87%	88%	N/A
	2016	74%	81%	94%	79%
Member Education					
7. In the last 6 months, have you received any material from your health plan about good health and how to stay healthy? (% answering Yes)	2015	58%	59%	62%	N/A
	2016	73%	57%	63%	67%
8. In the last 6 months, have you received any material from your health plan about care coordination and how to contact the care coordination unit? (% answering Yes)	2015	50%	48%	50%	N/A
	2016	60%	54%	51%	59%
Care Plan					
9. Did your care coordinator sit down with you and create a plan of care? (% answering Yes)	2015	24%	24%	64%	N/A
	2016	28%	25%	54%	35%
10. Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?					
Satisfied or Very Satisfied	2015	70%	71%	N/A	N/A
	2016	70%	83%	84%	71%
Fall Risk					
11. A fall is when your body goes to the ground without being pushed. In the last 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? (% answering Yes)	2015	22% (12 mo.)	18%	22%	N/A
	2016	23% (12 mo.)	17%	57%	29%
12. Did you Fall in the past 6 months? (% answering Yes)	2015	19%	18%	17%	N/A
	2016	21%	15%	52%	25%
13. In the past 6 months, have you had a problem with balance or walking? (% answering Yes)	2015	27%	24%	25%	N/A
	2016	26%	20%	21%	40%
14. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? (% answering Yes)	2015	23%	23%	26%	N/A
	2016	26%	21%	58%	38%

External Quality Review

CMS requirement CFR §438.340(b)(4)

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

HSD/MAD, in accordance with 42 CFR 438.354, has retained the services of an External Quality Review Organization (EQRO), HealthInsight New Mexico, to provide External Quality Review (EQR). The EQRO will conduct all mandatory and optional EQR reviews to assess quality

outcomes and timeliness of, and access to, the services provided to Medicaid beneficiaries and covered under each MCO.

The EQRO will follow CMS protocols that set forth the parameters that must be followed in conducting the EQR for the following activities:

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

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

The EQRO reports findings and recommendations to the State.

CMS requirement CFR §438.340(b)(10)

Describe how the state will ensure non-duplication of EQR **activities.**

To ensure non-duplication of EQR activities, HSD/MAD has a designated Contract Administrator authorized to represent HSD/MAD in all matters related to EQR. The Contract Administrator utilizes tracking sheets to monitor scope of work activities with relevant contractors within the division.

HSD conducts internal quality review activities such as:

- NF LOC audits by the HSD/MAD Nurse Auditor for review of service plan reduction determinations by the MCOs;

- NF LOC audits by the HSD/MAD Nurse Auditor for review of high NF LOC and low NF LOC denials on a quarterly basis to ensure the denials are appropriate and based on NF LOC criteria;
- Service Plan audits by the HSD/MAD Nurse Contractor to review service plans ensuring that the MCOs are using the correct tools and processes to create service plans. The review of service plans also ensures the MCOs are appropriately allocating time and implementing the services identified in the member's comprehensive needs assessment, and the member's goals are identified in the care plan;
- Care coordination audits evaluating and monitoring MCO care coordination activities. HSD/MAD monitors monthly progress reports from the MCOs outlining the MCOs' efforts to improve care coordination practices according to HSD/MAD's findings that required follow-up to recommendations and action steps;
- "Ride-alongs" by HSD/MAD staff were conducted with MCO care coordinators in 2015, 2016 and 2017 to observe member visits in the home setting. HSD/MAD ride-along experiences with the MCOs identified the need to continue care coordination trainings for member assessments and available services. Modifications to assessment tools and technical assistance were provided to the MCOs based on the observations. MCOs acknowledged the need for continued training and that the process was helpful to the MCO care coordinators. The ride-alongs focus on application by care coordinators of the Community Benefit Services Questionnaire (CBSQ), a tool developed collaboratively by HSD/MAD and the MCOs to educate members about available home and community based services. HSD/MAD observes the care coordinator's use of the Community Benefit Member Agreement (CBMA), to document if the member agrees to accept or decline available services;
- Monitoring MCO continued expansion of the PCMH model by engaging PCMH providers to conduct care coordination activities for their attributed members through value based purchasing (VBP) arrangements. Centennial Care 2.0 seeks to expand of this initiative by continuing to transition care coordination functions from the MCOs to the provider level (known as a delegated model). Monitoring activities shall occur through MCO reporting to HSD and verification of VBP initiatives.
- Delivery System Improvement Performance Targets (DSIPTs) allow MCOs to be recognized for their quality improvements in specific areas. In 2014 and 2015, HSD required four target areas for DSIPTs. In 2016, HSD expanded target areas by adding emphasis on five specific areas. Below is a description of DSIPTs target areas by year:

Delivery System Improvement Targets		
2014	**2015**	**2016**
HIE/HIT Increase the use of electronic health records by Contract Providers and increase the number of Contract Providers who participate in the exchange of electronic health information.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.	**Community Health Workers** Increase use of CHWs for care coordination activities, health education, health literacy, translation and community support linkages in Rural, Frontier, and underserved communities in Urban regions of the State.
Telehealth A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telehealth** A minimum of a 15% increase in telehealth "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**	**Telemedicine** A minimum of a 15% increase in telemedicine "office" visits with specialists, including BH providers, for members in Rural and Frontier areas. At least 5% of the increase must be visits with BH providers**.**
PCMH A minimum of a 5% of members served by PCMHs.	**PCMH** A minimum of a 5% increase in members served by PCMHs.	**PCMH** A minimum of a 5% increase of members being served by PCMHs, maintaining a minimum of 40% of membership being served by PCHMs.
ER Diversion A minimum of a 10% reduction of non-emergent use of the ER.	**ER Diversion** A minimum of a 10% reduction in the per capita use of emergency room.	**Behavioral Health** Percent of 7-day follow-up visits into community-based BH care for child and adult members released from inpatient psychiatric hospitalizations stays of 4 or more days.
		Hepatitis C Treat at least 50% of Hepatitis C drug treatments included in the capitated rate during the contract period.

Centennial Care Summary

Accomplishments for Centennial Care, now in its fourth year of operation, include the following:

- Streamlined program administration by consolidating a myriad of federal waivers that segregate the care of populations. Four MCOs administer the full array of services in an integrated model of care, serving approximately 700,000 Medicaid members;
- Built a care coordination infrastructure that promotes a person-centered approach to care. More than 900 care coordinators ensure members receive services when they need them;
- Increased access to long-term services and supports (LTSS) for people who previously needed a waiver allocation to receive such services. More than 29,750 individuals are

receiving home- and community-based services (HCBS) which represents an increase of 11.4% per year between 2014 and 2016;

- Continue to be a leader in the nation in spending more of its LTSS dollars to maintain the number of members receiving services in their homes and in community settings rather than in institutional settings;
- Advanced payment reforms in partnership with the MCOs and, in 2017, requiring VBP arrangements for at least 16% of all medical payments to providers; and
- Demonstrated improved utilization of health care services and cost-effectiveness of the program despite significant enrollment growth. Total enrollment in the Medicaid program has grown 8.5% per year since 2014 while per capita costs have decreased by 1.5% between 2014 and 2016.

NEW MEXICO

MEDICAID

MANAGED CARE PROGRAM

Summary of

External Quality Review Organization

Reports

October 2017

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

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How to Use This Report

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

The reports covered in this summary include:

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

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

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

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

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

1.0 Compliance Report CY 2014 and 2015

1.1. Compliance Report Comparison Executive Summary

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

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

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

Table 1: Overall Compliance Scores by MCO

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

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

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

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

1.2. Compliance Scores

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

Table 2: MCO Score by Subject Annual Comparison

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

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

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

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

1.3. Compliance Recommendations

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

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

Blue Cross and Blue Shield of New Mexico

BCBS Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that BCBS:

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

In CY 2015, the EQRO recommended that BCBS:

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

BCBS Care Coordination (MCO/HSD Contract Section 4.4)

For CY 2014, the EQRO recommended that BCBS:

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

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

For CY 2015, the EQRO recommended that BCBS:

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

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

In CY 2014, the EQRO recommended that BCBS:

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

In CY 2015, the EQRO recommended that BCBS:

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

BCBS Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that BCBS:

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

In CY 2015, the EQRO recommended that BCBS:

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

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

In CY 2015, the EQRO recommended that BCBS:

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

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

In CY 2015, the EQRO recommended that BCBS:

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

Molina Healthcare of New Mexico

MHP Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that MHP:

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

In CY 2015, the EQRO recommended that MHP:

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

MHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that MHP:

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

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

In CY 2014, the EQRO recommended that MHP:

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

In CY 2015, the EQRO recommended that MHP:

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

MHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that MHP:

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

In CY 2015, the EQRO recommended that MHP:

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

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

In CY 2015, the EQRO recommended that MHP:

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

Presbyterian Health Plan, Inc.

PHP Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that PHP:

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

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

In CY 2014, the EQRO recommended that PHP:

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

In CY 2015, the EQRO recommended that PHP:

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

PHP Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that PHP:

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

In CY 2015, the EQRO recommended that PHP:

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

PHP Approvals (MCO/HSD Contract Section 4.12.10)

In CY 2014, the EQRO recommended that PHP:

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

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

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

In CY 2014, the EQRO recommended that PHP:

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

In CY 2015, the EQRO recommended that PHP:

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

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

In CY 2014, the EQRO recommended that PHP:

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

United Healthcare of New Mexico, Inc.

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

In CY 2015, the EQRO recommended that UHC:

- Update the related policies to include contract required language:

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

UHC Program Integrity (NMAC 8.308.22)

In CY 2014, the EQRO recommended that UHC:

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

In CY 2015, the EQRO recommended that UHC:

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

UHC Care Coordination (MCO/HSD Contract Section 4.4)

In CY 2015, the EQRO recommended that UHC:

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

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

In CY 2014, the EQRO recommended that UHC:

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

In CY 2015, the EQRO recommended that UHC:

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

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

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

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

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

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

UHC Medical Records (MCO/HSD Contract Section 7.16.1)

In CY 2014, the EQRO recommended that UHC:

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

In CY 2015, the EQRO recommended that UHC:

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

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

In CY 2014, the EQRO recommended that UHC:

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

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

In CY 2015, the EQRO recommended that UHC:

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

UHC ISCA (CMS EQRO Protocol 5)

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

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

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

1.4. HSD Monitoring Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

PM Rates

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

Table 5: BCBS PM Rates and Historical Comparisons

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

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

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

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

Table 6: MHP PM Rates and Historical Comparisons

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

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

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

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

Table 7: PHP PM Rates and Historical Comparison

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

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

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

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

Table 8: UHC PM Rates and Historical Comparisons

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

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

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

2.2. PMP and PIP Recommendations

Blue Cross and Blue Shield of New Mexico

BCBS PMP Recommendations

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

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

BCBS PIP Recommendations

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

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

Molina Healthcare of New Mexico

MHP PIP Recommendations

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

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

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

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

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

Presbyterian Health Plan, Inc.

PHP PIP Recommendations

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

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

United Healthcare of New Mexico, Inc.

UHC PIP Recommendations

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

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

2.3 HSD PM and PIP Initiatives for CY 2016

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

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

3.0 Encounter Data Validation

3.1. Encounter Data Validation Executive Summary

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

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

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

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

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

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

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

3.2. Recommendations

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

HSD might consider:

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

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

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

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

4.0 Independent Assessment

4.1. Introduction

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

HealthInsight New Mexico conducted the review according to the following:

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

4.2. Purpose

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

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

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

4.3. Independent Assessment Access Findings Summary

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

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

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

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

Quality Findings

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

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

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

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

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

Cost-effectiveness Findings

The overall financial status was evaluated by considering the following:

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

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

Overall Findings

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

Overall Summary of Findings and Conclusions

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

4.4. Independent Assessment Recommendations

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

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

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

5.0 Glossary

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

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

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

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

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